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Supervisory alliance and countertransference disclosure of psychology doctoral students

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SUPERVISORY ALLIANCE AND COUNTERTRANSFERENCE DISCLOSURE OF PSYCHOLOGY DOCTORAL STUDENTS

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by

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ABSTRACT

Exploration of countertransference reactions is a critical component of effective supervision (Falender & Shafranske, 2004). This study investigated the supervisor-supervisee relationship (working alliance) and its influence on supervisee countertransference disclosures. Three hundred thirty-two doctoral students responded to a recruitment invitation, forwarded by e-mail by their directors of clinical training. Participants completed the Working Alliance Inventory – Supervisee form (WAI-S) (Bahrick, 1990), a demographic questionnaire, and a Personal Reaction Disclosure Questionnaire, which asked about the respondent's comfort and likelihood of disclosing countertransference in 8 commonly reported personal reactions of psychotherapists (Betan, Heim, Conklin, & Westen, 2005). Results indicated that there were positive associations between supervisory alliance and reported comfort and likelihood of supervisee countertransference disclosures ($p = < .05$). Variables such as gender, ethnicity, theoretical orientation match, or supervisee developmental level were not found to have an influence on the likelihood of or comfort with disclosures, suggesting that the strength of the working alliance has the strongest influence on disclosures in supervision.

Introduction

Supervisory Alliance and Countertransference Disclosure of Psychology Doctoral Students

Supervision directly impacts the development of graduate students, who are training to become psychologists (Falender & Shafranske, 2004). Whereas academic coursework in doctoral education leads to acquisition of knowledge or theory about mental disorders and psychological treatment, clinical supervision specifically provides opportunities for trainees to develop their clinical skills, to be exposed to professional culture, and to navigate personal issues that may bear on therapeutic process and outcome, including, for example, the management of countertransference (CT) reactions (Shafranske & Falender, 2008). Supervision provides the means to integrate knowledge, skills and attitudes (Kaslow, 2004), which leads to the acquisition of competencies and in turn are hypothesized to enhance therapeutic outcomes (Stein & Lambert, 1995). As such, clinical supervision with a skilled and experienced supervisor is essential in training psychologists and other mental health professionals. In addition to serving as a major component in training, supervision must balance responsibilities related to patient care and to the profession. Among the competencies that are addressed, supervision plays an important role in the management of countertransference, which has been identified as integral to ethical and effective practice.

Background

Personal factors and reactions have long been recognized as influential in the therapeutic process (Crowder, 1972; Erasmus, 2005; Gelso & Carter, 1994; Hayes, Gelso, & Hummel, 2011). Ethical principles of the American Psychological Association (APA)

(2002) clearly forewarn the likelihood that a psychologist's personal problems and conflicts present barriers to competent practice. Naturally, developing self-awareness is an important skill that is to be refined in supervision. Awareness of personal problems or feelings (which would inhibit a psychologist from performing work related duties adequately) allows the clinician to remediate the difficulty by seeking professional help or consultation (Section 2.06). Thus the ability to recognize and manage countertransference is paramount to competent and ethical practice.

Countertransference reactions were first identified by Freud (1910), who believed that analysts needed to "recognize and overcome" (p. 145) such feelings, since he viewed such reactions to pose an obstacle to objective understanding and proper treatment. The original psychoanalytic view understood countertransference to be the psychotherapist's response to the patient's unconscious transference. Departing somewhat from Freud's perspective, analysts influenced by Klein emphasized that such reactions were products of the patient's mental life, which had been projected into the therapist and were experienced as projective identifications (Shafranske & Falender, 2008). Today, countertransference is seen as a complex phenomenon jointly created by client and therapist, which plays a pervasive role in treatment (Gabbard, 2001). No matter the theoretical perspective, it appears that clients do evoke reactions in psychotherapists, which in turn impact the conduct of treatment.

In addition to clinical theory and case reports, empirical research has been conducted which demonstrates such effects. For example, Betan, Heim, Conklin, and Westen (2005) pooled the knowledge of dozens of clinical observers and identified common latent constructs (i.e., countertransference experiences) that reflect patterns that

individual observers may not have recognized on their own. Significant correlations were found in this study between countertransference patterns and patient personality disorder symptoms, suggesting that countertransference reactions transpire in predictable patterns, providing important diagnostic clues and insights into the way a patient is perceived by others. These findings were consistent among clinicians of diverse theoretical orientations, suggesting that the countertransference reactions were not "artifacts of the clinicians' theoretical preconceptions" (Betan, et al., 2005, p. 896). Further, these patterned responses emerged in treatment regardless of whether the clinician has been trained to attend to countertransference or even believe in it. Other studies have offered support for the proposition that countertransference does in fact impact psychotherapy and its outcomes (Dalenberg, 2004; Erasmus, 2005; Rosenberger & Hayes, 2002).

Over time, increasingly diverse views about the nature and therapeutic value of countertransference emerged both inside and outside psychoanalytic conceptualization (see Appendix A for a review of these viewpoints). A transtheoretical perspective was proposed that regarded countertransference as a phenomenon that results in atypical therapist behavior (Gelso & Hayes, 1998). Regardless of the continuing debate about the nature, inevitability, and value of countertransference, there is consensus that countertransference that is not properly managed is likely to damage the therapeutic process, whereas countertransference that is understood can be helpful in treatment.

This study employed the contemporary view of countertransference as the totality of personal reactions of the therapist towards the patient. These reactions are seen to be the products of the interpersonal interaction between the patient and clinician, including reactions to the patient's conscious or subconscious mental contents, as well as therapist

reactions related to his or her own unresolved conflicts (Anderson, 1992; Gelso & Hayes, 2001).

Implications Associated with Addressing Countertransference

We turn now to brief discussion of some implications related to countertransference management from the points of view of the patient, supervisee, and supervisor.

Implications for the patient. The therapist's awareness of reactions (e.g., intense love to intense hate) toward patients during a session, coupled with the ability to not express or act on the feelings, results in better psychotherapy outcome (Erasmus, 2005). Being aware of countertransference, which also includes knowing how to differentiate countertransference feelings from feelings that are based in reality, are viewed as important to therapeutic outcome.

Further, leaving countertransference unchecked can produce difficulties and strains in therapeutic relationships and in some situations may result serious ethical violations. For example, nearly 90% of therapists report having been sexually attracted to their clients, at least on occasion (Pope, Keith-Spiegel, & Tabachnick, 1986). If such reactions are not appropriated managed, unethical behavior may occur, posing risks to the patient as well as legal liability. Over half of the therapists surveyed reported feeling confused, guilty, or anxious about such attraction; reported not receiving any guidance or training on this issue, and that the attraction remained undisclosed to their supervisors (Pope et al., 1986). Although sexualized countertransference has received much attention, the following other types of reactions can also play a significant role in the therapeutic milieu: feeling overwhelmed, disorganized, helpless, inadequate, positive,

special, overinvolved, disengaged, parental, protective, criticized, or mistreated (Betan, et al., 2005). In addition, Cutler's classic study found that when patient material touched on a therapist's unresolved issues, the supervisor found the therapist's intervention to be inadequate (Cutler, 1958, as cited by Gelso & Hayes, 2001). It is therefore important that countertransference be addressed in clinical training.

Management of countertransference, when a student is in training, requires the supervisee to bring such reactions into meaningful discussion in supervision and requires the supervisor to facilitate the development of a supervisory relationship that is safe and offers an effective forum for the discussion of personal reactions affecting the therapeutic process. Thus, part of the effectiveness of clinical training relies on the student's likelihood of CT disclosure and their level of comfort in discussing countertransference in supervision. Such comfort is likely related to a number of features of the supervisory relationship. Features of the supervisory relationship, including the alliance, are believed to play an important role in the level of comfort a supervisee is likely to experience in disclosing countertransference reactions.

Implications for the supervisee. Countertransference reactions may affect the supervisee and his or her ability to effectively conduct psychotherapy. Certain types of therapeutic interactions appear in relation to patterns of negative and positive countertransference, which affect the therapeutic process and treatment outcome. For example, beginning therapists often experience a personal feeling of lack of clinical mastery. This feeling may inadvertently be transferred onto the patient, if not adequately addressed in supervision. The novice therapists' countertransference in particular may be principally determined by how self-efficacious they feel during the session, which in part

is determined by the clients' reactions (Tobin, 2006). Further, research has shown the more a client talks about issues related to the therapist's personal conflicts, the less the therapist perceived herself/himself to be socially attractive (friendly, supportive, warm, flexible), trustworthy, and an expert, even if she/he was aware of the personal conflict (Rosenberger & Hayes, 2002). If left unchecked, these communications and consequent feelings of ineffectiveness could result in poor treatment outcomes. Treating difficult patients (e.g., patients diagnosed with personality disorders) places beginning clinicians at particular risk of experiencing acute countertransference reactions, which may in turn lead to poor outcomes, including premature termination.

Clinical supervision is the trainee's opportunity to work with an experienced supervisor to decipher how much of the problems encountered in therapy are results of countertransference or are symptomatic of the patient's psychological difficulties, associated with the patient's diagnosis. In fact such therapist reactions may in themselves provide important diagnostic information that could help guide the treatment (Brody, 1990; Schwartz, Smith, & Chopko, 2007). Brody (1990) has suggested that the features of patient personality as well as diagnostic profile, may affect clinician reactions, which in turn influence the therapeutic process. For example, beginning therapists may be prone to identify with patients who feel self-doubt (via the mechanism of projective identification); these are often patients who employ primitive defenses to protect themselves from guilt (i.e., patients with narcissistic, borderline, and antisocial features) (Goodman, 2005), which lead to difficulties in their ability to participate in treatment. The unique features of patients may prompt a specific countertransference reaction. For example, depressed patients may elicit positive feelings of compassion and patients with

borderline traits may arouse more negative feelings in the therapist such as boredom, anxiety, and anger. Therapists often have strong feelings of being dominated and manipulated by patients with antisocial personality disorder (Schwartz et al., 2007). Patients with schizophrenia may induce a mix of positive and negative feelings, ranging from compassion and concern to fear. Countertransference reactions to patients with schizophrenia can include everything from an urge to want to refer the patient elsewhere, to thinking about the patient outside of sessions (Brody, 1990), to feeling well-liked, welcomed, and put in a decision-making role (Schwartz et al., 2007).

The pressure of countertransference may make beginning therapists feel enticed to inappropriately self-disclose or to withdraw from the patient, rather than to cultivate an understanding of the processes influencing the therapeutic process, including the patient's transference feelings (Davis, 2002). This is consistent with the observation that countertransference behavior is commonly manifested by either being over-involved or under-involved. Multiple case studies found that independent judges could readily observe counselor over-involvement and under-involvement, and that these behaviors were interpretable as valid indicators of countertransference (De Vita, 2002). By disclosing or withdrawing, the therapist may hide from the intensity of the relationship behind a cover of openness or anonymity.

Empirical research by Betan et al. (2005) yielded the eight specific clinically and conceptually coherent types of countertransference, independent of clinician theoretical orientation: (a) overwhelmed/disorganized, (b) helpless/inadequate, (c) positive, (d) special/overinvolved, (e) sexualized, (f) disengaged, (g) parental/protective, and (h) mistreated/criticized. Overwhelmed/disorganized reactions refer to clinician desire to

avoid of flee either the patient or strong negative feelings (i.e., dread, repulsion, resentment). These reactions were found aligned with clinical descriptions of reactions with narcissistic and borderline patients, those disorganized or unresolved attachment patterns. Helpless/inadequate countertransference refers to feelings of incompetence, helplessness, inadequacy, and concomitant anxiety. Positive countertransference is marked by experiencing a positive working alliance and close emotional connection with the patient. Special/overinvolved clinician feelings include a sense that the patient is "special" compared to others, and is marked by indications of problems with maintaining boundaries (i.e. self-disclosure, ending sessions on time, and feeling guilty, too responsible, or too concerned about the patient). Sexualized countertransference refers to having sexual feelings towards a patient or experiences of sexual tension. Disengaged includes feelings of distraction, withdrawal, annoyance, or boredom on the therapist's part. Parental/protective countertransference is identified by a wish to protect/nurture the patient in a parental way that is above and beyond typical positive feelings toward a patient. Criticized/mistreated countertransference is the result of feeling unappreciated, dismissed, or devalued by the patient. In light of the significant influence that countertransference can have on the therapist and the conduct of treatment, it is important that therapists in training develop familiarity with and skill in managing their personal reactions (Shafranske & Falender, 2008).

Implications for the supervisor. Identifying countertransference is an important aspect of supervision, as understanding is necessary to avoid tainting the supervisor's perception of the patient and assisting the supervisee to understand the dynamics that are influencing their behavior. To illustrate, when a trainee brings material into supervision,

the supervisor receives an image of the patient colored by the student's countertransference. Further misunderstanding can occur as the supervisor's own countertransference reactions may influence perception and understanding (Fink, 2007). Supervisors must therefore be mindful and attuned to their own reactions as well as to those of their supervisees. In addition to hearing verbal reports of psychotherapy process and therapist reactions, the review of videotapes play an important role in identifying behaviors that may suggest the influence of countertransference. Throughout the supervisory process, supervisors must also be aware of their own reactions as such reactions can be effectively used to assist in the identification of supervisee countertransference reactions and may lead to discussion of the trainee's countertransference. For example, Williams, Judge, Hill, and Hoffman, (1997) found that supervisor disclosure of countertransference actually increased trainees' discussion, understanding, and use of their own countertransference responses. In sum, attention to countertransference has important implications for patients, supervisees and supervisors.

Effective Supervision

Given the importance of clinical supervision, many have studied it to learn what makes this experience the most effective. Among the qualities that improve supervision effectiveness is the nature of the relationship between supervisor and supervisee. A review of empirical literature by Ellis and Ladany (1997) concluded that alliance is vital to successful supervision. Both parties will be more satisfied with the supervision if the alliance includes a strong emotional bond, respect, and mutual trust (Ladany & Friedlander, 1995). As in therapy, basic empathy is a foundational feature of all productive supervisory relationships. Bordin (1983) solidified the construct of

supervisory alliance by drawing from the therapeutic alliance between patient and therapist, and conceptualized the supervisory alliance as a process of forming bonds and goals (see Appendix B for a review of the working alliance literature).

Although the theoretical literature supports the premise that the working alliance in clinical supervision is essential for successful learning (Efstation, Patton, & Kardash, 1990; Goodyear & Benard, 1998; Ladany, Ellis & Friedlander, 1999; Patton & Kivlinghan, 1997), there are relatively few empirical studies examining the role and function of working alliance. It is posited that strong alliance, which includes trust and mutual respect, leads to greater satisfaction for both the supervisor and supervisee (Ladany & Friedlander, 1995) and supervisees with strong alliance with their supervisors are more likely to follow an agreed upon treatment plan (Goodyear & Bernard, 1998), and comply with ethical standards (Ladany, Lehman-Waterman, Molinaro, & Wolgast, 1999).

Supervisees were less satisfied with their supervision experience when they reported they could not disclose information because of a negative relationship with the supervisor, they felt their supervisor was incompetent, or they feared a negative evaluation from their supervisor (Ladany, Hill, Corbett, & Nutt, 1996). One of the most frequently stated reasons for nondisclosure was a poor working alliance with the supervisor (Ladany et al., 1996). The majority of supervisees report being aware of passively withholding information that ranges in importance from their supervisors (Ladany, et al., 1996). Twenty-two percent of supervisees reported that they did not disclose over-identification with the patient or the patient's issues, i.e., countertransference. Thus, supervision is ideally facilitated within the context of a strong

working alliance by a supportive and non-critical supervisor who possesses personal characteristics such as empathy, flexibility, openness, and respect and concern for as well as investment in their supervisees (Carifio & Hess, 1987; Ladany et al., 1996).

