2012

Supervisory alliance and countertransference disclosure in peer supervision

Sara Mack

Pepperdine University

Graduate School of Education and Psychology

SUPERVISORY ALLIANCE AND COUNTERTRANSFERENCE DISCLOSURE IN PEER SUPERVISION

A dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Sara Mack

March 2012

Edward P. Shafranske, Ph.D., ABPP – Dissertation Chairperson

This clinical dissertation, written by

Sara Mack

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Edward P. Shafranske, Ph.D., ABPP, Chairperson

Carol A. Falender, Ph.D.

Aaron Aviera, Ph.D.

TABLE OF CONTENTS

Page

LIST OF TABLES vi

DEDICATION vii

ACKNOWLEDGEMENTS viii

VITA x

ABSTRACT xv

INTRODUCTION 1

- Functions of Clinical Supervision 1
- Background 1
  - Peer Supervision 2
  - Management of Personal Factors as a Clinical Competence 6
  - Countertransference or Therapist's Personal Reactions 7
  - Empirical Research on Countertransference 9
  - Countertransference Management and Supervision 10
  - Therapeutic and Supervisory Working Alliances 12
  - Supervisory Alliance and Management of Countertransference 14
  - Disclosure and Nondisclosure in Supervision 14
  - Limitations and Gaps in Supervision Literature 15
- Purpose of this Study 16
- Research Questions and Hypotheses 17

METHOD 19

- Research Approach 19
- Participants 20
  - Characteristics of Peer Supervision 20
- Instrumentation 21
  - Working Alliance Inventory-Supervisee 21
  - Reaction Disclosure Questionnaire 22
  - Demographic Questionnaire 23
- Pilot Study 24
- Procedure 25
  - Recruitment 25
  - Protection of Human Subjects 26
  - Potential Risks and Benefits 26
  - Consent for Participation 27
  - Data Collection 28

Page

Data Analysis 28

RESULTS 30

Relationship Between Working Alliance and Countertransference Disclosure 31
Dyad Comparisons of Comfort with and Likelihood of Countertransference Disclosure 32

DISCUSSION 35

Implications for Clinical Training and Professional Psychology 37
Limitations and Recommendations for Future Research 38
Conclusion 42

REFERENCES 43

TABLES 52

APPENDIX A: Literature Review Tables 64

APPENDIX B: Working Alliance Inventory 201

APPENDIX C: Reaction Disclosure Questionnaire 207

APPENDIX D: Demographic Questionnaire 217

APPENDIX E: Recruitment Letter to Program Directors 222

APPENDIX F: Recruitment Letter to Participants 224

APPENDIX G: Follow-up Letter to Program Directors 226

APPENDIX H: Introduction to the Survey and Consent to Participate 228

APPENDIX I: Pepperdine IRB Application 231

LIST OF TABLES

Page

Table 1. Participant Demographics 52

Table 2. Peer Supervisor Demographics.....54

Table 3. Supervisor Demographics.....55

Table 4. Summary of Means, Standard Deviations, and Intercorrelations for Scores on the Working Alliance Inventory for Supervision and the Reaction Disclosure Questionnaire 56

Table 5. Summary of Regression Analysis.....57

Table 6. Differences Between Comfort with and Likelihood of Disclosure and Working Alliance (WA) in Peer and Primary Supervisory Dyads 58

Table 7. Attitudes and Experiences Influencing Disclosure in Peer Supervision.....59

DEDICATION

To my family, who inspired my love of learning and who have always believed in me.

ACKNOWLEDGEMENTS

There are many individuals I would like to recognize at the conclusion of this dissertation process. First of all, I would like to thank my wonderful committee members for their knowledge, support, and passion for clinical supervision and training. Dr. Edward Shafranske, I would like to thank you for deepening my knowledge of psychodynamic/analytic theory and therapy, for giving me the opportunity to conduct this study, and for being a great mentor. Dr. Carol Falender, I would like to thank you for your enthusiasm for and guidance with all things related to professional development. Dr. Aaron Aviera, thank you for setting the supervision bar high for my doctoral training and for introducing me to peer supervision.

Certainly, I would like to thank all my supervisors: Laura Pogue, Dr. Aaron Aviera, Dr. Joan Rosenberg, Dr. Susan Himelstein, Dr. Enrique Lopez, Dr. Carole Goguen, Dr. Carissa Klevens, Dr. Anne Eipe, Dr. Nikki Saltzburg, Dr. Dan Alonzo, Dr. Veronica Stotts, and Dr. Mark Stevens. I would like to thank my peer supervisors Janet and Marissa, as well as Sarah, Jessica, and Maureen. I would also like to thank Lauren and Nicole, my peer supervisees. I have taken a piece of each of you with me.