Earlier research on working alliance suggests that alliance influences the therapist's skills as a mental health professional (Bordin, 1983). Imperative to these skills is the capacity to analyze personal factors impacting treatment (Shafranske & Falender, 2008). Essentially, a strong alliance would provide a safe environment for trainees to candidly explore roadblocks to treatment, and a weak alliance has been found to be the cause of non-disclosure of important matters that could lead to poor treatment outcomes, ethical violations, and countertransference behaviors (Ladany et al., 1996). To further test this proposition, Daniel (2008) investigated the impact of the supervisory alliance on the likelihood of intern countertransference disclosure in clinical supervision and self-reported comfort in making such disclosures. One hundred and seventy-five participants completed the Working Alliance Inventory-Supervisee (WAI-S) version (Bahrick, 1990), the Personal Reaction Disclosure Questionnaire, and a demographics questionnaire. The findings revealed positive associations between working alliance in supervision and the likelihood of countertransference disclosures to supervisors, as well as in the level of comfort supervisees have in making such disclosures. Supervisees also rated themselves as being more likely to disclose countertransference reactions, even if they did not feel comfortable doing so, provided that the working alliance is strong. It was found that strength of the working alliance has the greatest influence on likelihood of or comfort with disclosures in supervision, regardless of supervisee-supervisor similarity on gender, ethnicity, or theoretical orientation.

Supervisor countertransference and alliance. The supervisee's ability to use supervision to develop competence in managing countertransference may be compromised by poorly managed reactions of supervisors. A supervisor's feelings about a trainee, including countertransference reactions, may also affect the supervisory alliance. Most supervisors acknowledge that they had inadequate training in addressing issues of supervisor countertransference towards trainees and may experience challenges in effectively addressing personal styles and unresolved issues (Ladany, Constantine, Miller, Muse-Burke, & Erickson, 2000). Most supervisors who consulted with colleagues to manage their reactions toward a trainee believed that their countertransference towards a trainee initially weakened their supervisory relationship, but later, following consultation, strengthened the relationship (Ladany et al., 2000).

In contrast to earlier models that endorsed either a purely countertransference-centered supervision or supervision that focuses solely on the patient's presentation, Zaslavsky, Nunes and Eizirik (2005) advocate for a logical approach to supervision, where the supervisor combines material from the patient's presentation and integrates it with the therapist's reactions (assuming that the therapist is actually disclosing those reactions). Thus, the effectiveness of supervision relies on the trainee's willingness to use supervision time to actively inform the supervisor. Clinical supervisors are cautioned to be aware of the supervisee's countertransference in order to be able to consider and reject hypotheses about the patient in the context of what he/she understands of the supervisee's characteristics (Astor, 2000).

Countertransference management. Taking into consideration APA Ethics (American Psychological Association, 2002), the extensive clinical literature, and

findings from recent empirical research, it is clearly evident that countertransference (however conceptualized) requires clinicians to develop competence in its management. The development of awareness of countertransference reactions and skill at addressing those personal reactions in a clinically effective manner begins in clinical supervision.

Several aspects of supervision influence the development of competence in effective countertransference management. Gelso and Hayes (2001) present five interrelated areas of clinical competence that therapists need to build and draw on to manage countertransference. While they appear to be basic areas of proficiency for all therapists, Gelso and Hayes argue that these skills are essential in working successfully with countertransference. These fundamental skills are self-insight (therapist awareness of his or her feelings and understanding the basis of these feelings), self-integration (therapist has an intact, healthy character structure so he or she is able to differentiate self from other to maintain ego boundaries), anxiety management (therapist experiences the anxiety while controlling the intensity so it does not color his or her response toward the patient), empathy (therapist appreciates and somewhat identifies with another's emotional experience that allows him or her to focus on the patient's needs rather than his or her own needs), and conceptualization ability (therapist applies theory to understand the patient's dynamics in regards to the therapeutic relationship). These core areas of competence rely on each other in helping a beginning therapist manage personal reactions. Self-insight is a logical prerequisite to the self-integration that allows the therapist to have healthy ego boundaries to keep the self separate from the patient while empathizing with high levels of distress. Although graduate education emphasizes the

development of a theoretical foundation, clinical training is the primary mode of learning the skills associated with the profession.

Clinical supervision provides the means to enhance a trainee's competence in conducting psychotherapy, while preventing therapeutic oversights. An essential part of clinical competence is the development of awareness of personal factors that contribute to countertransference reactions. A seminal article by Fouad et al. (2009), delineates competency benchmarks at the levels of practicum, internship and professional practice. One of the essential components the foundational competency of professionalism is integrity-honesty, personal responsibility and adherence to professional values. A behavioral anchor of this benchmark at the intern level is the "ability to share, discuss and address failures and lapses in adherence to professional values with supervisors/faculty as appropriate" (p. S9). Clinical supervisors facilitate this process by setting clear expectations, modeling reflection-in-action, and incorporating both theoretical and empirical knowledge into skills and values, i.e., self-awareness and integrity (Shafranske & Falender, 2008). It is up to the clinical supervisor to encourage and support the trainee, as eager and novice therapists may be unsure of their abilities and may occasionally feel personally exposed (Davis, 2002). As such, it is clear that in order for supervision to be effective, the supervisee must feel comfortable disclosing to the clinical supervisor who evaluates closely watches his or her failures, struggles, and successes.

Although a lack of knowledge can be addressed in coursework, problems with basic interpersonal skills, unresolved psychological issues, reactions elicited from working with difficult patients, rigidity, and prejudice are challenges that are best worked through in supervision, and require an established working alliance and trust between

supervisor and supervisee (Shafranske & Falender, 2008). Supervision provides a place to appreciate the supervisee's personal characteristics that inform his or her reactions to and clinical understanding of patients. The supervisor serves as a guide in the necessary activity of helping the supervisee become aware of countertransference in therapy. Supervisees must inform their supervisors of countertransference feelings in order for the supervisors to normalize and receive objective information about countertransference, and receive guidance on how to effectively respond to it (Schwartz et al., 2007). Discussing countertransference can also help the therapist determine if the reaction is client-induced or idiosyncratic.

Supervision provides the opportunity to process personal reactions that are stimulated by the patient. Supervisors typically address countertransference when it seems to present an obstruction to clinical progress (Tuttle, 2000). By routinely examining the therapist's reactions to patients, the supervisor is available to foresee and avert mishandling the patient's therapeutic needs, as well as support the supervisee's efforts to create a helpful therapeutic experience for the patient. In their discussion of personal processes that occur during supervision, Shafranske and Falender (2008) identify two types of countertransference. Objective countertransference is defined as the therapist's patient-induced reactions arising from the patient's maladaptive perceptions, affects, and behaviors; these reactions are consistent with the responses of significant others in the patient's life. This type of countertransference allows the therapist to better understand how people in the person's life relate to him/her, can increase the therapist's empathy for the patient, and increase the likelihood that the therapist will be able to manage feelings elicited by the patient's personal characteristics. In contrast, subjective

countertransference is uncharacteristic, and is at times a function of the therapist's maladaptive reactions arising from his/her own personal factors.

Students and interns are more likely than licensed practitioners to view their emotional reactions to patients as too strong, too frequent, potentially detrimental to treatment, and something to be defended against (Brody, 1990). However, countertransference is instrumental in helping therapists reach a more direct and complete understanding of patient's transference issues and dynamics (Dubé & Normandin, 2007). By viewing countertransference as a valuable tool, the therapist is able to draw upon it to understand the client and increase empathy. In light of the important clinical material revealed in countertransference, and conversely, its potential to harm the patient's therapy, managing countertransference is an ethical responsibility shared by the supervisor and supervisee. Developing competence in addressing countertransference is an important task of supervision. Other resources can also be meaningfully employed to assist the trainee to enhance their awareness of personal factors and countertransference. For example, personal therapy has also been found to be effective in countertransference management when client issues trigger idiosyncratic responses from the clinician (Deutsch, 1985; Duthiers, 2005). Therapists reported that personal therapy almost always positively influenced their clinical work in terms of increased personal awareness, greater empathy, and greater awareness and appreciation of transference and countertransference processes (Duthiers, 2005).

As discussed, the ability to recognize and to management countertransference reactions is an important competence. Clinical supervision provides the primary means for the development of this competence. Further, theory and the findings of preliminary

research suggest that the quality of the supervisory relationship and the strength of the alliance impact the likelihood that countertransference will be addressed in supervision. In light of this review, it is clear that more is needed to be known about factors that affect consideration of countertransference in supervision.

Purpose and Importance of the Study

While there is consensus regarding the importance of addressing countertransference in supervision, there is little research investigating the factors that contribute to effective supervision in respect to countertransference management. To better understand the factors that influence countertransference disclosure, this study proposes to replicate and build upon Daniel's (2008) dissertation research in which she examined the relationship of working alliance to countertransference disclosure in psychology doctoral interns. The current study addressed limitations of previous research. Although the number of respondents in the previous study was higher than most studies of interns, a larger participant pool was important to insure a more representative sample. Also, this research expanded the population that was studied – from interns to clinical and counseling psychology doctoral students at all levels of training – practicum through internship. This provided a way to study the possible impacts of developmental level on countertransference disclosure. Additionally, Daniel's study recruited participants through internship training sites, whereas this study recruited through students' academic directors of clinical training (DCTs) who had less direct involvement with students' training sites and supervision. One of the limitations in Daniel's study was the fact that interns were recruited with the cooperation of directors of clinical training institutions and, although the interns were not being asked to report on their experiences

of their internship supervisors, directors may have been reluctant to forward the recruitment materials. That potential limitation was eliminated in this study, since recruitment was directed to the academic DCTs.

Specific content areas that stimulate countertransference were examined based on Daniel's research method. This study also investigated how specific content areas that have been identified as precipitating countertransference influence disclosure of such feelings. Characteristics such as age, gender, ethnicity, theoretical orientation, and similarity/dissimilarity between supervisor and supervisee were examined in regards to their influence on disclosure.

In addition to studying the relationship between supervisory alliance and comfort and likelihood of supervisee countertransference disclosure, as previously mentioned, this investigation included an examination of the role of developmental level on countertransference comfort and disclosure. Consideration of developmental level drew upon the model of supervisee development as proposed by Stoltenberg and Delworth (1987). According to their Integrated Developmental Model of Supervision (IDM) there are four stages of supervisee development, (IDM Levels 1, 2, 3, and 3*i*), and it is predicted that a trainee's autonomy increases with experience. This model has been used to assess trainee experience and development in many studies since it was introduced; however, it has not been empirically employed in respect to supervisee countertransference disclosure. The expanded participant pool allowed for an initial examination of the impact of developmental level on countertransference disclosure.

Research Hypotheses and Questions

The following research hypotheses were tested:

1. There is a positive association between supervisory alliance and reported comfort in supervisee countertransference disclosure.
2. There is a positive association between supervisory alliance and reported likelihood of supervisee countertransference disclosure.

In addition to the research hypothesis, the following relationships were explored:

1. What topics or content areas are students most comfortable disclosing? What topics or content areas are students most likely to disclose?
2. Do specific demographic characteristics (i.e., gender, ethnicity, theoretical orientation, demographic similarity between supervisor and supervisee) influence countertransference disclosure?
3. Does the number of years of supervised experience in psychotherapy a supervisee has received influence reported comfort in countertransference disclosure?
4. Does the number of years of supervised experience in psychotherapy a supervisee has had influence his or her reported likelihood of countertransference disclosure?

Method

Research Approach and Design

This study involved a replication and expansion of a previous study of the effects of the supervisory alliance on self-reported comfort and likelihood of countertransference disclosure in supervision by doctoral psychology students. Replication studies provide an opportunity to improve on the current research, use a higher number of study participants, increase reliability, and improve upon study instruments, thus making them vital in scientific research. Replicating a study with such improvements enhances knowledge about how robust the observed effects truly are (Thomas & Hersen, 2003). If indeed the effects of working alliance on countertransference disclosure among interns are large enough, they will be reproduced in replication studies.

This replication of Daniel's (2008) previous research tested the same hypothesis, while taking into consideration the additional variable of developmental level, which was operationalized as the number of years of clinical supervision in psychotherapy the doctoral student or intern has received. The previous study investigated the experiences of interns (related to their last practicum experience), findings were limited to that point in time and could not investigate the role of supervisee developmental level. By examining a broader population, this study also examined the impact of supervisee developmental level. Additionally, this study examined the current supervisory relationship, creating a data set more likely to reflective of experiences that are fresh in the minds of participants.

A survey approach was used to obtain self-report data of supervisees. An online survey was chosen because it was at once the most economical option to sample a large

population and was also be designed to protect confidentiality and anonymity. Completing the survey online was a faster, more convenient, and natural procedure for current doctoral practicum students, a generation comfortable with use of the Internet. This design allowed participants to complete the measures at their own convenience and provided anonymity, which in part reduced risk for social desirability and presumably enhanced honest reporting.

Participants

Participants eligible for the study were students enrolled in APA-accredited clinical or counseling doctoral programs. Inclusion criteria included participation in clinical practicum/clinical training between September 2010 and August 2011. Three hundred ninety two doctoral students participated in this study. Sixty were excluded due to missing data, resulting in a final sample of 332.

General characteristics of participants. Demographic characteristics of the 332 participants are displayed in Table 1. Demographics related to the participants' training sites and experiences are displayed in Table 2. Table 3 displays supervisors' demographic information.

Instrumentation

The survey instruments employed in the Daniel (2008) study were used to collect anonymous information for the purposes of this study (as per the requirements of a replication study). The survey was compiled of three parts: participant demographic questionnaire, the Working Alliance Inventory-Supervisee Form (WAI-S), and the Personal Reaction Disclosure Questionnaire (see Appendices A and B). The

demographic questionnaire was modified to include an item assessing developmental level.

Working Alliance Inventory-Supervisee Form. The Working Alliance Inventory-Supervisee Form (Bahrick, 1990) was modeled after Horvath and Greenberg's Working Alliance Inventory (1989). The WAI-S is a 36-item questionnaire and employs a 7-point Likert scale. The three components of the alliance (goals, task, and bond) are each assigned 12 items. Although the WAI is used to appraise therapeutic alliance between therapist and the patient, Bahrick adapted it in 1990 to evaluate alliance between supervisor and supervisee. Permission to use this instrument was granted by Audrey Bahrick (Appendix E).

While face validity for the WAI-S has been established, there have not been auxiliary tests of its psychometric properties. Previously reported inter-rater reliability was established with a 97.6% agreement on items assessing the bond component of the alliance, 60% agreement on items assessing the bond component, and 64% agreement on items assessing the task component (Bahrick, 1990). Subscales of the WAI are meaningful by finding the mean of the task, bond, and goal subscales. Internal consistency estimates for the Working Alliance Inventory in previous studies have exceeded .92 for all scales (Ladany & Friedlander, 1995; Ladany, Ellis, et al., 1999; Lehrman-Waterman & Ladany, 2001). Reliability of the WAI for this sample was found to be = .96, = .73 for task, = .90 for bond, and = .94 for goal, indicating very strong reliability overall, and for the bond and goal subscales.

Countertransference Reaction Disclosure Questionnaire. This instrument was developed by Daniel to determine how likely a supervisee is to disclose

countertransference feelings and behaviors to their supervisor in a number of hypothetical countertransference situations. Use of this measure holds constant the countertransference stimuli, and limits the intensity of personal reactions related to actual real-life scenarios. Using such a hypothetical limits the amount of variability that would arise as a result of trainees being directed to reflect on their own experiences.

Eight hypothetical scenarios are presented, and the participant is asked to rate their likelihood of disclosing countertransference reactions using a 7-point Likert scale ranging from 1 (not at all likely) to 7 (would definitely disclose), totaling a possibility of 56 points (56 points would indicate high disposition to disclosure) and, in like manner, to rate their level of comfort in disclosing countertransference reactions.

Demographic questionnaire. Items on the demographics instrument developed by Daniels are based on demographic categories listed by the Association of Psychology Postdoctoral and Internship Centers (APPIC) in 2007 (http://appic.org/directory/appendices/2006-2007_AppendicesAB.pdf). The demographic questionnaire will include one modification in which developmental level with be assessed.

Research Procedures

The following sections present the recruitment process, human subjects protections, and survey administration.

Participant recruitment. The investigator contacted directors of clinical training at all APA-accredited doctoral programs in clinical, counseling or professional-scientific psychology located in the United States by e-mail. The investigator obtained a list of all APA accredited programs from a publically accessible list found on www.apa.org.

Names and e-mails of training directors were obtained through inspection of program websites. Many names and e-mails were obtained from a list posted on the Council of University Directors of Clinical Psychology website (http://cudcp.us/). If contact information for the director of clinical training was unavailable, the recruitment letter was sent to the institution's program director. The e-mail consisted of a letter of introduction, describing the study and soliciting their cooperation in forwarding the recruitment e-mail to doctoral students in their programs. The contents of the recruitment statement to potential participants and link to the study website (Appendix H) were provided. This is the only method by which to contact all current doctoral students in clinical and counseling psychology, and has the potential of reaching all students enrolled in clinical training, from practicum through pre-doctoral internship. Participant recruitment was conducted from April 18, 2011 through May 16, 2011.

Ideal sample size to achieve adequate confidence was determined by the use of an accepted statistical procedure. There are 285 clinical, counseling, and combined psychology APA accredited programs (American Psychological Association, 2010) and approximately 19,039 students currently enrolled in these programs (American Psychological Association, 2002). To obtain information accurate at a 95% confidence level with a confidence interval of 6, a sample of at least 263 participants was required (Creative Research Systems, n.d; Kazdin, 2003).

A letter of introduction and request for participation was e-mailed to all directors of training of the 285 APA accredited programs, describing the nature of the study. Directors of clinical training were informed of the purpose of the study and invited to forward the survey to students. Training directors were not informed if their students

completed the survey or not, thereby assuring anonymity. Participants found a link to the study website. Measures were administered online, and participant's e-mail addresses were not provided to the researcher, protecting anonymity. A follow-up e-mail to training directors was sent 2 weeks after the initial request as a reminder.

Participants were asked if they desire to receive a summary of the results when the study is completed and to send an e-mail to the investigator to make this request. In addition, to express gratitude to the participants for their participation, all participants (regardless of their completion of the study) were given an opportunity to enter into a drawing to win one of two $50 gift certificates. A separate e-mail address was created for the purpose of this drawing.

Human subjects protection. Before beginning the recruitment and data collection processes, an application to the Institutional Review Board of Pepperdine University was submitted for approval. Approval made certain that the study follows the guidelines of the Belmont Report, U.S. Code of Regulations, DHHS (CFR) Title 45, Part 46: Entitled Protection of Human Subjects, and Parts 160 and 164: Standards for Privacy if Individually Identifiable Health Information and the California Protection of Human Subjects in Medical Experimentation Act (http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm). This study underwent expedited IRB review, as there was little possibility that the hypothetical scenarios would result in unmanageable discomfort in the participants since the questions were not based on the participant's personal experience. An important facet of psychology doctoral programs is training students to develop self-awareness as a way to recognize and manage countertransference reactions. Courses in theories and techniques of

psychotherapy as well as professional ethics likely included discussions of managing personal reactions, e.g., countertransference similar to the hypothetical scenarios presented in this study.

Consent for participation. Because the only contact with the pool of participants was through e-mail recruitment and online survey administration, the investigator was granted a waiver or alteration of informed consent to eliminate the requirement to have written consent from each participant. A waiver of documentation of consent has been requested to allow for implied consent from Directors of Clinical Training, meaning that directors demonstrate implied consent as a representative of the institution by forwarding the materials, as was stated in the recruitment letter. This is a commonly used procedure in research aimed at psychology trainees and interns, since mailing lists of psychology interns and trainees are not available. Requiring the Directors of Clinical Training to confirm their willingness to cooperate in the recruitment of potential subjects (by forwarding the recruitment e-mail) is not only burdensome and inconsistent with commonly used practices of recruitment of graduate students, it also eliminates one level of anonymity in respect to potential participants.

Potential participants were informed of the study's purpose and intent, the potential risks and benefits, and the procedures on the website that contains the study instruments. At the beginning of the survey, the consent information was presented and the participants were asked to check an item, indicating that they have read the consent information and that their participation provides consent. By checking the consent item, the participant confirms that she or he understands the nature, risks, and benefits of the

study, their rights to confidentiality, steps being taken to ensure confidentiality, and their right to refuse to participate or withdraw participation at any point.

Potential benefits and risks. While there is no direct benefit of participation, participants may derive satisfaction from knowing that they are contributing to the science of psychology and clinical supervision. They may also benefit from having the opportunity to reflect on countertransference disclosure and the supervisory alliance. Whether or not the survey was completed, participants had additional an opportunity to enter a drawing for one of two $50 gift certificates.

All possible attempts were made to reduce the possibility of risk as a result of participation. There is the potential for participants to be reminded of negative supervisory experiences, which may change their current participation in supervision, or the supervision experience. It is believed that the Working Alliance Inventory will not present discomfort or harm, as participants will be involved in individual supervision and will be discussing alliance and evaluation with their supervisors. In fact, evaluation and discussion of supervision is listed as a Benchmark in psychology (Fouad et al., 2009) as well as criteria for APA training site accreditation (http://www.apa.org/ed/accreditation/guiding-principles.pdf, see section III, C, domain E).

Although there was some possibility that a participant will feel some discomfort, the discussion of countertransference reactions is an integral aspect of supervision, and participants would likely disclose countertransference reactions during the course of their training. The hypothetical scenarios were presented in a very general manner, and were

based on previous research that has identified common reactions that occur frequently in psychotherapists (Betan et al., 2005).

However, the potential for minimal risk remained. It was possible that some participants might have had a strong emotional reaction to the material presented. To properly manage these feelings, participants were instructed to discuss their reactions with their supervisor or another clinician at their site, or contact their school's director of clinical training, or another faculty member they feel comfortable with. They also had the opportunity to consult with two experts on supervision to provide support and to address and potential negative impacts. If necessary, the researcher or the advisor of this study, Edward Shafranske, Ph.D., ABPP, would contact the participant's local psychological association to locate an appropriate psychotherapy referral. No contacts were made with the investigator, advisor, or the available experts.

Data Analysis

Data collection and recording. The researcher contacted academic clinical training directors and asked them to forward the request for participation e-mail to their students currently in clinical training in their doctoral program, including students in their internships. Directors were not informed whether or not their students choose to participate. Opening up the survey to a broad population of psychology trainees brings about the potential for sampling bias. It was possible that participants were self-selecting and may over-represent students with polarized views of their supervisory alliance.

The survey website did not collect participant e-mail addresses, therefore, the data was collected anonymously. The survey website automatically entered participant data into an SPSS compatible spreadsheet. To protect confidentiality, all files will be stored on

the researcher's computer in a password-protected file. After five years, all data will be destroyed.

Data analysis and description of study variables. Descriptive statistics, MANOVA, t-test, and Kruskal-Wallis one-way ANOVA by ranks were used to analyze the data. Descriptive data analysis illustrates the distribution of demographic variables, providing information about the sample without identifying any participant individually. Because the data had normal distribution (similar to the investigation it was replicating), MANOVA was used to examine the research hypotheses, thus inspecting the way that the independent variables (alliance) influences patterns of response in the dependent variables (disclosure). T-tests were used to examine results on the measures with regards to demographic differences. Kruskal-Wallis one-way ANOVA by ranks were used to gather information related to the exploratory questions, and evaluate significance of the relationship between participant and supervisor variables, and scores on the measures. For variables with non-normal distribution and are not significant within MANOVA analysis, a Kruskal-Wallis analysis may be used (see Tables 4 and 5 for statistical analyses and description of study variables).

Definitions. Many terms that appear in this text have different meanings depending on theory or context. The following is a brief description of the key terms and their definitions for the purpose of this study.

Countertransference refers to the totality of personal reactions of the therapist towards the patient. These reactions include the products of the interpersonal interaction between the patient and clinician, reactions to the patient's conscious or subconscious

mental contents, as well as therapist reactions related to his or her own unresolved conflicts.

Trainees' *developmental level* refers to stages of supervisee development wherein the trainee's autonomy increases with experience. For the purpose of this study, the developmental level is operationalized as number of years of supervised experience in psychotherapy. Assessment supervision is not included in this definition because it is less likely to include consideration of countertransference.

The terms *supervisory alliance* and *working alliance*, refer to the relationship between supervisor and supervisee. The nature of this relationship may be positive or negative and depends on the presence and quality of mutually agreed upon tasks, goals, and an emotional bond. For example, a high quality supervisory alliance includes the freedom to share negative emotional responses, and the ability to mindfully and critically engage in analysis of relational patterns (Horvath, 2006). The building of this alliance is at the root of the change and learning processes.

Results

Research Hypotheses

As a first step in data analysis, the distribution of the WAI-S variable was examined.It was determined that there was a positive skew in the WAI-S as a majority of trainees report adequate or above rapport with their supervisors. The results should be interpreted with caution as they apply to generally positive supervisory alliances. Nonetheless, the skew and kurtosis of the distributions indicated an adequate distribution which supported the statistical analysis conducted for this study.

The first research hypothesis suggested that there is a positive association between supervisory alliance and reported comfort in supervisee countertransference disclosures. Results supported this hypothesis. Correlational analysis revealed that all three WAI subscales were found to be significant and adequate in strength in predicting a trainee's level of comfort in disclosures with Bond being the strongest, followed by Task and Goal, task $r = .50$, bond $r = .56$, goal $r = .44$, $p < 0.01$. Multiple regression analysis was conducted to examine if different components of the working alliance would explain the levels of comfort in disclosing CT reactions. Results with level of comfort as the criterion variable and three components of the working alliance (Task, Bond, Goal) as predictor variables suggest that approximately 33.7% of the variances in supervisees' level of comfort can be explained by the three components of working alliance, $R^2 = 33.7\%$, $F\ (3, 328) = 55.61$, $p = < .001$. Further, stronger alliances in Task and Bond predicted higher levels of comfort in supervisee, $\beta = .42$, $p < .001$, $\eta^2 = (.201)^2 = .04$ and $\beta = .49$, $p < .001$, $\eta^2 = (.335)^2 = .11$. However, stronger alliances in the Goal component

of working alliance predicted lower level of comfort in the supervisees in this study, β = -.33, p = .005, $\eta^2 = (-.156)^2 = .02$.

The second research hypothesis suggested that there is a positive association between working alliance and likelihood of countertransference disclosure. Results supported this hypothesis. Results with likelihood of disclosure as the criterion variable and three components of the working alliance (Task, Bond, Goal) as predictor variables suggest that approximately 35.9% of the variances in supervisees' likelihood to disclose can be explained by the three components of working alliance, R^2 = 35.9%, F (3, 328) = 61.1, p = < .001. Further, stronger alliances in Task and Bond predicted higher levels of supervisee likelihood of disclosure, β = .37, p < .001, $\eta^2 = (.14)^2 = .02$ and β = .51, p < .001, $\eta^2 = (.36)^2 = .13$. However, stronger alliances in the Goal component of working alliance predicted lower level of likelihood to disclose, β = -.19, p = .005, $\eta^2 = (-.09)^2$ = .008. Comfort and likelihood were found to be correlated with each other, r = .73.

Exploratory Questions

MANOVA analyses were conducted to examine if there were significant differences in levels of comfort in disclosing between CT content areas. Results indicated that there were significant differences between different vignettes, Wilks' Lambda = .19, F (7, 318) = 197.60, p < .001 η^2 = .813. Trainees reported their comfort to disclose the 8 content areas in the following order: Positive, Overwhelmed/Disorganized, Mistreated/Criticized, Disengaged, Special/Overinvolved, Parental/Protective, Helpless/Inadequate, and Sexualized, M = 6.07, M = 5.23, M = 5.35, M = 5.17, M = 5.10, M = 4.67, M = 4.67, M = 2.75.

Repeated measures multivariate analyses of variances were conducted to examine if there were significant differences in levels of likelihood in disclosing different content areas. Results indicated that there were significant differences between different vignettes, Wilks' Lambda = .35, F (7, 321) = 90.82, $p < .001$ $\eta^2 = .664$. Trainees reported their likelihood to disclose the 8 content areas in the following order: Mistreated/Criticized, Positive, Overwhelmed/Disorganized, Disengaged, Parental/Protective, Special/Overinvolved, Helpless/Inadequate, Sexualized, $M = 6.10$, $M = 5.82$, $M = 5.62$, $M = 5.52$, $M = 5.37$, $M = 5.08$, $M = 4.95$, $M = 4.01$.

T-tests were used to determine if demographic characteristics and matches in supervisor/supervisee demographics influence countertransference disclosure. Due to a lack of differences in ethnic background of participants, no statistically significant comparisons can be made using ethnicity as a factor. Matches in supervisor/supervisee gender, sexual orientation, or theoretical orientation were not found to have a significant relationship with overall likelihood or comfort in countertransference disclosure.

Although there was not a significant gender difference in levels of comfort in reporting sexualized countertransference, male supervisees in this study reported significantly higher likelihood to disclose sexualized countertransference than their female counterparts, t(325) = -2.04, p = .042, p = .128. Based on the finding that males were more likely to discuss sexualized CT, a post hoc analysis was conducted to further examine if gender pairing in the supervision dyad was a factor in this significant finding. Results from the one-way ANOVA indicated that there were significant differences in the likelihood to report sexualized CT in supervision different based on the gender pairing of

the supervision dyad, $F(3, 322) = 2.93$, $p = .034$, but no differences were found in the level of comfort based on gender pairing.

More specifically, results from the Dunnete T3 post hoc (homogeneity not assumed, Levene's $F(3, 344) = 4.58$, $p = .004$ revealed that, when it is the opposite gender pairing, male supervisees (with female supervisors) are more likely to report sexualized CT than female supervisees (with male supervisors).

There were no significant differences between theoretical orientations for overall comfort and likelihood of disclosure. However, post hoc analyses revealed significant differences in theoretical orientations with regards to comfort and likelihood of disclosing certain themes. Trainees who identified themselves as psychodynamic reported themselves as more likely to disclosed sexualized countertransference than family systems trainees, $M = 1.35$, $SE = .45$. Psychodynamic trainees were more likely to admit feeling disengaged compared to trainees who identified themselves as primarily family systems, $M = -.95$, $SE = .31$ and cognitive-behavioral, $M = -.52$, $SE = .16$.

Results of the Simple Linear Regression analyses, using Levels of Comfort and Likelihood as criterion variables, and years of supervised experiences as predictor variable, suggested that years of supervised experience was not predictive of neither the comfort nor likelihood of CT disclosures in supervisees.