In addition, Dr. Yuying Tsong, I would like to thank you for your statistical assistance and for your patience with me. I would also like to thank my internship training director Dr. Julie Pearce and my fellow interns for their support and encouragement through the final stages of this process. Furthermore, to my fabulous friends at Pepperdine, thank you for your support. I am so grateful to have you all in my life. To my parents, thank you for all that you have done and continue to do – you have

made this journey possible. And finally, to my husband, thank you for your infinite love and for sticking with me through both the laughter and tears.

VITA

SARA MACK

EDUCATION

September 2008 – present
PEPPERDINE UNIVERSITY, Los Angeles, CA
Expected Spring 2012 Doctoral Degree in Clinical Psychology (Psy.D.)

May 2008
CHESTNUT HILL COLLEGE, Philadelphia, PA
M.S. in Clinical and Counseling Psychology

May 2005
UNIVERSITY OF SOUTHERN CALIFORNIA, Los Angeles, CA
B.A., Theatre; Minor: Communications and the Entertainment Industry
Summa Cum Laude

CLINICAL TRAINING EXPERIENCE

August 2011 – present
California State University, Northridge
University Counseling Services
Northridge, CA
Psychology Intern
Primary Supervisor: Anne Eipe, Ph.D.

- Provide short-term individual psychotherapy to undergraduate and graduate students of diverse backgrounds with a variety of presenting concerns
- Conduct three intake evaluations per week
- Co-facilitate two structured groups:
    - Relaxation/Guided Imagery
    - Body Esteem Boot Camp
- Co-facilitate weekly process group for graduate students
- Provide crisis intervention and management with ongoing clients and during intakes
- Participate in weekly individual supervision
- Present clinical cases in monthly video case conference
- Provide outreach programming and consultation to campus community
- Participate in weekly professional seminars, training modules, case disposition meetings, and staff meetings

August 2010 – July 2011
VA Los Angeles Ambulatory Care Center
Psychology Service
Los Angeles, CA
Psychology Practicum Student
Primary Supervisor: Carole Goguen, Psy.D.

- Co-facilitated weekly psychoeducational group for Filipino WWII veterans centered on Posttraumatic Stress Disorder and depression

- Provided short-term individual psychotherapy to veterans with various diagnoses in an outpatient setting
- Participated in weekly individual supervision
- Co-facilitated weekly groups for veterans with serious mental illness in the Psychosocial Rehabilitation and Recovery Center
    - Two recovery process groups
    - Psychoeducational group utilizing SAMHSA's Illness Management and Recovery Evidence-Based Practice curriculum
- Participated in weekly training seminars (Law & Ethics, Behavioral Medicine) and monthly High Risk case conference

July 2008 – July 2011

Pepperdine Psychological and Educational Clinic
Los Angeles, CA
Practicum Trainee
Supervisors: Joan Rosenberg, Ph.D. September 2009 – July 2011
Aaron Aviera, Ph.D. July 2008 – August 2009

- Provided individual psychotherapy to primarily young adult clients of diverse backgrounds in an outpatient setting
- Provided crisis management for clients with suicidality
- Conducted intake evaluations to formulate treatment plans
- Conducted comprehensive psychoeducational evaluation including cognitive, academic, and emotional assessments, wrote full report, and conducted feedback session (Supervisor: Susan Himelstein, Ph.D.)
- Presented clinical cases in weekly 1-hour group supervision (September 2009 – July 2011) and individual supervision (July 2008 – August 2009)
- Participated in weekly 1-hour peer supervision with advanced Psy.D. student (July 2008 – August 2010)
- Participated in weekly case conferences (September 2008 – May 2009)

September 2009 – August 2010

Cedars-Sinai Medical Center
Psychiatry and Behavioral Neurosciences
Los Angeles, CA
Neuropsychology Extern
Supervisor: Enrique Lopez, Psy.D.

- Conducted comprehensive neuropsychological evaluations for child, adolescent, and adult outpatients of diverse backgrounds with a variety of medical and psychiatric diagnoses (e.g., ADHD, neurodevelopmental disorders, depression)
- Selected cognitive and psychological assessments to address clients' concerns regarding cognitive and emotional functioning
- Conducted brief ADHD screening batteries for child and adolescent clients

- Administered and scored tests, interpreted findings, and wrote full report for each client
- Received training to administer a neuropsychological research battery for a study examining the effects of HIV and aging
- Participated in weekly case conference with multidisciplinary members of Child Psychiatry Department
- Participated in weekly individual and group supervision
- Participated in periodic didactic seminars
- Attended weekly grand rounds for Department of Psychiatry

May 2007 – April 2008 Belmont Center for Comprehensive Treatment
Philadelphia, PA
Master's Level Student Intern at private psychiatric hospital
Supervisor: Laura E. Pogue, M.S., LPC, NCC

- Facilitated and co-facilitated group psychotherapy for adult patients of diverse backgrounds experiencing exacerbations of serious mental illness (e.g., Schizophrenia) or acute episodes of anxiety or mood disorders
- Co-facilitated group therapy (creative arts and recreation) for child patients with depression, anxiety, and behavior disorders
- Completed clinical documentation
- Participated in multidisciplinary treatment team meetings

PEER SUPERVISION EXPERIENCE

September 2010 – July 2011 Pepperdine Psychological and Educational Clinic
Los Angeles, CA
Peer Supervisor
Supervisor: Aaron Aviera, Ph.D.