Discussion

This study examined the relationship between supervisory alliance and countertransference disclosures. The research hypotheses were confirmed, as the supervisory alliance was found to positively influence both a trainee's comfort and likelihood of disclosing countertransference reactions, pointing to the importance of studying and building this essential relationship. This is congruent with previous findings that conclude that alliance is an integral part of success and satisfaction in supervision (Ellis & Ladany, 1997; Ladany & Friedlander, 1995).

The results replicated previous findings in research by Daniel (2008). A comparison of findings is summarized in Table 6.

This study replicated previous findings (Daniel, 2008) that demonstrate that stronger alliances result in higher comfort and likelihood of a trainee's countertransference disclosure in supervision. An improvement upon the previous study was that this replication achieved a large and statistically significant sample size, and the results may be generalized to a national population of doctoral trainees. This replication of findings points to the robust nature of the influence of working alliance on countertransference disclosure, this time with a broader and larger population. Samples differed slightly as the previous study had more ethnic diversity and this sample had broader theoretical representation. Additionally, the influence of specific content areas and supervisee developmental level were explored as possible factors in supervisee countertransference disclosure.

There was a positive association between working alliance and comfort in CT disclosure. Being able to feel confident that they are liked and respected by a supervisor

frees the supervisee from worrying about losing respect, being judged harshly, or evaluated poorly. It follows naturally, that when there is a positive relationship, a supervisee feels more comfortable discussing personal reactions than when the relationship is poor. Comfort and likelihood were also found to be correlated with each other, indicating that as a trainee becomes more comfortable disclosing CT, they are also more likely to do so.

There was a positive association between working alliance and likelihood of CT disclosure. While it has already been shown that working alliance is a necessary ingredient of successful supervision (Ellis & Ladany, 1997), this study highlights the importance of using the relationship to help trainees become more likely to disclose CT. Supervisors must be aware of and mindful of supervisee countertransference to prevent it from hindering treatment for which the supervisor is ultimately responsible. As a poor alliance is one of the most frequently cited reasons for non-disclosure (Ladany et al., 1996), it follows that a strong alliance is crucial for creating a safe environment where the student feels secure in disclosing personal reactions towards patients. A weak alliance has been found to be the cause of non-disclosure of important matters that could lead to poor treatment outcomes, ethical violations, and countertransference behaviors (Ladany et al., 1996).

It is important to note that of the three components of working alliance, the bond component is the most highly correlated with comfort and likelihood of disclosure. This parallels the importance of a strong bond in psychotherapy (Bordin, 1983), and points to the significance of cultivating an emotional bond between supervisor and supervisee and creating an environment of mutual respect and not one of judgment or intimidation

(Ladany et al., 1996). The goal component was negatively correlated with comfort and likelihood of CT disclosure. While no literature was found explain this finding, it may be hypothesized a strong focus on therapeutic and professional goals may feel antithetical to success in supervision in the eyes of a trainee who is unaccustomed to CT disclosure in general. Future research would be useful to further clarify the meaning of this finding.

Trainees are most comfortable disclosing positive countertransference. As it has been shown that trainees are careful to not appear incompetent in conversations with supervisors (Goodman, 2005), it follows naturally that the type of countertransference that they are most comfortable to disclose is a positive one, where they feel a liking towards the patient, sessions flow smoothly, and the therapy is effective. Revealing such a countertransference would serve to enhance the supervisor's positive perception of the trainee.

Conversely, trainees reported being most likely to disclose feelings of being mistreated or criticized by the patient, perhaps in an attempt to elicit supervisor help, support, or empathy when faced with a difficult patient. Beginners are also prone to taking on feelings of inadequacy and self-doubt via projective identification when working with patients with primitive defenses (Brody, 1990). This creates a cycle of feelings of inadequacy and possible failures, and such feelings make it difficult for the therapist to be effective. They may feel compelled to disclose such reactions as these feelings can be quite strong, particularly for beginning clinicians who are likely already feeling uncertain about their abilities.

Trainees reported being least likely and least comfortable disclosing their sexualized countertransference. While supervision has the potential to make trainees feel

personally exposed in general (Davis, 2002), trainees are more likely than licensed clinicians to view their emotional reactions to patients as too strong, too frequent, potentially detrimental to treatment, and something to be defended against (Brody, 1990). Most trainees view acting on sexual attraction to a patient as a clear and very serious ethical violation, and may feel uncomfortable and shameful of having these feelings come up at all. Findings of this study suggest that they may want to do away with sexualized feelings even more than other types of countertransference. Although this was true for both genders, males reported being significantly more likely to disclose sexualized countertransference than females. As the sample is representative of trainees (APPIC applicant survey 2011 indicated that 80% of participants were female), this gender difference warranted further exploration. Post hoc analysis revealed that male supervisees were more likely to report their sexualized CT to a female supervisor more than any other gender combination of supervisory dyad.

It has been noted that gender stereotypes may confound the outcome of supervision and it would be naïve for supervisors to believe that trainees are not predisposed to gender biases that are products of a lifetime of socialization (Bernard & Goodyear 2009). Men's and women's supervisory approach is also informed by their socialization, with women socialized to provide sort of "voice of care" (p. 139) which includes concepts such as reciprocal love, listening, and response and men to provide a "voice of justice" (p.139) which centers on equality, reciprocity, and fairness between people (Gilligan, Brown, & Rogers, 1990). Although these roles may not always be at play, the finding that male trainees are more likely to report sexualized CT to a female supervisor may indicate the expectation of love and understanding.

Wester and Vogel (2002) examined the concept of Gender Role Conflict (GRC) as it pertains to male psychologists and trainees. GRC occurs when the situation calls for behaviors that confront previously held assumptions about gender role behavior. Learning to become a proficient therapist could exacerbate GRC as the male pattern of Success, Power, and Competition may cause a trainee to feel too uncomfortable to discuss the suggestion of coming close to such a grave ethical failure that stems from having sexualized CT, especially with a male supervisor in front of whom a trainee may feel compelled to uphold traditional gender roles such as power and success.

There was a difference in likelihood of discussing sexualized CT among some theoretical orientations. Study participants who consider themselves primarily psychodynamic reported being more likely to discuss sexualized countertransference and feelings of being bored/disengaged as compared to family systems trainees. This difference may be attributed to the fact that it is acceptable and even encouraged within the psychoanalytic tradition for the therapist to use their own associations and reveries as a way of making sense of the patient's world (Ogden, 1994).

This open attitude toward the process of discovery extends to therapist attraction and boredom. While they are two polar concepts, attraction and boredom may provide powerful clues about the therapeutic relationship, possible transferences, and the projection of the patient's unconscious world. In a psychodynamic context, countertransference feelings such as boredom and attraction are interpretable, and when interpreted carefully and skillfully, can be useful to therapeutic work. Such is not the case in a family systems framework in which the therapist is an observer of the system and not a participant.

Although supervisee developmental level was not correlated with overall comfort or likelihood of disclosure, it was associated with the task subscale of the WAI. This finding suggests that as trainees get more supervision, they acquire increased insight into what is expected of them in supervision, the tasks that need to be accomplished, and accomplish tasks efficiently. Although agreement on task is less relational than shared bond or goal, agreement on task is an important part of the supervisory relationship overall. While findings did not support the connection of developmental level with countertransference disclosure, it is important to note that the measure of developmental level (by years) is rudimentary. Assessing developmental level with a more sensitive instrument, or description of experience may yield significant results.

Conclusion

This study examined the influence of the supervisory alliance on countertransference disclosure. Three hundred thirty two doctoral students at various levels of training who participated in this study indicated a positive and significant relationship between the strength of the working alliance and the likelihood and comfort of countertransference disclosure in supervision. As such this study replicated previous findings that support the notion of the importance of the supervisory relationship as it bears on countertransference disclosure, a critical aspect of clinical supervision.

Implications

Prior research on the supervisory alliance has focused mainly on the factors that influence it (Chen & Bernstein, 2000; Hatcher & Barends, 2006). This study was prompted by a lack of empirical data studying the relationship between supervisory alliance and how it makes supervision effective in regards to supervisee self-disclosure.

Effective supervision provides a safe environment for trainees to honestly examine their reactions to patients and overcome related roadblocks. Countertransference management through disclosure in supervision is imperative, as it influences treatment outcomes for which the supervisor is ultimately responsible, and is an important competency for beginning clinicians to develop (Hayes, McCracken, Hill, Harp, & Carozzoni, 1998; Shafranske & Falender, 2008).

The findings of this study are consistent with current research that examines the significance of the supervisory alliance (e.g., Falender & Shafranske, 2004; Ladany et al., 1996). This information is critical in understanding what makes supervision effective, and has implications for supervisor, supervisee, and patient, and failure to discuss countertransference has been shown to result in poor therapeutic progress (Friedman & Gelso, 2000), and potential legal/ethical violations (Ladany, Lehman-Waterman, Molinaro, & Wolgast, 1999). Thus it would greatly benefit supervisors to take the time to assess and develop alliance.

Trainees' reluctance to disclose sexualized CT is an important demonstration of shortcomings in the training system in regards to addressing unwanted countertransference in general. Pope, Keith-Spiegel, and Tabachnick (1986) posit that inattention in training to the topic of sexual attraction to clients may be at least in part due to the taboo nature of the topic and the belief that this phenomenon is "dangerous and antitherapeutic" (p. 106). They also draw attention to the lack of research on the topic, leaving teachers without empirical material to rely on. As programs and training sites, by their ignoring and stigmatizing behavior, suggest that sexualized CT is dangerous and should be shunned, it is natural that therapists feel very unsettled about having these

feelings. To be successful, training programs and supervisors must begin to recognize that it is human for attractions to clients to occur. The stigma against discussing this topic and other types of CT that student's are reluctant to share must be eradicated before open and serious discussions about therapists' reactions to clients can take place. In line with contemporary views on intersubjectivity and countertransference (Jacobs, 1999), the examination of these reactions is both a clinical skill and a tool to use towards therapeutic progress that should not be neglected. The value of investing the time and effort to build strong relationships with supervisees where countertransference will be openly discussed is inherent.

This study also expanded on previous research by examining all trainees from practicum through internship, and also measured the influence of supervisee developmental level. No differences were found across developmental levels using years of experience as a variable. However, this expansion is relevant as it demonstrates the importance of alliance on trainees' comfort and likelihood of disclosure. Exploration of countertransference was not found to be a skill that is acquired in time alone, as alliance was shown to make a large impact regardless of years of training.

Limitations and Directions for Future Research

This study only examined comfort and likelihood of disclosure related to the eight most common types of countertransference experienced by psychiatrists who work with clients diagnosed with personality disorders (Betan et al., 2005). While this was the only empirical study that identified common countertransference reactions, there may be other types of reactions worth investigating and this warrants future investigation. Replication of Betan's study and replications with different therapist populations would usefully

expand the exploration of countertransference phenomena. For example, there may be differences between the reactions of psychiatrists and psychology trainees. A qualitative investigation of psychology trainees may reveal other attitudes and reactions.

There is a need for further research on the working alliance. Future research may address the gap in knowledge about how the alliance develops and the factors that influence it. Supervisee developmental level was positively correlated with the task subscale of the WAI, suggesting increased insight into supervisor expectations and the process of supervision with increased development and experience. Agreement on task is important to the supervisory relationship. Future research may examine this and identify other changes in the working alliance along the developmental trajectory, and the factors that may become more or less salient as a trainee moves from practicum through internship, preparing for the role of colleague rather than that of a student.

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TABLES

Table 1

Participant Demographics

	N	%
Race/ethnicity		
African-American	8	2.4
American Indian/AK native	1	0.3
Asian/Pacific Islander	14	4.2
Hispanic/Latino	9	2.7
White (non-Hispanic)	281	84.6
Biracial/Mulitiracial	10	3
Total	323	97.3%
Gender identity		
Female	268	80.7
Male	60	18.1
Other (transgender, intersex, androgynous)	3	.9
Total	331	99.7%
Sexual Orientation		
Heterosexual	286	86.1
Gay	9	2.7
Lesbian	10	3
Bisexual	22	6.6
Other	3	0.9
Total	330	99.4%

Table 2

Training Demographics

	N	%
Training Site		
Veterans Affairs	18	5.4
Community counseling center	90	27.1
University counseling center	87	26.2
Consortium	3	.9
Hospital	31	9.3
Correctional facility	19	5.7
Private outpatient clinic	24	7.2
School District	19	5.7
Armed Forces medical center	1	.3
Child/Adolescent psychiatric or pediatrics	19	5.7
Other	20	6
Total	331	99.7%
Primary Population		
Adults	193	58.1
Child/Adolescent	84	25.3
Geriatric	2	.6
Combined	50	15.1
Total	329	99.1%
Time conducting individual therapy (%)		
100%	43	13
75-99%	109	32.8
50-74%	86	25.9
25-49%	47	14.2
Less than 25%	45	13.6
Total	330	99.4%
Primary Orientation		
Cog-Behavioral	158	47.6
Existential/Humanistic	33	9.9
Family Systems	17	5.1
Psychodynamic	72	21.7
Other	51	15.4
Total	331	99.7%

(*table continues*)

	N	%
Doctoral Program		
Clinical	275	82.8
Counseling	54	16.3
Combined	2	.6
Total	331	99.7%
Degree	109	32.8
Ph.D.	220	66.3
Psy.D	329	99.1%
Total		
Months at site		
0-3	12	3.6
3-6	17	5.1
6-9	147	44.3
9-12	103	31
12 or more	51	15.4
Total	330	99.4%
Developmental level by years		
Less than 1	65	19.6
1	24	7.2
2	82	24.7
3	66	19.9
4	53	16
More than 4	41	12.3
Total	331	99.7%

Table 3

Supervisor Demographics

	N	%
Supervisor's theoretical orientation		
Cog-Behavioral	144	43.4
Existential/Humanistic	28	8.4
Family Systems	32	9.6
Psychodynamic	65	19.6
Other	62	18.7
Total	331	99.7%
Supervisor's gender		
Female	199	59.9
Male	131	39.5
Total	330	99.4%
Supervisor's ethnicity		
African-American	12	3.6
Asian/Pacific Islander	15	4.5
Hispanic/Latino	280	84.3
White (non-Hispanic)	9	2.7
I don't know/other	13	3.9
Total	329	99.1%
Supervisor's sexual orientation		
Same as me	271	81.6
Different than me	44	13.3
I don't know	16	4.8
Total	331	99.7%

Table 4

Statistical Analyses

Variables	Analysis
Alliance strength + CT disclosure total	MANOVA
Clinical population + CT disclosure total	T Test
CT disclosure total + Sexualized disclosure total	MANOVA
Degree program + CT disclosure total	T test
Ethnicity Match + CT disclosure total	T test
Gender Match + CT disclosure total	T test
Gender Match + Sexualized disclosure total	T test
Orientation match + CT disclosure total	T test
Orientation match + Sexualized disclosure total	T test
Clinical population	Univariate
Gender	Univariate
Degree program	Univariate
Doctoral program	Univariate
Ethnicity	Univariate
Sexual orientation	Univariate
Theoretical orientation (primary)	Univariate
Theoretical orientation (secondary	Univariate
Time at training site (months)	Univariate
Training site focus	Univariate
Orientation match (supervisor and supervisee)	Univariate
Gender match (supervisor and supervisee)	Univariate
Ethnicity match (supervisor and supervisee)	Univariate
Developmental level + comfort in disclosure	T test
Developmental level + likelihood of disclosure	T test

Table 5

Description of Study Variables

Variable	Nature of Variable
Alliance Strength	Continuous
Task Score	Continuous
Bond Score	Continuous
Goal Score	Continuous
CT Disclosure Score	Continuous
Sexualized CT Score	Continuous
Clinical Population	Categorical
Adult	Categorical
Child/Adolescent	Categorical
Geriatric	Categorical
Combined	Categorical
Other	Categorical
Ethnicity	Categorical
African-American/Black	Categorical
American Indian/Alaskan Native	Categorical
Asian/Pacific Islander	Categorical
Hispanic/Latino	Categorical
White (non-Hispanic)	Categorical
Other	Categorical
Ethnicity Match	Categorical
Gender	Categorical
Male	Categorical
Female	Categorical
Other	Categorical
Gender Match	Categorical
Training Site	Categorical
Armed Forces medical center	Categorical
Child/Adolescent psychiatric or pediatrics	Categorical
Community counseling center	Categorical
Consortium	Categorical
Correctional facility	Categorical
Private general hospital	Categorical
Private outpatient clinic	Categorical
Private psychiatric hospital	Categorical
Psychiatric hospital	Categorical

(*table continues*)

Variable	Nature of Variable
School district	Categorical
State/county/other public hospital	Categorical
University counseling center	Categorical
Veterans Affairs hospital or medical center	Categorical
Other	Categorical
Degree Program	Categorical
Ph.D.	Categorical
Psy.D.	Categorical
Other	Categorical
Doctoral Program	Categorical
Clinical	Categorical
Counseling	Categorical
Combined	Categorical
Other	Categorical
Sexual Orientation	Categorical
Heterosexual	Categorical
Gay	Categorical
Lesbian	Categorical
Bisexual	Categorical
Other	Categorical
Sexual Orientation Match	Categorical

Table 6

Comparison of Results

	Daniel, 2008	Pakdaman, 2011
N =	175	332
H_1: There is a positive association between supervisory alliance and reported comfort in supervisee CT disclosure.	Confirmed	Confirmed
H_2: There is a positive association between supervisory alliance and reported likelihood in supervisee CT disclosure.	Confirmed	Confirmed
What topics or content areas are students most comfortable disclosing? What topics or content areas are students most likely to disclose?	N/A	Most comfortable: positive, helpless/inadequate, and mistreated/criticized. Most likely: mistreated/criticized, positive, disengaged, and helpless/inadequate.
Do matches in demographic characteristics (i.e., gender, ethnicity, or theoretical orientation) between supervisor and supervisee influence CT disclosure?	No significant relationships found.	No significant relationships found. This sample's ethnic diversity was not large enough to make meaningful comparisons.
Does the number of years of supervised experience in psychotherapy a supervisee has received influence reported comfort or likelihood in CT disclosure?	N/A	No
Does the type of degree program of the intern affect comfort with CT disclosure and likelihood of disclosure?	No	No
Does theoretical orientation affect comfort with CT disclosure and likelihood of disclosure?	This sample's theoretical diversity was not large enough to make meaningful comparisons	Post hoc analyses revealed some differences for specific content areas

Table 7

Summary of Theoretical Countertransference Literature

Theorist	Main Contributions
Freud, 1910	Limitations of our own issues and character intrude upon our ability to understand and communicate accurately, however, one can develop sufficient insight to overcome such resistance.
Ferenczi, 1919	CT is inevitable and valuable in understanding the patient. Efforts to completely master CT would cause the therapist to be counterproductively inhibited.
Stern, 1924	CT may arise from the therapist's personal conflicts (posing an obstacle to understanding), or may be a response to the patient's transference (which is useful in analysis). The therapist must allow his feelings to connect with the patient's unconscious to better understand it.
Deutsch, 1926	The patient's free associations spark the therapist's memories and fantasies, which become the basis for intuition and empathy.
Glover, 1927	Psychosexual conflicts within the patient evoke developmentally similar conflicts in the analyst.
Low, 1935	Therapist's subjectivity is a pathway to understanding the patient's subconscious.
Winnicott, 1949	CT may be a legitimate objective response and not a product of the therapist's neuroses. Negative CT is an important part of treating disturbed patients, by providing useful information about how the patient interacts with others and the feelings that others derive from this person's presence.
Heimann, 1950	CT is a better way of understanding the patient's unconscious, as it is more acute and in advance of the analyst's conscious conception of the circumstances. Relies on the principle of projective identification (Klein, 1946).
Racker, 1953	Complementary CT is detrimental as it becomes tempting to react in a way similar to how the patient's primary objects may have. Concordant CT refers to identifying with the patient's experience. The degree to which the therapist falls short of reaching concordant identification reflects the degree to which the complimentary identification will arise and recreate the patient's past.

(*table continues*)

Theorist	Main Contributions
Kernberg, 1965	CT is influenced by object relations of both patient and analyst, which are activated in the therapeutic relationship. CT may also help clarify the transference paradigms arising from the severe regression of a patient who uses primitive defenses.
Lacan, 1966	Acceptance of patient's projective identification, an impossible wish for certainty in working with the patient, and seeking particular responses from the patient, particularly responses that serve to confirm the correctness of the therapist's interpretations, are detrimental CT reactions.
Bion, 1967	The analyst's values, tendency to adhere to theory, and prior knowledge of the patient, are unintentionally and inevitably communicated, which influences the patient's surfacing material. This hinders the analyst's ability to effectively hear and respond to the patient.
Kohut, 1968	Empathy is rooted in the analyst's ability to use vicarious introspection. To understand the patient's unconscious communications, the analyst must use intersubjectivity, including countertransference feelings, as therapeutic tools.
Stolorow, 1984	Analysis is intersubjective. Both the patient's and the analyst's subjective worlds are activated in therapy.
Arlow, 1993	The therapist must become consciously aware of her own associations in order to formulate accurate interpretations.
Renik, 1993	Therapist is influenced by CT before it comes to surface. *Post facto* exploitation of CT is inherently flawed, as CT is necessarily retrospective and preceded by enactment. CT is inevitable, the therapist should not attempt to eliminate it, but rather explore it and use it.
Ogden, 1994	Therapists can use their own reveries to draw out and make sense of the patient's world. The "analytic third" is an always present creation of co-constructed ideas, beliefs and imaginations, demonstrating how the analyst's unconscious actions can be interpretations, and useful to the analytic work.
Levine, 1997	Patient material that resonates within the therapist, evokes the therapist's memories of similar or parallel psychological experiences.

(*table continues*)

Theorist	Main Contributions
Gabbard, 1997	Minor countertransference enactments provide knowledge about what is being recreated in the therapy setting. The core of this technique is the therapist's ability to find a way out of the projected role or enactment and not attempt to maintain artificial neutrality.

Table 8

Summary of Empirical Studies Addressing Countertransference

Study	Sample	Results
Betan et al., 2005	*N* = 181 psychiatrists	Identified 8 distinct ct reactions in therapists who work with clients with diagnosed personality disorders.
Daniel, 2008	*N* = 175 interns	Likelihood of CT disclosure and comfort in disclosure was positively correlated with supervisory working alliance. Participants reported being likely to report CT reactions even if it would feel uncomfortable as long as the alliance was strong. Alliance was found to have the greatest influence on disclosures and comfort, whereas similarity in gender, ethnicity and theoretical orientation did not have a significant effect.
Dalenberg, 2004	*N* = 132 trauma patients	Therapists displayed mild annoyance/anger to 30.6% of patients; displayed sadness and discomfort to 16.42%. Patients see and interpret CT reactions and are more satisfied with treatment when therapist addresses and discuss the reaction.
Duthiers, 2005	*N* = 57 interns	Having experienced personal therapy since beginning graduate training was not found to be related to any aspect of CT management as measured by the CFI. This is divergent from the literature.
Friedman & Gelso, 2000	*N* = 26 supervisors	Developed the Inventory of CT Behaviors; identified positive and negative CT behaviors. Even positive CT can be detrimental to treatment and outcome.

(*table continues*)

Study	Sample	Results
Hayes & Gelso, 2001	Literature review	Identified origins, triggers, and manifestations of CT; chronic and acute ct; internal and external reactions; affective, cognitive, and behavioral manifestations occur.
Ligiero & Gelso, 2002	*N* = 51 doctoral students	Positive and negative CT are related to evaluation of the working alliance.
Pope, Keith-Spiegel, & Tabachnick, 1986	*N* = 575	87% of therapists reported sexual attraction to clients, at least on occasion. 63% feel guilty, anxious, or confused about the attraction. 50% have not received any guidance or training on this issue. Only 9% reported that their training or supervision on this issue was adequate.
Pope & Tabachnick, 1993	*N* = 285 psychologists	80% reported feeling fear, anger, or sexual excitement towards a client during session; less than 25% reported having adequate graduate training regarding such feelings.
Rosenberger & Hayes, 2002	*N* = 13 therapy sessions of 1 therapist	The greater amount of negative CT, the poorer the working alliance.
Schwartz, Smith, Chopko, 2007	*N* = 73	Therapists displayed significantly stronger CT feelings of being dominated (i.e. exploited, manipulated, talked down to) by clients with APD, but manifested significantly stronger positive CT feelings (i.e. being liked and welcomed and being in charge, that is, being put in a decision-making role) when working with clients with schizophrenia.
Tobin, 2006	*N* = 30	Patterns of negative and positive CT appeared in relation to certain therapeutic interactions, suggesting that therapists' CT is largely determined by how effective they believe they are being in the session.

Table 9

Summary of Theoretical Literature on Supervisory Alliance

Study	Selected findings
Allen, Szollos, & Williams, 1986	Quality in supervision was defined by perceived expertise and trustworthiness of the supervisor. Specific discriminators of superior expertise were "skill" and "reliability." Detriments to supervision were authoritarian treatment and sexist behavior.
Bordin, 1983	The term "alliance" is broadened beyond therapist and patient, and includes clinical supervisor and intern. Bordin's description consists of three parts that strengthen the alliance: Agreement on the tasks of therapy, the goals of therapy, and healthy bond between the dyad ensures a strong working alliance.
Bordin, 1979	Not only the stating goals, but developing a consensus regarding tasks and goals in collaboration is required for successful alliance.
Carifio & Hess, 1987	Concept of an effective supervisory alliance comes from idea that the supervisory relationship parallels the therapeutic relationship.
Hatcher & Barends, 2006	Alliance is focused on the work of supervision and is a reciprocal, interactive relationship based on agreed upon problems and goals. Both parties are responsive and respectful, however, the intern is the more significant contributor. Potentiating bond should convey engagement and optimism, however it should not feel like friendship, which may inhibit intern's autonomy.

Table 10

Summary of Empirical Literature on Supervisory Alliance

Study	Sample	Findings
Bahrick, Russell, & Salmi, 1991	*N* = 19	Exposing trainees to an audiotaped role-induction procedure resulted in clearer conceptualization of the supervision process, viewing supervisors as teachers, and being more capable of recognizing their needs, concerns, and worries in supervision.
Borders, 1990	*N* = 44	Trainees reported increases in dependency/autonomy, self-awareness, and therapy/skills acquisition across 3 supervisors longitudinally.
Borders, Fong, & Neimeyer, 1986	*N* = 80 first year students	Significant relationship between ego-level scores and ratings on precounseling tape. Score on counseling skills exam and posttraining counseling tape rating were correlated. There was a significant effect of pretraining counseling rating on counseling ability.
Carey, Williams, & Wells, 1988	*N* = 7 post-Ph.D. 10 doctoral students 31 MS students	Trainee performance ratings were significantly correlated to ratings of supervisor expertness (r = .36), attractiveness (r = .39), and trustworthiness (r = .56).
Chen & Bernstein, 2000	*N* = 2	A complimentary relationship between supervisor and supervisee resulted in stronger alliance and better outcome.
Cook & Helms, 1988	*N* = 225	Supervisor's liking and positive feelings toward trainee accounted for 69.4% of variance and restrained involvement accounted for 8.7% of variance with the supervisee. Trainees felt more liked rather than disliked, and more emotionally close to their supervisors rather than distant.

(*table continues*)

Study	Sample	Findings
Cummings, Hallberg, Martin, Slemon, & Hiebert, 1990	*N* = 4	The more experienced counselors displayed ore consistency in their conceptualizations, employed more interactional concepts, and used the concepts of family background and current relationships as start point for conceptualizing client's problem, and used more domain specific concepts than the novice counselors.
Daly, 2004	qualitative	Supervisors are most effective when organized, emotionally supportive, use theory and objective techniques (i.e. video review) to conceptualize clients and evaluate trainee performance. Supervisees do not express dissatisfaction or supervision needs for fear of a negative evaluation.
Daniel, 2008	*N* = 175	Strong supervisory alliance predicts comfort and likelihood of supervisee countertransference disclosures in supervision.
Davis, Savicki, Cooley, & Firth, 1989	*N* = 120	Being dissatisfied with supervision was positively related to intensity of emotional exhaustion and frequency of feelings of depersonalization, and negatively related to feelings of personal accomplishment.
Ellis & Dell, 1986	*N* = 19 supervisors	No evidence that level of experience (trainee or supervisor) affected the supervisor's description of supervision.
Efstation, Patton, & Kadash, 1990	*N* = 10 experienced supervisors at APA approved university counseling center, acting as subject experts in a task analysis. *N* = 185 supervisors and 178 trainees participated. Dyads were created.	Development and validation of the SWAI (Supervisory Working Alliance Inventory). Three supervisor factors (client focus, rapport, and identification) and two trainee factors (rapport and client focus) were extracted by factor analysis. Supervisors and trainees perceive that a focus on working to understand the client and rapport are commonalities in their experience of the relationship.

(*table continues*)

Study	Sample	Findings
Fisher, 1989	*N* = 16	Focus of supervision or type of trainee relationship was not found to be significantly different between "beginning" and "advanced" trainees.
Friedlander, Keller, Peca-Baker, & Olk, 1986	*N* = 52	An inverse relationship was found between performance and anxiety and between anxiety and counselor self-efficacy when there was role conflict in the supervisory relationship.
Gray, Ladany, Walker &Ancis, 2001	*N* = 13	Trainees typically attributed experiences of counterproductive events to their supervisors dismissing their feelings and thoughts. Most did not believe that the supervisor was aware of the event's negative nature and that the counterproductive event weakened supervisory alliance, and changed their approach to their supervisors. Although most believed that the event negatively affected their work with clients, most did not disclose their experience with their supervisor.
Guest & Beutler, 1988	*N* = 9 supervisors *N* = 16 supervisees	At the end of training year, supervisor's scores on the belief that the therapist's personality is crucial to therapy predicted trainees score on that factor. Supervisor's orientations found to exert significant influence on trainees' theoretical orientations 3-5 years after the end of the training experience.
Horvath, 2006		Quality of alliance is one of the better predictors of outcome, across modalities. Alliance is similar across different types of therapy and is uniform over time.

(*table continues*)

Study	Sample	Findings
Horvath & Greenberg, 1989	Items were rated by experts (*N* = 7), and then by professionals (*N* = 21).	Development and validation of a self-report instrument for measuring the quality of alliance. Found preliminary validity in the scale to measure alliance between client and therapist. Measure and items are based on Bordin's (1980) conceptualization of the alliance (bonds, goals, and tasks).
Horvath & Symonds, 1991	Meta-analysis	Strong supervisory alliance increased therapeutic outcomes for clients of supervisees.
Kennard, Stewart, & Gluck, 1987	*N* = 94 supervisors who identified as having positive, negative, or mixed relationship experiences with trainees. *N* = 26 trainees	The positive experience group received significantly higher overall ratings by supervisor, and was significantly different in both trainees' interest in the supervisor's suggestions regarding professional development, and the trainee's interest in supervisor's feedback. They also rated their supervisors higher on behavior style dimensions of "supportive," "instructional," and "interpretive." Positive pair members more likely to have similar interpretive style and theoretical orientation.
Kivlighan, Angelone, Swafford, 1991	*N* = 93	Clients of early stage trainees receiving live supervision perceived sessions as rougher, but with stronger working alliances than did clients of therapists receiving videotaped supervision. The live supervision group used more relationship, set limits and support intentions than trainees receiving videotaped supervision.