- Provided face-to-face consultation on a weekly basis to two 1st year practicum trainees (1 hour each) as well as additional consultation in-person or via telephone as needed
- Participated in weekly 1-hour group supervision for peer supervisors
- Participated in monthly case conferences, which involved facilitating discussion and assisting trainees with case conceptualization, diagnosis, and treatment planning

RESEARCH EXPERIENCE

December 2009 – August 2010 Graduate School of Education and Psychology
Pepperdine University
Los Angeles, CA
Research Assistant to Edward Shafranske, Ph.D., ABPP and Carol Falender, Ph.D.

- Compiled references for manuscript in preparation for publication, *Getting the most out of clinical supervision: A practical guide for interns and trainees*

- Assisted with various projects related to their work on clinical supervision

August 2009 – December 2009 Carol Falender, Ph.D.
Los Angeles, CA
Research Assistant
- Compiled references for manuscript
- Reviewed manuscript for content editing suggestions

September 2006 – April 2008 Department of Professional Psychology
Chestnut Hill College
Philadelphia, PA
Graduate Assistant to Scott Browning, Ph.D. and Department
- Reviewed manuscript for content editing suggestions and assembled proposals to send to publishers
- Conducted literature reviews on stepfamily therapy
- Created video catalog for the department educational media
- Performed clerical duties for the faculty and administration

October 2005 – March 2006 The University of Southern California Family Studies Project
January 2005 – May 2005 Los Angeles, CA
Volunteer Research Assistant
- Transcribed interviews on marital conflict and aggression from audio tape into computer program
- Assisted in participant family interviews to study how families cope with stress
- Obtained cortisol samples from participant family members in order for lab members to analyze physiological responses when participants were thinking about and discussing conflict
- Entered data into statistical analysis programs

PUBLICATIONS AND PRESENTATIONS

Articles

Lopez, E., Morales, G., Saucedo, C., Aguirre-Girón, L., **Mack, S.**, & Goodkin, K. (2010). Commentary: A proposition against using the terms 'Hispanic' and 'Latino' in research on HIV-associated neurocognitive disorders. *Ethnicity & Disease, 20*(4)*,* 479-484.

Neugebauer, Q., **Mack, S**., Roubin, A., & Curiel, A. (2011). Primary prevention of eating disorders in children and a proposed parent education program. *Graduate Student Journal of Psychology, 13,* 52-59.

Presentations

Mack, S., & Falender, C. J. (2010, August). Countertransference disclosure and peer supervision.

In T. R. Burnes (Chair), *Training the next generation of professionals--Current issues in counseling supervision and training.* Symposium conducted at the American Psychological Association Annual Convention, San Diego, CA.

Sloane, R., & **Mack, S.** (2009, June). *Mindfulness*. Community outreach presentation at Union Rescue Mission, Los Angeles, CA.

ABSTRACT

Peer supervision is an evolving mode of training used in counselor/psychologist/therapist education and professional development. Little is known, however, about the format of peer supervision in clinical and counseling psychology doctoral programs, its effectiveness, or differences in the processes or outcomes of traditional supervision (supervisor of record and supervisee) and peer supervision (consultation between clinical trainees and/or graduate student classmates). This study aimed to examine one aspect of peer supervision and to provide a comparison between supervision of record and peer supervision. The study examined the role of alliance on countertransference disclosure. Fifty-two clinical and counseling psychology doctoral students from APA accredited programs completed the Working Alliance Inventory/Supervision (WAI-S; Bahrick, 1990) and the Reaction Disclosure Questionnaire (Daniel, 2008) for both their peer and primary supervisors as well as completed a demographic questionnaire. The results supported the research hypotheses: supervisory working alliance was found to be positively correlated with the degree of comfort with and the likelihood of countertransference disclosure to peer supervisors as well as to primary supervisors. No significant variances were found between degree of comfort with or likelihood of countertransference disclosure to peer or primary supervisors or between working alliance with peer and primary supervisors. These results are consistent with previous research on the positive correlation between supervisory working alliance and comfort with and likelihood of countertransference disclosure (Daniel, 2008; Pakdaman, 2011) and contribute to the larger body of literature on therapists' management of personal reactions. Limitations of this study include those related to a small sample size

(representative of primarily Caucasian females), inability to infer causation, and methodology (e.g., self-report methods, potentially inadequate sensitivity of instruments). Recommendations for future research include a determination of the number of doctoral programs with peer supervision, an exploration of peer supervisees' experiences in peer supervision as well as critical incidents, and an investigation of the efficacy of peer supervision on therapy outcome.