(*table continues*)

Study	Sample	Findings
Krause & Allen, 1988	*N* = 87 supervisors *N* = 77 doctoral students	Supervisors perceived themselves as behaving differently with trainees of different developmental levels (as defined by Stoltenberg, 1981 model), but trainees did not perceive these differences. Trainees, but not supervisors, who were congruent in their perception of the trainee's level, reported significantly more satisfaction. All trainees preferred a more collegial, self-reflective, and mutually respectful interaction.
Ladany, Brittan-Powell, & Pannu, 1997		Supervisees who experience a strong working alliance have enhanced competency with multicultural issues.
Ladany, Hill, Corbett, & Nutt 1996	*N* = 108	92.7% of supervisees reported withholding information from their supervisors, frequently because of perceived unimportance, nondisclosure was too personal, negative feelings, and poor alliance. Most frequent type of non-disclosure was negative reactions to supervisor, then personal issues, evaluation concerns, clinical mistakes, and general client observations. 22% did not disclose ct feelings (defined as over-identification with client or client topics). Supervisor style was related to content and reasons for nondisclosure. Supervisees were less satisfied when they reported negative reactions to supervisor, and when they did not disclose because of poor alliance, supervisor incompetence, and fear of impression management/political suicide.
Ladany, Ellis, & Friedlander, 1999	*N* = 35 male and *N*= 72 female counseling practicum to intern-level trainees.	Contrary to prediction, changes in alliance were not predictive of changes in trainee self-efficacy. However, improvements in emotional bond between trainees and supervisors were associated with greater satisfaction.

(*table continues*)

Study	Sample	Findings
Ligiéro & Gelso, 2002	*N* = 50 supervisee and supervisor dyads	Therapist attachment style did not correlate with either CT behaviors or working alliance. Negative CT behaviors were negatively related to the quality of the therapist-client working alliance as rated by both supervisors and therapists. Positive CT was not related to therapist or supervisor ratings of the overall working alliance, however it was negatively related to the bond component of the working alliance as rated by supervisors.
Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989	*N* = 23	Novice therapist trainees required more extra help with client-specific concepts to conceptualize individual clients and their problems than did more experienced therapists.
McNeill, Stoltenberg, & Pierce, 1985	*N* = 91	Study confirmed expected significant differences according to Stoltenberg 1981 model between beginning vs. intermediate trainees in Self-Awareness and Dependency-Autonomy, for intermediate vs. advanced trainees in Dependency-Autonomy and Theory/Skills Acquisition, and for beginning vs. advanced trainees in Self-Awareness, Dependency-Autonomy, and Theory/Skills Acquisition.
McNeil, Stoltenberg, & Romans, 1992	*N* = 144	Significant differences found between beginning vs. advanced student trainees, and between intermediate vs. advanced in the expected direction.

(*table continues*)

Study	Sample	Findings
Matazzoni, 2008	*N* = 10	Content, not amount, of perceived supervisor self-disclosures was important to development of WA bond. Disclosures about supervisor's past experiences correlated with strong working bond. Extraneous or irrelevant disclosures were associated with weaker bond, but less so for students with more months of supervision. Students with high scores on a measure of self-awareness felt more frequently bonded to their supervisors; that bond strengthened with experiential disclosures and weakened with extraneous ones.
Nelson & Holloway, 1990	*N* = 40 supervisors *N* = 40 graduate students	Female and male supervisors reinforced female trainees' high-power messages with low-power, encouraging messages less often than they did with male trainees. Female students found to be significantly less likely to assume expert role in response to supervisor low-power than male students.
Patton & Kivilighan, 1997	*N* = 75 supervisee and client dyads 25 supervisors	Significant relationships were found between the trainee's perception of the supervisory alliance and the client's perception of the counseling working alliance. Supervisory alliance has a differential impact on the types of learning that occur in supervision, but not technical activity of the trainee.
Putney, Worthington, & McCullough, 1992	*N* = 84 supervisors *N* = 84 interns	Humanistic-psychodynamic supervisors were perceived to emphasize supervisory WA more than cognitive-behavioral supervisors. Greater perceived theoretical similarity, greater degree of theoretical match, and supervisor gender (female supervisors perceived as more effective) predicted individual supervisor effectiveness.

(*table continues*)

Study	Sample	Findings
Rabinowitz, Heppner, & Roehlke, 1986	*N* = 45	Most important issues across all experience levels related to supervisory support, treatment planning, and advice and direction from the supervisor. Clarifying the supervision relationship was the most important to all trainees in the first 3 weeks of the semester. Mid-semester, beginning trainees were most concerned with their supervisors believing that they are skilled enough to be competent, developing a treatment plan, and receiving support from their supervisor.
Riggs & Bretz, 2006	*N* = 87 doctoral level psychology interns	Perceived supervisor attachment style was significantly associated with supervision task and bond, regardless of intern attachment style. Interns reporting secure supervisors rated the bond higher than with insecure supervisors.
Riley, 2004	*N* = 10	Supervisors' multicultural competence accounted for all variance in supervisees' working alliance, in a negative direction. Mixed race supervision dyads are vulnerable to misperceptions, and supervisor multicultural competence in counseling does not generalize to the supervision relationship, it is the opposite.
Robyak, Goodyear, & Prange, 1987	*N* = 56 supervisors	Male and less experienced supervisors reported greater preference for the referent power base. Supervisors who focused on self-awareness preferred the expert power base.
Samstag, Batchelder, Muran, & Winston, 1998		Weakened alliance is correlated to early and unilateral termination.

(*table continues*)

Study	Sample	Findings
Schiavone & Jessell, 1988	*N* = 86 trainees	Perceptions of supervisor expertness not affected by interactions of supervisor gender, trainee gender, or attributed supervisor expertness. Supervisor ascribed expertness was rated significantly more favorably than was ascribed non-expertness.
Stoltenberg, Pierce, & McNeil, 1987	*N* = 91	Counselor trainees' needs change as a function of developmental level. Significant differences in needs for structure, feedback, and overall needs were found based on level of education, semesters of previous counseling experience, and semesters of previous supervision.
Strozier, Kivlighan, & Thoreson, 1993	*N* = 1 dyad	Both the supervisor and trainee indicated that Relationship, Change, Explore, and Restructure were the most helpful intention clusters on the SEQ and Helpfulness Rating Scale. Both indicated that the supervisor's interventions were more helpful when the trainee used the supported reaction cluster.
Thome (2006)	*N* = 10	Supervisors of trainees who reported high working alliance rated trainee counseling skills and personal development higher than supervisors in low alliance relationships. Rapport in the working alliance had the greatest impact on supervisory ratings. Trainee self-ratings of counseling skills and personal development were not affected by level of supervisory WA.
Ladany, Walker, & Pate-Carolan, 2003		Strong supervisory working alliance is predictive of supervisee self-disclosure

(*table continues*)

Study	Sample	Findings
Wiley & Ray, 1986	*N* = 71 supervisors *N* = 107 trainees	Most trainees were in supervision type that was congruent to their developmental level. Satisfaction and learning as perceived by both trainees and supervisors were not related to the degree of congruency between the person and the environment.
Winter & Holloway, 1991	*N* = 26 doctoral students and 30 master's students	Results support developmental supervision models suggesting that as trainees gain experience, they increasingly prefer to focus on personal issues/personal growth and are less fearful of negative evaluation. Less experienced trainees preferred focus on client conceptualization. Trainees with higher conceptual levels were more likely to prefer development of counseling skills.
Worthington, 1987	Meta-analysis	Research generally supports supervisors' and supervisees' perceptions that trainees change sequentially and in a way that is consistent with developmental theories.

APPENDIX A

Literature Review: Countertransference

However brief his discussion of it was, Freud's sparse comments on countertransference sparked debate between currents of analytic thinking and theorizing for generations to come. As the first to identify and describe the countertransference phenomenon, Freud (1910) wrote, "No psychoanalyst goes further than his own complexes and resistances permit, and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his own observations on his patients" (pp. 141-142). Thus, the limitations of our own issues and character intrude upon our ability to understand and communicate accurately with another. However, embedded within this notion is the hope that one could develop sufficient insight to overcome countertransference resistance.

Giving Freud's view of ever-present countertransference a new importance, a number of modern analysts use the analyst's subjectivity more liberally (Renik, 1993), and place less emphasis on the fact that Freud likened countertransference as an impediment to progress, an obstacle that the analyst must overcome (Jacobs, 1999). What Freud observed also became the foundation for the opposite view of countertransference: it is not only inevitable, but it is an instrument that can be used to understand the patient's unconscious, and plays an essential role in treatment. Freud recognized that analysis involves communication between the patient's unconscious and the therapist's unconscious. In 1912, Freud advised analysts to attune to the unconscious of the patient like a telephone receiver, acknowledging that countertransference was the analyst's transference to the patient's transference. Heimann (1950) still located the origins of countertransference in the patient, and later emphasized that this metaphor implies a two-way transmission: countertransference contains the patient's unconscious

and the therapist's. This idea that the patient's and therapist's unconscious were in constant communication led to the now widely accepted idea that analysis expectedly involves two psychologies (Ogden, 1994).

Partly in rebellion against Freud, Ferenczi (1919) straightforwardly spoke of the inevitability of countertransference and its value in understanding the patient. Ferenczi pointed out that efforts to completely master countertransference would cause the therapist to be inhibited and less capable of free-floating mental processes, essential elements in analytic listening and empathic understanding. Contemporary interest in Ferenczi's work may stem from newer intersubjective and constructivist views, greater appreciation of the interactive dimension, and the flexibility of the transference-countertransference situation in analysis (Jacobs, 1999).

The situations in which analysts find themselves in countertransference are as diverse as people themselves. Stern (1924) discussed two types of countertransference: one that arises from the therapist's personal conflicts (posing an obstacle to understanding), and another that is a response to the patient's transference (which is useful in analysis). Stern posited that the therapist must allow his feelings to be brought up and connect with the patient's unconscious in order to better understand it. This notion of freely hovering responsiveness relates well to Freud's (1912) notion that the therapist works with his own freely hovering attention.

Other theorists advocate for using countertransference in similar ways. Similar to Kohut's emphasis, Deutsch (1926) believed that the patient's free associations spark the therapist's memories and fantasies, which become the basis for intuition and empathy. Decades later, Arlow (1993) argued one step further, that the therapist must also become

consciously aware of her own associations in order to formulate accurate interpretations. Renik (1993) holds a contradicting view that the therapist cannot help but to act on their subjectivity well before it reaches a conscious level where it can be processed as Arlow recommends (Jacobs, 1999).

Another topic in countertransference that has been recently revisited is the patient's psychosexual conflicts. Glover (1927) pointed out that the patient's psychosexual conflicts evoke developmentally similar conflicts in the analyst. Modern analysts such as Levine (1997) concur that when the patient touches upon material that resonates within the therapist, it serves to evoke the therapist's memories of similar or parallel psychological experiences. It is up to the therapist to learn how to manage such reactions and use them to enhance empathy.

In 1935, Low continued the contention with Freud's view that countertransference should be eliminated, by stating ways in which it could be helpful in understanding patients. She held that the analyst's subjective experiences may be used to understand the patient more accurately, a view that was later adopted by the Kleinians (Jacobs, 1999). That the therapist's subjectivity is a pathway to understanding the patient's subconscious, became the central notion of the contemporary view of countertransference. However, it is an issue that received little attention by Freud, and was treated as a peripheral issue for many years.

After WWII, analysts were faced with more trauma patients, leading to greater interest in the now more visible effects of trauma on personality. As analysts became more exposed to trauma, they found themselves reacting strongly to being the targets of patients' displaced primitive affects, such as expressions of blatant sexuality or raw

aggression. Competing with the force of countertransference also became a major issue in working with borderline and psychotic patients. Within that cultural context, Winnicott (1949) published 'Hate in the Countertransference.' This groundbreaking paper legitimized countertransference responses that are objective responses to qualities in the patient and not a product of the therapist's neuroses. Winnicott noted that negative countertransference is an important part of treating disturbed patients, and that these reactions actually facilitate treatment by providing useful information about how the client interacts with the world and the feelings that significant others derive from this person's presence.

This shift in opinion about countertransference was followed by another liberating step. Heimann (1950) argued that countertransference was not only useful for knowing the patient, but "an instrument of research into the patient's unconscious" (p. 81). Here, countertransference is recognized as a product of the patient, and is extolled as a better way of understanding the patient's unconscious as it is more acute and in advance of the analyst's conscious conception of the circumstances.

Winnicott's and Heimann's views both equate countertransference with the patient's displaced and projected inner experiences (Jacobs, 1999). Underlying this view is the Kleinian assumption of projective identification as the core of countertransference. It is then up to analysts to notice experiencing the impact of the patient's primitive mechanisms, and manage countertransference responses, forming the heart of therapeutic work.

Racker (1953) also proposed that the analyst might identify with the patient's objects, causing the analyst to experience the patient as other objects in his or her life do.

This *complementary countertransference* is a threat to treatment, as it places the analyst in a position where it is tempting to react in a way similar to how the patient's primary objects may react. Racker uses the term, *concordant countertransference,* to refer to the analyst identifying with the patient's experience. The degree to which the therapist falls short of reaching concordant identification reflects the degree to which the complimentary identification will arise, "be acted upon, and create a repetition of the client's past" (Thompson & Cotlove, 2005, p. 225).

Besides reenacting the patient's past, it is also possible to recreate aspects of the analyst's history in the countertransference situation. In Racker's theory, all pathological aspects of countertransference contain an element of neurosis attributed to the analyst's psychosexual development. This view posits that countertransference and transference enactments are centered in the Oedipus complex: all male patients represent the father and all female patients represent the mother. It follows that the analyst's failure to resolve his Oedipal complex results in re-enactment of his internalized objects, resulting in neurotic countertransference manifestation. The degree to which the countertransference influences the patient's behavior is then naturally related to the analyst's own mastery of his Oedipal complex and object relations.

Bion (1967) stressed that analysis involves two people's lives, and that the two are bonded in an intense relationship. The analyst's values, tendency to adhere to theory, and prior knowledge of the patient, are unintentionally and inevitably communicated to the patient, which influences the patient and the surfacing material. This poses an obstacle to free association in the most literal sense, and analytic work. Bion demands that the analyst approach each session without memory or desire, so that the process is

uninhibited by prejudicing subjectivity that would prevent the analyst from effectively hearing and responding to the patient (Bion, 1967).

Similarly, Gabbard (2001) identified countertransference as a joint creation between patient and therapist, asserting that the patient evokes responses in the therapist, and the therapist's own self- and object-relations establish the nature of the countertransference response. Recognizing and subsequently managing countertransference responses requires particular skill when he material is troubling to the analyst, as the analyst might inadvertently focus on material that is less personally disturbing.

As upsetting as the feelings may be to the analyst, countertransference is helpful in evaluating the degree of the patient's pathology, or in Kernberg's (1965) view, the patient's regression. Kernberg's theory echoes Kleinian thought, in that countertransference is influenced by the object relations of both patient and analyst, and is activated in the therapeutic relationship. Patients with potential for severe regression in analysis tend to cultivate severe countertransference, namely counteridentification, excessive and lasting identification with the patient, involving "a duplication in the analyst of some constituent identification of the patient" (p. 45). Countertransference may also help clarify the transference paradigms arising from severe regression, demonstrated by a patient who utilizes very primitive defenses. Thus, counteridentification disrupts true treatment as it causes the analyst to get caught in an identification, returning love for love and hate for hate, which gives the analyst narcissistic gratification. Kernberg goes on to suggest that counteridentification is related to the limited reactivation of the analyst's early ego identifications and early defensive mechanisms.

Counteridentifications may be the source of important information about the analytic situation, however, they pose complications which can be particularly salient when treating patients with potential for severe regression and whose conflicts center on pregenital aggression. Counteridentifications threaten analysis, prompting the analyst to fall into a chronic countertransference fixation, characterized by reappearance of the analyst's abandoned neurotic character traits in interactions with a particular patient, emotional detachment from the analysis, unrealistic dedication to the patient's analysis, and micro-paranoid attitudes toward the patient.

The analyst's attitudes can in fact effectively block the process from progressing. Lacan (1966, cited in Jacobs, 1999) noted that several of the analyst's reactions can obstruct the analytic process, including the analyst's acceptance of the patient's projective identification, an impossible wish for certainty in working with the patient, and seeking particular responses from the patient, particularly responses that serve to confirm the correctness of the therapist's interpretations. Lacan held that if the therapist continuously searches for evidence to either formulate or confirm an interpretation, this counters the openness, curiosity, and free association, thus inhibiting analysis from deepening. In order for the analysis to be effective, exploration must be open-ended, explorative, and open to what the unconscious reveals in images, symbols, and metaphors (Lacan, 1966).

By the late 1960s, there appeared to be more freedom in the analytic climate for analysts to explore their personal feelings and reactions. In his work with narcissistic children, Kohut (1968) illuminated the need for empathy, rooted in the analyst's ability to use vicarious introspection. Kohut emphasized that in order to understand the patient's

unconscious communications, the analyst must use intersubjectivity, including countertransference feelings, as therapeutic tools. Over the years, aspects of Kohut's view concerning the indispensability of the analyst's self-reflection and self-monitoring in regards to emotional reactions to patients became more widely accepted and integrated into analytic thought (Jacobs, 1999).

The concept of intersubjectivity was further expanded by Stolorow (1984) arguing against the traditional idea of analysis being the psychology of only one person, noting that the patient's and the analyst's subjective worlds are activated in therapy (Jacobs, 1999). These ideas are very similar to the work of Ogden (1994). Using the Kleinian concept of projective identification, Ogden advocates for therapists to use their own reveries to draw out and make sense of the patient's inner world. Ogden also developed the concept of the analytic third present in all analyses. A creation of ideas, beliefs and imaginations co-constructed by analyst and analysand, this analytic third is asymmetrical, and defined by analytic context and roles. Thus, although each party experiences it differently, it has a psychic meaning for each and affects them both. Its use is as a vehicle to understanding the totality of the patient, both conscious and unconscious. This concept creates a context of ideas about interdependence and the transference-countertransference phenomena, demonstrating how the analyst's unconscious actions interpretive, and useful to analytic work.

Modern views on countertransference imply that the therapist must be influenced by countertransference even before it comes to the surface. Older views suggest that in order for it to be useful to the analytic process, the analyst must first *think* about the countertransference and then avoid acting on it. This "skillful recovery of an error"

(Renik, 1993, p. 555) is the commonly suggested way of using countertransference. Renik argues that this *post facto* exploitation of countertransference is inherently flawed, as awareness of countertransference is necessarily retrospective and preceded by enactment. Even the slightest nuance in disposition influences how the analyst hears material, influences whether she intervenes or remains silent, the choice of words, tone, and so on, which all have the greatest influence. The issue of the analyst having constant subjectivity begs the question of whether there is a difference between analytic work and exploitation of the analytic situation by the therapist. To solve this perplexing puzzle, Renik suggests a new guiding metaphor of the therapist as a surfer or skier: "Someone who allows herself or himself to be acted upon by powerful forces, knowing that they are to be managed and harnessed, rather than completely controlled" (p. 565). Classical ideals of neutrality and transcending countertransference do not protect analysts from exploiting the analytic situation; rather, pursuing such an ideal is unrealistic.

Renik (1993) suggests that in facilitating a patient's self-exploration, the analyst can be present in his or her own interpretation of reality although it may differ from the patient's, and that the analyst can communicate this interpretation to the client. If an analyst can accept that he or she is subjective, the analyst is free to express his or her own point of view, which the patient can autonomously consider in making up his or her mind. In Renik's view, the surest way to avoid imposing subjectivity on the patient is not for the analyst to try to deny those constructions, but to acknowledge, identify, and question them, and to consider how much the analyst is idealized by the patient, and given undeserved authority before the analyst chooses to inform the patient.

The concept of countertransference has come a long way since Freud's initial controversial statements, and has branched into three general directions. The "classical view" (i.e. Freud, 1912) focused narrowly on the therapist's neurotic and unconscious reactions to the patient's transference. The second perspective, or "totalistic" view encompasses all conscious and unconscious reactions towards the patient, regardless of their origins (Heimann, 1950). The third definition (also used for the purposes of this research) represents a moderate perspective that holds that countertransference represents the therapist's reactions to the patient, *and* that those reactions are based on the therapist's unresolved conflicts (Gelso & Hayes, 1998). This joint creation differs from pure subjectivity, in that subjectivity includes aspects of the therapist's psyche that may be evoked by the patient's material, but are independent of it.

Current technique literature is suggestive of more tolerance for the "inevitable partial enactments" of countertransference that happen in treatment (Gabbard, 2001, p. 990). All theorists would agree that the patient inevitably tries to transform the therapist into a transference object, and that the enactments provide knowledge about what is being recreated in the therapy setting. At the core of psychodynamic technique is the therapist's ability to find a way out of the projected role or enactment that the patient places on him or her. Maintaining artificial neutrality is neither useful nor desirable. Tables 7 and 8 summarize theoretical and empirical studies on countertransference.

APPENDIX B

Literature Review: Supervisory Alliance

This section provides an overview of the concept of working alliance based on the theory and research surrounding Bordin's work on alliance, and Stoltenberg's developmental model of supervision.

The working alliance in psychotherapy has been cited as one of the keys, if not, the key to the process of change (Bordin, 1979; Horvath & Bedi, 2002, Wampold, 2001), and similar to the parallels that occur between the patient's life and interactions with the therapist, a parallel process exists between supervisor and supervisee (Walker & Jacobs, 2004). Bordin (1983) proposes that the concept of alliance may be generalized beyond the scope of psychotherapy to other processes of change, and theorized that the supervisory working alliance facilitates supervision outcomes.

Working alliance applies directly to and is an essential element for success in training in regards to the supervisor-supervisee relationship (Bordin, 1983). According to Bordin's model, change is an attribute of two elements: the strength of the alliance between the one who seeks change and the change agent, and the power of the tasks incorporated into that alliance. This model proposes a supervision process that includes mutual agreements in regards to tasks and a mutual bond. Bordin notes that establishment of the alliance in supervision must contain dialogue about goals and the process by which goals will be attained. The building of the alliance is at the root of the change and learning processes.

From the supervisee's view, the main objectives of working alliance are to master skills, understand both theory and individual clients, enlarge awareness of process issues, increase self-awareness and awareness of subjectivity's impact on the process, to overcome intellectual and personal obstacles to learning, research, and maintaining a

standard of treatment. Later on in the supervisory process, goals should be reviewed, as should satisfaction or dissatisfaction with the alliance that has been established. For example, a high quality supervisory alliance includes the freedom to share negative emotional responses, and the ability to mindfully and critically engage in analysis of relational patterns (Horvath, 2006).

Tables 9 and 10 summarize theoretical and empirical literature on supervisory alliance.

APPENDIX C

Literature Review: Integrated Developmental Model of Supervision

Models of supervision have evolved to account for the stages in a trainee's development. Originally, Stoltenberg (1981) presented a more simple and general model that described four stages that therapist trainees move through in their development from beginner to master. This model also proposed types of supervision environments that would benefit trainees at each level, beginning with very structured and directive, towards less structured and nondirective as growth in competency is achieved. However, this model failed to take into account that supervisees could simultaneously reach varying levels of competence in different domains of learning and practice.

Developmental theories in supervision have stimulated significant research and indications for practice, including the notion that gaining proficiency is a developmental process (Hatcher & Lassiter, 2005). The Integrated Developmental Model (IDM) (Stoltenberg, McNeill, & Delworth 1998) provides a useful structure for understanding the ways that trainees grow over time, and how supervision environments and interventions can support or deter development of professional competency depending on the trainee's developmental level in regards to clinical practice. This model is useful in conceptualizing how psychologists increase competency in various practice domains. The IDM relies on developmental theory and is more specific in describing changes in trainees over the developmental trajectory, including the most beneficial supervision environments and supervisor interventions most appropriate for each of the three levels of development (Stoltenberg, 2005). The interventions described in the IDM are proposed by Loganbill, Hardy, and Delworth (1982), and account for trainees' development in regards to self and other awareness, motivation, and autonomy.

Beginners (IDM Level 1) experience significant anxiety, and on the other hand, a high level of motivation. The focus for these trainees is on their own behavior (implementing skills), thoughts (understanding the client, planning during session), and emotions (managing the balance of anxiety, frustration, and hopefulness). Supervision at Level 1 is highly structured. Prescriptive interventions consist of specific directions and input, and conceptual interventions are practical in helping supervisees link theory and research to practice. Across all levels, facilitative interventions are recommended to communicate support and encouragement.

Increased skill and comfort, and a shift in attention towards the client characterize Level 2 trainees. Therapists in this stage are capable of more insight into the patient's thoughts and feelings, which may result in increased empathy, motivation and autonomy, or lead to confusion, decreased effectiveness and motivation, and less autonomy. Supervision provides less external structure as skill level and understanding increase. Catalytic interventions are useful in helping trainees transition from Level 1 to Level 2, as they aim to increase the supervisee's awareness and focus further beyond the self. Catalytic interventions remain useful in different levels, to encourage trainees to expand their thinking even further.

At Level 3, the trainee experiences a change in awareness, where he or she is able to focus on the client, empathize, and understand, while simultaneously being aware of his or her own thoughts, emotions, and behavior during the session. The trainee has increased confidence, autonomy, and skill, demonstrated by the ability to reflect on the process, and access and utilize prior knowledge as situations unfold. Level 3*i* refers to the

next stage, when the trainees are able to integrate knowledge across an assortment of domains of clinical practice.

Paying attention to the client and therapist is typical at the practicum level, however, the focus shifts during internship to focusing on the supervisory relationship (Stoltenberg, 2005). At higher levels of skill and understanding, trainees are more capable of taking responsibility for their growth and learning, thus requiring less structure from the supervisor. If there is a period of stagnation in motivation, supervisors may use confrontive interventions to challenge trainees to expand their repertoire of skills and interventions, moving beyond what is familiar and comfortable. This shift marks the a change in the trainee, when he or she begins to perceive the supervisor as more confrontational, willing to give negative feedback and explore personal issues, and treating him or her more like a colleague.

The IDM is a useful framework from which to understand why and when certain interventions are successful. Having this structure guides supervisors towards testable hypotheses regarding which interventions will be the most positive and potent with certain supervisees. Using this model as a map, supervisors can better reflect on each trainee's developmental progress, and tailor teaching to each student in a way that is developmentally appropriate, encouraging, and successful.

A brief review of studies that use the IDM to assess trainee experience and development follows here. Guest and Beutler (1988) found beginning trainees generally valued technical direction and support, and that their appreciation for a supervisor's complex views of change increased as they gained experience. Advanced trainees more frequently placed importance on personal issues and relationships affecting the therapy

process. Another study examined supervisors and supervisees who classified the supervisee according to the four levels of Stoltenberg's (1981) model. Results signified that supervisors perceived themselves as providing different supervision environments according to the supervisee's needs, but the supervisees did not perceive these changes in supervisor behavior. It was also found that if there was a match in the trainee's perceived developmental level between supervisor and supervisee, there was significantly greater satisfaction and impact in supervision, thus highlighting the importance of sharing feedback regarding where the supervisee stands in terms of his or her development.

Another study researched trainees' perceptions of the most important supervisor interventions after each supervision session, and at the end of the supervisory relationship (Rabinowitz, Heppner, & Roehlke, 1986). Beginning, advanced-practicum, and internship trainees indicated that there was an establishing of a working alliance, before there was a gradual movement away from dependency on the supervisor to autonomy. Newer trainees tended to move more slowly through this shift and remained dependent on structure and support the longest.

Wiley and Ray (1986) found that the characteristics of trainees and their supervision environments varied by developmental level. Additionally, the supervisor's perception of the supervision environment for specific trainees (according to developmental level) was consistent with Stoltenberg's (1981) counselor complexity model.

These studies present considerable evidence for a trajectory of change as trainees gain experience over time. This maintains Worthington's (1987) assertion that there is support for general developmental models, supervisor and supervisee perceptions that are

consistent with developmental theories, that supervisors provide a different environment as the therapist gains experience, and that as therapists gain experience, the supervision relationship changes as well. However, there is still room for growth and sophistication in the field of supervision research, as viewing supervisees as different serves to encourage trainee development. In a review of changes in supervision as trainees gain experience by Stoltenberg, McNeill, and Crethar (1994) suggests that future efforts should aspire to determine the most effective combination of supervisor level, supervisory intervention, and level of trainee, at any point in time working with different types of patients in different contexts.

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APPENDIX D

Working Alliance Inventory-Supervisee Form

WORKING ALLIANCE INVENTORY: SUPERVISEE FORM

Instructions: On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her supervisor. As you read the sentences, mentally insert the name of your supervisor in place of _____ in the text. Beside each statement there is a seven point scale:

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

If the statement describes the way you always feel (or think), select the number "7"; if it never applies to you, circle the number "1". Use the numbers in between to describe the variations between these extremes.

Please work fast. Your first impression is what is wanted.

1. **I feel uncomfortable with _____.**

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

2. **_____ and I agree about the things I will need to do in supervision.**

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

3. **I am worried about the outcome of our supervision sessions.**

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

4. **What I am doing in supervision gives me a new way of looking at myself as a counselor.**

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

5. **_____ and I understand each other.**

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

6. **_____ perceives accurately what my goals are.**

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

7. **I find what I am doing in supervision confusing.**

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

8. I believe _____ likes me.

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

9. I wish _____ and I could clarify the purpose of our sessions.

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

10. I disagree with _____ about what I ought to get out of supervision.

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

11. I believe the time _____ and I are spending together is not spent efficiently.

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

12. _____ does not understand what I want to accomplish in supervision.

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

13. I am clear on what my responsibilities are in supervision.

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

14. The goals of these sessions are important to me.

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

15. I find what _____ and I are doing in supervision will help me to accomplish the changes that I want in order to be a more effective counselor.

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

16. I feel that what _____ and I are doing in supervision is unrelated to my concerns.

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

17. I believe _____ is genuinely concerned for my welfare.

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

18. I am clear as to what _____ wants me to do in our supervision sessions.

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

19. _____ and I respect each other.

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

20. I feel that _____ is not totally honest about his or her feelings towards me.

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

21. I am confident in _____'s ability to supervise me.

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

22. _____ and I are working toward mutually agreed-upon goals.

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

23. I feel that _____ appreciates me.

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

24. We agree on what is important for me to work on.

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

25. As a result of our supervision sessions, I am clearer as to how I might improve my counseling skills.

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

26. _____ and I trust one another.

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

27. _____ and I have different ideas on what I need to work on.

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

28. My relationship with _____ is very important to me.

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

29. I have the feeling that it is important that I say or do the "right" things in supervision with _____.

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

30. _____ and I collaborate on setting goals for my supervision.