Introduction

Functions of Clinical Supervision

Supervision provides the essential foundation for the training of professionals in the mental health field (Bernard & Goodyear, 2009) and has the critical functions of assuring the integrity of clinical services and building competence in the supervisee (Falender & Shafranske, 2004). Among the competencies that are developed during clinical training is the ability to recognize and to appropriately respond to the impact of personal factors and therapist reactions on the therapeutic process. In addition to formal supervision, clinical training may include peer supervision, which serves as a form of consultation in which more experienced peers provide (under supervision) many (but not all) of the functions found in the supervision of record. One area in which peer supervision may play a particularly important role is in providing consultation specific to the management of personal reactions, heretofore referred to as countertransference. It was hypothesized that countertransference may be more readily disclosed and addressed by supervisees with their peer supervisors, as peers may provide additional support, validation, and connection (Butler & Constantine, 2006) without the threat of evaluation (Benshoff, 1994). This study intended to examine supervisee countertransference disclosure within peer supervision and the role alliance plays in such disclosure. We now turn to a review of the major areas under study.

Background

This section includes the following areas related to clinical supervision: (a) peer supervision, (b) countertransference management as a clinical competence, (c)

supervisory alliance, (d) nondisclosure in supervision, and (e) limitations and gaps in the supervision literature.

Peer supervision. The supervisee's training experience may be enhanced by peer supervision, which is a developing trend in professional psychology (Bernard & Goodyear, 2009). Other disciplines such as social work (e.g., Schreiber & Frank, 1983), psychiatry (Todd & Pine, 1968), nursing (e.g., Bos, 1998), psychiatric nursing (e.g., Barry, 2006), medicine (e.g., Renko, Uhari, Soini, & Tensing, 2002), and mediation (Minkle, Bashir, & Sutulov, 2008) utilize peer supervision in teaching (e.g., Brown, Hogg, Delva, Nanchoff-Glatt, & Moore, 1999), training models (e.g., Bos, 1998), and peer consultation groups for professionals (e.g., Barry, 2006). Benefits of peer supervision include consultation and help with problematic cases (e.g., Barry, 2006; Lewis, Greenburg, & Hatch, 1988; Page, Pietrzak, & Sutton, 2001), skill and technique development (e.g., Benshoff, 1993; Benshoff & Paisley, 1996), and support (e.g., Akhurst & Kelly, 2006; Counselman & Weber, 2004). Peer supervision also offers trainees the opportunity to learn how to supervise, a competence that most psychologists will employ at some point in their careers. Indeed, improvement in supervision and consultation skills has been cited as a benefit of the practice (Benshoff, 1994; Benshoff & Paisley, 1996).

It is important to note that peer supervision is a distinct practice from clinical supervision and formal professional consultation. Peer supervision has an ongoing format within a collegial, peer relationship between individuals of the same profession. The activity involves monitoring and feedback but is not evaluative. Rather than client-centered, the focus may be more counselor-centered and provide goal setting to promote professional growth (Wilkerson, 2006). In contrast, clinical supervision is

> an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for those who are to enter the particular profession. (p. 7)

Multiple factors influence the practice of supervision, and there is variation based on issues of evaluation, hierarchy, length, and purpose. For example, the theoretical orientation of different psychotherapy-based approaches to supervision will determine the nature of the hierarchical relationship. In relational psychodynamic supervision, although the relationship is unequal and the supervisor has more power, the supervisory relationship is viewed as a reciprocally influential relationship that is co-created by supervisee and supervisor (Beck, Sarnat, & Barenstein, 2008). In cognitive therapy supervision, the relationship is one of "collaborative teamwork" (Beck et al., 2008, p. 60), and a more collaborative stance involving empowerment of the supervisee characterizes the relationship in feminist supervision (Porter, 2009). In regard to peer supervision, variation exists depending on the setting in which the arrangement occurs. For instance, in some settings peer supervision may involve evaluation and a hierarchical relationship. Length of peer supervision may vary as the duration may be only for a semester course. In addition to supervision of record's dual purposes of improving professional functioning and monitoring client wellbeing (Bernard & Goodyear, 2009),

peer supervision may have the purpose of teaching trainees how to supervise (i.e., as part of a course or a training module).

Although consultation may be sought from a consultant who has expertise in a specific area of interest, the consultee holds the clinical responsibility for the case. Consultation is not typically a requirement, is shaped by the consultee's needs, and may be provided by a member of a different profession (Thomas, 2007). The consultee is not obligated to follow the consultant's suggestions (Caplan, 1970). Furthermore, peer supervision is different from mentoring, in which a skilled often older individual guides, teaches, and serves as a role model for a less experienced, often younger individual, in the context of a personal relationship (Clark, Harden, & Johnson, 2000). Mentoring has an ongoing, voluntary format and consists of both formal and informal activities in which the overall aim is to help a less experienced individual become successful in his or her profession (Kaslow & Mascaro, 2007). The mentoring relationship is reciprocal, while the supervisory relationship is evaluative and focuses more on providing technical direction (Johnson, 2007) in addition to upholding the quality of client care and serving a gatekeeper function for the profession (Falender & Shafranske, 2004).