1	2	3	4	5	6	7

Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

31. I am frustrated by the things we are doing in supervision.

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

32. We have established a good understanding of the kinds of things I need to work on.

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

33. The things that _____ is asking me to do don't make sense.

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

34. I don't know what to expect as a result of my supervision.

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

35. I believe the way we are working with my issues is correct.

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

36. I believe _____ cares about me even when I do things that he or she doesn't approve of.

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

APPENDIX E

Permission to use Working Alliance Inventory, Supervisee Form

from Bahrick, Audrey S <[redacted].edu>
to Shirley Pakdaman <[redacted].edu>
date Wed, Jun 24, 2009 at 12:48 AM Jun 24
subject RE: Request for permission: Working Alliance Inventory

Dear Shirley,

Yes, you may have my permission to use the WAI-S for your dissertation. Your topic sounds most interesting!

Best Regards,
Audrey

Audrey S. Bahrick, Ph.D.
[redacted]

APPENDIX F

Countertransference Reactions Questionnaire

Instructions: Consider your relationship with your current primary supervisor. How comfortable do you feel disclosing your personal reactions to your clients to him or her? While keeping your supervisor in mind, read the following scenarios carefully. Rate your comfort in discussing these scenarios in supervision with your current primary supervisor.

1. You have been seeing a client for several sessions and have begun to notice that you are feeling particularly excited about working with this client due to many similarities you share with him or her. Sessions run smoothly since you seem to be able to help your client based upon your own experiences with similar issues. How comfortable would you be discussing these feelings in supervision with your current supervisor?

1 Extremely uncomfortable | 2 Very uncomfortable | 3 Uncomfortable | 4 Uncertain | 5 Comfortable | 6 Very comfortable | 7 Extremely comfortable

How likely would you be to disclose these feelings with your current supervisor?

1 Extremely unlikely | 2 Very unlikely | 3 Unlikely | 4 Uncertain | 5 Likely | 6 Very likely | 7 Extremely likely

2. After reviewing several audiotapes of your sessions with a particular client, you notice that you have been avoiding furthering discussions of certain topics. Upon reflecting on these sessions, you realize that you are avoiding discussing difficult issues that you struggled with in your own life. How comfortable would you be to disclose these feelings with your current supervisor?

1 Extremely uncomf. | 2 Very uncomfortable | 3 Uncomfortable | 4 Uncertain | 5 Comfortable | 6 Very comfortable | 7 Extremely comf.

How likely would you be to discuss this with your current supervisor?

1 Extremely unlikely | 2 Very unlikely | 3 Unlikely | 4 Uncertain | 5 Likely | 6 Very likely | 7 Extremely likely

3. Your client has been making progress towards his or her goals, and you feel that you have developed a strong working alliance with him or her. Sessions flow smoothly, you are able to utilize interventions at appropriate times, and you tend to enjoy your work together. How comfortable would you be with discussing this reaction in supervision with your current supervisor?

1 Extremely uncomf. | 2 Very uncomfortable | 3 Uncomfortable | 4 Uncertain | 5 Comfortable | 6 Very comfortable | 7 Extremely comf.

How likely would you be to disclose these feelings with your current supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	Extremely likely

4. Your last three sessions with your client have each run over by about ten minutes, even though you normally end all sessions on time. You've felt particularly worried about this client, and feel somewhat guilty about not being able to solve their problems for them. In addition, you made a few self-disclosures about your personal life to the client in your last sessions-something that you tend to not be comfortable doing. How comfortable would you be with discussing this reaction in supervision with your current supervisor?

1	2	3	4	5	6	7
Extremely uncomf.	Very uncomfortable	Uncomfortable	Uncertain	Comfortable	Very comfortable	Extremely comf.

How likely would you be to disclose these feelings with your current supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	Extremely likely

5. You have a client who you find to be very attractive. You sense that there is a mutual attraction on his or her end, but it has not been discussed in session. During sessions you have a hard time concentrating on what the client is saying because the sexual tension is very intense between the two of you. Outside of sessions, you have had sexual thoughts and fantasies about this client. How comfortable would you be with discussing this reaction in supervision with your current supervisor?

1	2	3	4	5	6	7
Extremely uncomf.	Very uncomfortable	Uncomfortable	Uncertain	Comfortable	Very comfortable	Extremely comf.

How likely would you be to disclose these feelings with your current supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	Extremely likely

6. Every session with a particular client results in you feeling bored. Before sessions, you feel slightly agitated and annoyed with this client for no reason. During sessions, you find yourself daydreaming, thinking about other things, and otherwise withdrawing from the client. How comfortable would you be with discussing this reaction in supervision with your current supervisor?

1	2	3	4	5	6	7
Extremely uncomf.	Very uncomfortable	Uncomfortable	Uncertain	Comfortable	Very comfortable	Extremely comf.

How likely would you be to disclose these feelings with your current supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	Extremely likely

7. During session your client reveals to you that he or she is having problems accepting and understanding a close friend's homosexuality. You begin to feel anxious as they discuss this. How comfortable would you be with discussing this reaction in supervision with your current supervisor?

1	2	3	4	5	6	7
Extremely uncomf.	Very uncomfortable	Uncomfortable	Uncertain	Comfortable	Very comfortable	Extremely comf.

How likely would you be to disclose these feelings with your current supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	Extremely likely

8. Over the course of treatment, your client has criticized you, repeatedly questioned your ability to help them, and told you that you are a terrible therapist. You feel unappreciated, devalued, and mistreated by your client. These feelings have impacted your treatment towards this client, and you feel really angry because of them. How comfortable would you be with discussing this reaction in supervision with your current supervisor?

1	2	3	4	5	6	7
Extremely uncomf.	Very uncomfortable	Uncomfortable	Uncertain	Comfortable	Very comfortable	Extremely comf.

How likely would you be to disclose these feelings with your current supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	Extremely likely

APPENDIX G

Demographic Questionnaire

Please select the answer that is most appropriate for you. If you find that there is not an answer that is applicable to you, please select "other", and write in your response.

1. Which of the following best describes your current training site?
    A. Veterans Affairs hospital or medical center
    B. Community counseling center
    C. University counseling center
    D. Consortium
    E. Private general hospital
    F. State/county/other public hospital
    G. Correctional facility
    H. Psychiatric hospital
    I. Private outpatient clinic
    J. School district
    K. Armed Forces medical center
    L. Child/Adolescent psychiatric or pediatrics department
    M. Private psychiatric hospital
    N. Other _____

2. Which of the following best describes the population you are primarily working with at your training site?
    A. Adults
    B. Children/adolescents
    C. Geriatrics
    D. Combined

3. What percentage of your client contact hours is devoted to conducting individual psychotherapy?
    A. 100%
    B. 75-99%
    C. 50-74%
    D. 25-49%
    E. Less than 25%

4. Which of the following best describes your primary theoretical orientation?
    A. Cognitive-Behavioral (including cognitive and behavioral)
    B. Existential/Humanistic
    C. Family Systems
    D. Psychodynamic
    E. Other

5. Which of the following best describes your secondary theoretical orientation?
    A. Cognitive-Behavioral (including cognitive and behavioral)
    B. Existential/Humanistic
    C. Family Systems

D. Psychodynamic
E. Other

3. Current doctoral program type:
   A. Clinical
   B. Counseling
   C. Combined
   D. Other

4. Degree you are seeking:
   A. Ph.D.
   B. Psy.D.
   C. Other

5. How many months have you worked at your current training site so far
   A. 0-3
   B. 3-6
   C. 6-9
   D. 9-12
   E. 12 or more

6. Which of the following best describes your racial/ethnic identification? Check all that apply.
   A. African-American/Black
   B. American Indian/Alaska Native
   C. Asian/Pacific Islander
   D. Hispanic/Latino
   E. White (non-Hispanic)
   F. Other _____

7. What is your gender identity
   A. Female
   B. Male
   C. Other (transgender, intersex, androgynous)

8. What is your sexual orientation?
   A. Heterosexual
   B. Gay
   C. Lesbian
   D. Bisexual
   E. Questioning
   F. Other

9. Which of the following best describes your primary supervisor's theoretical orientation?

A. Cognitive-Behavioral (including cognitive and behavioral)
B. Existential/Humanistic
C. Family Systems
D. Psychodynamic
E. Other

10. Which of the following best describes your primary supervisor's gender?
    A. Female
    B. Male
    C. Other (transgender, intersex, androgynous)
    D. I don't know

11. Do you believe that you and your supervisor are of the same sexual orientation?
    A. Yes
    B. No
    C. I don't know

12. Which of the following best describes your primary supervisor's racial/ethnic identification? Check all that apply.
    A. African-American/Black
    B. American Indian/Alaska Native
    C. Asian/Pacific Islander
    D. Hispanic/Latino
    E. White (non-Hispanic)
    F. I don't know

13. How many years of supervised psychotherapy experience do you have?
    A. Less than 1
    B. 1
    C. 2
    D. 3
    E. 4
    F. More than 4

APPENDIX H

Recruitment Letter: Training Directors

Dear Director of Training,

I am a student in the Psy.D. Program in Clinical Psychology at Pepperdine University. My dissertation examines the relationship between supervisory alliance and disclosure of therapists' personal reaction about psychotherapy clients. Doctoral students, including interns, from all APA-accredited clinical and counseling psychology programs are invited to participate in this study. Since names and addresses of graduate psychology students are not available, I am requesting the assistance of academic directors of training to forward this e-mail to their students as an invitation to participate in the research.

Participation in the study entails completing an on-line survey that includes a demographic section, description of their current supervision experience, and likely comfort and willingness to disclose personal reactions or countertransference in supervision to brief hypothetical clinical scenarios. The approximate time to complete the survey is 10 minutes. In appreciation of their time, participants may choose to send an e-mail to an address provided at the end of the survey to enter a drawing for one of two a $50 gift cards to Amazon.com. It is possible for participants to quit at any time and enter the drawing by clicking a link provided on each page. E-mail addresses collected for the raffle will in no way be connected to survey data.

Participation in this study poses no more than minimal risk. While I do not anticipate any harm to be experienced by your students as a result of participation, there is the risk that some of the hypothetical examples may elicit discomfort or describing their current supervisory experience may potentially result in discomfort. If such occurs, I am advising students to either contact a trusted clinician, their training director, another faculty member, or Dr. Edward Shafranske or Dr. Carol Falender, members of this dissertation committee, who have expertise in supervision, to assist in addressing any negative experiences. Please be advised that forwarding a link to the surveys to your students indicates that you acknowledge that you have been informed of the nature of the study, and that you have voluntarily agreed to participate.

Link to the survey: http://www.surveymonkey.com/s/workingallianceanddisclosure

An abstract of this study is available upon request, and your school does not need to participate in order to receive a copy of the abstract. The data collected will not be analyzed by Pepperdine University. I can be contacted at my e-mail address, [redacted], for any questions about this study. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Yuying Tsong, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at [redacted].

It would be much appreciated if you would kindly forward this e-mail to your students. Thank you again for your assistance.

Sincerely,

Shirley Pakdaman, MA
Doctoral Student,
Pepperdine University

APPENDIX I

Recruitment Letter to Participants and Statement of Consent

Dear Psychology Student,

I am a student in the Psy.D. Program in Clinical Psychology at Pepperdine University. I am studying the relationship between supervisory alliance and personal reaction disclosure in my dissertation. I would deeply appreciate your help in completing this study. The surveys ask about your experience in supervision as well as your responses to several hypothetical situations. The time to complete the surveys is about 10-15 minutes.

Of course, your participation is voluntary. The survey information will be obtained anonymously, no identifying information will be asked, and results will be reported as aggregate data. As a participant, you would complete an online survey related to your experience with your current primary supervisor, your comfort in discussing reactions to therapy clients, and a brief demographics questionnaire. In appreciation of your time, you may choose to send an e-mail to an address provided at the end of the survey to enter a drawing for one of two a $50 gift cards to Amazon.com. Participation is not required to enter the drawing and participants may quit at any time. Two winners will be notified by e-mail. Drawing entrants' e-mail address will be kept confidential and will in no way be linked to survey responses.

Participation in the study poses no more than minimal risk. While I do not anticipate you to experience any harm as a result of participation, there is the possibility that some of the hypothetical examples may elicit discomfort or describing your current supervisory experience may potentially result in discomfort. If such occurs, I recommend that you consult with a trusted faculty member, clinical supervisor, or mental health professional to address any negative experiences. You may also consult with Drs. Falender or Shafranske through Pepperdine University at [redacted] to assist in addressing any negative experiences should they arise.

Benefits for your participation will be contributing to a greater understanding of the impact that the supervisory relationship has on students' willingness to disclose reactions, and possibly winning a $50 gift card. Please be advised that participating indicates that you acknowledge that you have been informed of the nature of the study, and that you have voluntarily agreed to participate.

An abstract of the study is available upon request by e-mail, and you do not need to participate in order to receive the abstract. If you have any questions or comments regarding the study, you may contact me at my e-mail address, [redacted]. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Yuying Tsong, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at [redacted].

Thanks again for your help with the completion of this dissertation project! Completion of the online survey by **May 13, 2011** is greatly appreciated.

Sincerely,

Shirley Pakdaman, MA
Doctoral Student
Pepperdine University

Statement of Consent to Participate

This survey examines the relationship between supervisory alliance and the disclosure of personal reactions to clients in supervision. The survey asks about your experience in supervision as well as your responses to several hypothetical situations. Survey completion time is approximately 15 minutes. This study is part of the dissertation scholarship conducted by Shirley Pakdaman, supervised by Edward Shafranske, Ph.D., ABPP, at Psy.D. Program, Pepperdine University. This study has been approved by Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University.

Consent to Participate

I understand that my participation is voluntary and that my anonymity will be maintained because no identifying information will be requested and no IP addresses will be recorded. All results will be reported as aggregate data.

I understand that as a participant, I will be asked to provide demographic information and to respond to questions/items related to my experiences with my current primary supervisor and comfort in discussing personal reactions to therapy clients in supervision as well as to hypothetical situations.

I understand that, although there are no direct benefits to all participants in this study, my participation will contribute to obtaining greater understanding of the impact that the supervisory relationship has on doctoral students' willingness to disclose personal reactions in supervision. Also, I may choose to enter a drawing for one of two a $50 gift cards to Amazon.com by sending an e-mail to an address provided at the end of the survey. I understand that participation is not required to enter the drawing and participants may discontinue completing the survey at any time. Two winners will be notified by e-mail. Drawing entrants' e-mail address will be kept confidential and will not be linked to survey responses.

I understand that participation in this study poses no greater than minimal risk and that I may decline to participate or discontinue participation at any time. While the investigator does not anticipate that a participant would experience any harm as a result of participation, there is the possibility that describing current supervisory experiences or reflecting on the hypothetical examples might elicit discomfort. If such occurs, it is recommended that I consult with a trusted faculty member, clinical supervisor, or mental health professional to address any negative experiences. Also, I have been advised that I may consult with Dr. Falender or Dr. Shafranske through Pepperdine University at [redacted] to assist in addressing any negative experiences should they arise.

I understand that the study has been approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board and that should I have any questions or comments regarding the study, I may the investigator at her e-mail address, [redacted]. I may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Yuying Tsong, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at [redacted].

I understand that by checking "I agree" I indicate my voluntary consent to participate and that I have been informed of the nature of the study, the potential benefits and risks, and that my anonymity is ensured because survey information will be gathered with no related identifying information or IP addresses obtained.

___ I voluntarily consent to participate in this study.

___ I do not give my consent to participate in the study and wish to exit the study.