Peer supervision has been described in a variety of ways over the past 35 years. Spice and Spice (1976) described a triadic model of peer supervision for counseling trainees in which students rotated roles of supervisee, commentator, and facilitator at each session to learn the skills of case presentation, critical commentary, meaningful dialogue, and here-and-now process. In Wagner and Smith's (1979) model, counselor trainees rotated between peer supervisee and peer supervisor each week with the goal of building a support system that would continue beyond the supervisor of record. Remley,

Benshoff, and Mowbray (1987) described a peer supervision model for counselors of 10 hour-long sessions with a clear structure involving goal-setting, case presentations, audio or videotape review of sessions, and discussion of readings. These early models have served as templates for several structured peer supervision models (e.g., Benshoff & Paisley, 1996).

Furthermore, various terms such as *peer consultation, peer review,* and *peer mediated learning experiences* (Zins, Ponti, & Murphy, 1992) have been used to refer to peer supervision. An early definition of peer supervision was "a process in which counselors-in-training help each other become more effective and skillful helpers by using their relationships and professional skills with each other" (Wagner & Smith, 1979, p. 289). Later, peer supervision or consultation referred to "arrangements in which peers work together for mutual benefit" involving "a process in which critical and supportive feedback is emphasized while evaluation is deemphasized" (Benshoff, 1994, para 2). Wilkerson (2006) constructed a particularly comprehensive definition for the arrangement:

> a structured, supportive process in which counselor colleagues (or trainees), in pairs or in groups, use their professional knowledge and relationship expertise to monitor practice and effectiveness on a regular basis for the purpose of improving specific counseling, conceptualization, and theoretical skills. (p. 62)

Although various labels exist, to date, there does not seem to be an agreed-upon definition for this type of educational and professional activity.

In addition, there is ambiguity in the meaning and nature of peer supervision depending on the context in which it is used. In some settings, non-licensed individuals

provide supervision under the direction of the supervisor of record, while peer supervision in other settings does not include an evaluative component and may have a different duration (e.g., for a semester during a course). Thus, uncertainty over the nature of peer supervision may lead to misunderstanding about issues related to authority and boundaries. Moreover, the supervision of peer supervision is important to consider. The peer supervisor may or may not be supervised by the peer supervisee's supervisor of record. If another individual supervises the peer supervisor, there may be greater likelihood of the peer supervisee receiving incongruent feedback.

Indeed, peer supervision has been an evolving arrangement utilized for counselor/therapist training and professional development. This study intended to advance understanding of peer supervision, specifically with respect to the clinical competency of management of countertransference, or therapist personal reactions in therapy (Shafranske & Falender, 2008). In this study, peer supervision was defined as an ongoing relationship in which a more senior trainee serves as a consultant to a less senior trainee. The primary supervisor referred to the supervisor at the training site who is responsible for the supervisee's work and under whose license the supervisee practices.

Management of personal factors as a clinical competence. In the last 20 years, professional psychology has emphasized the identification of core competencies to assess the learning outcomes of trainees. Moreover, documentation of acquired competencies throughout training is becoming necessary for licensure (Fouad et al., 2009). In regards to supervision, competence refers to knowledge, skills, and values developed, assembled into competencies, and assessed through formative and summative evaluations (Falender & Shafranske, 2004). One aspect of clinical competence is awareness of personal factors,

their impact on therapy, and the ability to utilize them to further treatment (Shafranske & Falender, 2008). Countertransference is a personal factor that impacts therapy. Whereas personal responsiveness reflects a clinician's empathy with a client's experience and fosters engagement and understanding, countertransference refers to the therapist's reactivity, which may lead to the therapist's failures in accurate empathy, heightened emotional reactions, disconnection, difficulties in self-reflection, and engagement in unplanned behaviors (Shafranske & Falender, 2008). Countertransference management may be considered to be an aspect of the foundational competency of reflective practice and the functional competency of supervision (Fouad et al., 2009). Furthermore, psychologists must develop competence in reflective practice, as the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002) indicates that psychologists should attempt to benefit and do no harm to those with whom they work (Principle A) as well as respect differences and be aware of their own biases (Principle E). Thus, countertransference management is one of the competencies that supervisees need to develop.

Countertransference or therapist's personal reactions. The construct of countertransference originated in the early development of psychoanalysis. Freud (1910) considered the personal reactions of the doctor, beyond professional care and concern, to be counter-transference and to stem from the patient's influence on the analyst's unconscious. While different perspectives were shaped in its 100-year development, the generally accepted idea today is that countertransference is created in part by the therapist's internal dynamics and in part shaped by feelings generated by the patient. Thus, countertransference has moved from the limited concept of the therapist's

transference to the patient's transference to an unavoidable, mutually constructed event that permeates treatment (Gabbard, 2001).

Countertransference may be defined as all of the personal responses of the therapist, referred to as the comprehensive model, or only the reactions originating from the therapist's transference, that is, his or her unconscious conflicts and needs (Falender & Shafranske, 2004) – the latter definition being psychoanalytic. Even though the majority of the countertransference literature has come from psychoanalysis, Gelso and Hayes (1998) argued that countertransference is "pervasive and pantheoretical" (p. 81) and can be addressed from different perspectives. Indeed, theorists from a variety of orientations have begun to discuss the therapist's personal responses. Humanistic as well as family and couples therapists consider their personal responses to be valuable information that enables greater understanding of the client or family/couple (Grant & Crawley, 2002). In cognitive psychology, countertransference may be viewed as the therapist's schema (Gelso & Hayes, 1998). Ellis (2001), a pioneer of cognitive therapy, acknowledged that the therapist's problematic feelings, which might intersect with client material, are nearly inevitable. He considered countertransference to originate in biology and social learning, consisting of the therapist's prejudiced thoughts, emotions, and behavior. Ellis (2001) advocated experimenting with countertransference to benefit treatment.

Furthermore, since practicing clinicians predominantly use integrative or eclectic approaches (Grant, 2006), a transtheoretical perspective on countertransference may be the most beneficial to study. An alternative perspective suggests placing emphasis on the consideration of the impact of personal factors or personal reactions of various origins

(e.g., individual, cultural, religious) on the therapeutic relationship rather than employing the term countertransference, which for some is limited by its close association with psychoanalytic theory (Falender & Shafranske, 2010; Shafranske & Falender, 2008).

Empirical research on countertransference. Hayes and Gelso (2001) reviewed the countertransference research conducted in the past 50 years. Their findings were organized into Hayes's (1995) framework of origins, triggers, manifestation, management, and effects. They used Gelso and Hayes's (1998) definition of countertransference as the therapist's reactions that originate in his or her unresolved internal conflicts. Indeed, most studies on countertransference have utilized this definition. Studies that defined the construct differently (e.g., as all of the therapist's reactions) were excluded. In addition, Kiesler (2001) proposed a framework for empirical investigation of countertransference that would connect the various constructs and labels to the empirical base of the therapist's behavior. In this framework, subjective (i.e., stimulated by the therapist's unresolved issues) and objective (i.e., mainly elicited by the client) countertransference could be observed when the therapist's behaviors and experiences with a client in session deviated from a certain baseline (e.g., with the same client or other clients).

This investigator attempted to add to research conducted by Daniel (2008) and Pakdaman (2011) on countertransference disclosure among trainees. Thus, countertransference in this study was defined as "the therapists' internal and overt reactions to clients" (Daniel, 2008, p. 35), which is consistent with the transtheoretical perspective.

Countertransference management and supervision. The literature supports the notion that successful management of countertransference is required for effective treatment and preventing harm (Gelso & Hayes, 2001), since the therapist's not noticing or labeling countertransference and then engaging in behaviors that deviate from his or her baseline of experiences and behaviors is destructive (Kiesler, 2001). Moreover, if the impact of countertransference is inevitable, then clinicians must use this personal factor to further treatment (Falender & Shafranske, 2004). Exploring and managing countertransference is essential for the therapeutic relationship and treatment and is therefore a requirement for ethical practice. Clinical supervision provides the context for the supervisee to develop competence in recognizing and managing personal reactions, commonly referred to as countertransference.

Not only is countertransference management a competence learned in supervision, but addressing countertransference is a task that supervisees seem to value (Falender & Shafranske, 2004; Jacobsen & Tanggaard, 2009). Shafranske and Falender (2008) described a countertransference conceptual model that can be used in supervision to identify states of mind that arise in the therapist and to explore the influence of personal factors. This model complements the work of Gelso and Hayes (2001), who proposed five factors essential for countertransference management. These factors, or skills, consist of self-insight, self-integration, anxiety management, empathy, and case conceptualization. While exploration of the personal factors leading to countertransference reactions is often important in managing such reactions, it is essential to maintain the boundary between supervision and personal psychotherapy (Falender & Shafranske, 2004).

Other formats besides individual supervision allow for identification and exploration of countertransference or personal reactions. For instance, small group supervision can provide a supportive environment for observing and identifying parallel process (Counselman & Gumpert, 1993). Similarly, Markus and colleagues (2003) described how a peer group experiential model utilized primary process to direct, explain, and resolve countertransference. Shared risk-taking and vulnerability were considered to be advantages of this model (Markus et al., 2003). Trainees and practicing clinicians have viewed a process-centered group supervision approach as safe and less competitive compared to alternative models of supervision. In particular, typically quiet students appeared to be comfortable and empowered to share their perspectives (Bransford, 2009). With peers, trainees may be more open to receiving feedback as well as more willing to disclose, which may have implications for client treatment.

Thus, peer supervision may provide an opportunity to develop the competency of countertransference management. For example, peer supervision has been perceived to be different than other supervision – less threatening, more informal and comfortable (Benshoff, 1993) – since the specter of evaluation is absent (Benshoff, 1994) in some settings that use peer supervision. A lack of formal evaluation, however, may lead to unclear obligations in areas such as client care and professionalism as well as potentially marginalize the importance of feedback that is given. Nonetheless, peers, who may be dealing with similar professional issues, may provide additional support, validation, and connection (Butler & Constantine, 2006). Notably, identification and attention to emotional responses and countertransference (Greenburg, Lewis, & Johnson 1985; Schreiber & Frank, 1983; Todd & Pine, 1968) has been cited as a benefit. We turn now

to an examination of an essential aspect of effective clinical supervision – supervisory alliance.

Therapeutic and supervisory working alliances. In terms of successful supervision, a connection between quality of supervision and client outcome can be logically inferred (Bernard & Goodyear, 2009) – although this relationship has rarely been investigated. Many factors may lead to effective supervision in general, and more specifically, to the development of competence in countertransference management. In a meta-analysis of clinical supervision research, Ellis and Ladany (1997) determined that relationship quality is vital to effective supervision. The supervisory relationship is complex as individual, developmental, and cultural differences affect the supervisory encounter (Bernard & Goodyear, 2009). Not unlike the ideal therapist, the ideal supervisor has characteristics of respect, empathy, and genuineness, is supportive and noncritical (Carifio & Hess, 1987), as well as possesses skill in conducting evaluation, giving feedback, and training. Moreover, supervisory style involves variable levels of attractiveness, interpersonal sensitivity, and task orientation depending on trainee experience (Friedlander & Ward, 1984). Supervisor characteristics and style influence the supervisory relationship, which is the basis for the alliance wherein the critical functions can be accomplished (Falender & Shafranske, 2004).

Bordin (1983) conceptualized the supervisory alliance out of his view of the therapeutic working alliance. In this alliance, the therapist and client continuously build a relationship that involves three interconnected aspects of agreement on goals, agreement on tasks, and development of an emotional bond. In this conceptualization, the strength of the working alliance is central to the change process (Bordin, 1979). The working

alliance, however, is not an intervention or sufficient condition; it is a vehicle that supports and interacts with particular strategies (Horvath & Greenberg, 1989). Alliance is the way the "relationship reflects[s], embod[ies] and assist[s] the participants' purposive, collaborative work" (Hatcher & Barends, 2006). Furthermore, the quality of the working alliance has continually been associated with therapy outcome, and the strength of the association seems to hold across therapy orientation (Horvath, 2001). Similar to the therapeutic alliance, Bordin (1983) conceptualized the supervisory alliance as collaboration for change founded on mutually agreed-upon goals (e.g., competence in specific skills) and methods to accomplish them. The emotional bond (i.e., feelings of liking and trusting) is built through working together toward the goals. Bordin (1983) proposed that the amount of change in the supervisee is due to building and repairing the working alliance.

Supervisee-supervisor theory and research has drawn on client-therapist relationship research (Bernard & Goodyear, 2009). To investigate the supervisory working alliance and related factors, most researchers have either modified the most recognized measure of therapeutic alliance (Horvath & Greenberg, 1989) or developed an instrument for supervision (Bernard & Goodyear, 2009). For example, the Working Alliance Inventory/Supervision (WAI; Bahrick, 1990) is an adaptation of Horvath and Greenberg's (1989) Working Alliance Inventory. The supervisory working alliance has been associated with the client's perception of therapeutic alliance (Patton & Kivlighan, 1997), supervisor style (Chen & Bernstein, 2000; Ladany, Walker, & Melincoff, 2001), greater supervisor self-disclosure (Ladany & Lehrman-Waterman, 1999), discussions of cultural factors in supervision (Gatmon et al., 2001), supervisee satisfaction (Bahrick,

1990; Ladany, Ellis, & Friedlander, 1999), and less supervisee role conflict and ambiguity (Ladany & Friedlander, 1995). In addition, Ladany, Lehrman-Waterman, Molinaro, and Wolgast (1999) found that a greater amount of ethical violations by supervisors was correlated with weaker supervisory alliance and less supervisee satisfaction. Of note, just over half of supervisees in their study discussed their reactions with someone other than the supervisor; of these, 84% discussed them with a peer or friend. Thus, the peer relationship is worth exploring.

Supervisory alliance and management of countertransference. The supervisory relationship can help trainees understand their responses to clients and develop skills to manage them (Falender & Shafranske, 2004). A supervisory alliance wherein taking into account personal values and factors has been encouraged provides the best foundation for exploring countertransference (Falender & Shafranske, 2004). In fact, Daniel (2008) found that a strong supervisory working alliance was positively associated with the likelihood of countertransference disclosures to supervisors, as well as supervisee comfort level in disclosing. Of note, a match between supervisee and supervisor on gender, ethnicity, or theoretical orientation did not influence the likelihood of or comfort with supervisee disclosure (Daniel, 2008).

Disclosure and nondisclosure in supervision. Supervisee disclosure is a critical aspect of supervision. The supervisee must share information with the supervisor for him or her to help the supervisee develop competence as a clinician (Ladany, Hill, Corbett, & Nutt, 1996). Supervisee comfort level with self-disclosure and perceived supervisor affirmative attitudes (i.e., liking and respecting the supervisee, valuing the supervisee's culture) were shown to predict satisfaction with supervision (Duan & Roehlke, 2001).

However, Ladany and colleagues (1996) found that most supervisees engaged in nondisclosure, that is, they withheld information of a moderate level of perceived importance. Moreover, most nondisclosures (53%) were discussed with a peer or friend in the field. Poor supervisory alliance was a frequent reason for nondisclosure. Thus, a good alliance is necessary if the supervisee is to have comfort in sharing important information. Furthermore, it has been found that greater self-disclosure by the supervisor predicted stronger supervisory alliance (Ladany & Lehrman-Waterman, 1999).

Similarly, Yourman and Farber (1996) found that 30-40% of supervisees, doctoral students in clinical psychology, withheld material (e.g., admitting to clinical errors) from supervisors. More frequent supervisee satisfaction and supervisor discussion of countertransference were associated with less frequent supervisee nondisclosure. No demographic variables (e.g., supervisee age, supervisee gender, supervisor gender, gender interactions, ethnicity, theoretical orientation match or mismatch, and supervisee's years in the program) were significantly related to nondisclosure. Additionally, Hess and colleagues (2008) found that all predoctoral interns in their qualitative study withheld information from their supervisors. Negative feelings and concerns regarding evaluation were common reasons for nondisclosure. Power imbalances (e.g., impeding theoretical expression) as reasons for nondisclosure were not found in good supervisory relationships. Since nondisclosures may compromise client welfare and supervisee training (Hess et al., 2008; Ladany et al., 1996), countertransference discussion may be a challenging but productive activity (Yourman & Farber, 1996).

Limitations and gaps in supervision literature. A move to empirically demonstrate efficacy within professional psychology has resulted in a growing body of

literature on supervision process and outcomes (Falender & Shafranske, 2004). Numerous reviews of empirically based supervision studies have been done (Ellis, Ladany, Krengel, & Schult, 1996). Overall, the quality of clinical supervision research is inadequate due to statistical and methodological threats, high Type I and II error rates, and medium effect sizes (Ellis et al., 1996). Additionally, few replication studies have been conducted (Ellis & Ladany, 1997).

Substantial gaps exist in the literature on peer supervision. For instance, few peer or peer group supervision models have been evaluated on their effectiveness (Stanard & Hughes, 2008). Often, supervision has been restricted to providing feedback on a specific skill set taught in class (e.g., Stanard & Hughes, 2008). Little is known about the format of peer supervision in clinical and counseling psychology doctoral programs that lies between traditional supervision and consultation among clinical trainees and/or graduate student classmates. Thus, an initial exploratory study was determined to be beneficial.

In summary, the previous sections provided a brief overview of the functions of clinical supervision and an introduction to peer supervision. Therapist personal response management (or countertransference management) as a clinical competence, the supervisory alliance, nondisclosure in supervision, and limitations and gaps in the supervision literature were also reviewed.

Purpose of this Study

The purpose of this study was to provide the first empirical investigation of the role of alliance on countertransference disclosure in peer supervision as well as to provide an initial comparison between alliance and such disclosures in peer supervision and the supervision of record. Moreover, given the high rate of nondisclosure reported

(Hess et al., 2008; Ladany et al., 1996; Yourman & Farber, 1996), this study aimed to contribute as well to the empirical research on the relationship between supervisory alliance in general and countertransference disclosure (Daniel, 2008).

Research Hypotheses and Questions

Based on Daniel's (2008) finding that the supervisory alliance was related to the likelihood of and comfort with countertransference disclosure, it was hypothesized that this association exists in peer supervision. The following research hypotheses were tested:

1. Comfort level with countertransference disclosure in peer supervision is positively related to supervisory alliance with peer supervisor.
2. Likelihood of countertransference disclosure in peer supervision is positively related to supervisory alliance with peer supervisor.

In a sample of doctoral-level clinical and counseling psychology peer supervisory dyads the following research questions were answered:

For the peer supervisory dyads:

1. What is the relationship between the peer supervisee's perceived working alliance with the peer supervisor and his or her degree of comfort with countertransference disclosure?
2. What is the relationship between the peer supervisee's perceived working alliance with the peer supervisor and his or her likelihood of countertransference disclosure?

For the primary supervisory dyads:

3. What is the relationship between the peer supervisee's perceived working alliance with the primary supervisor and his or her degree of comfort with countertransference disclosure?
4. What is the relationship between the peer supervisee's perceived working alliance with the primary supervisor and his or her likelihood of countertransference disclosure?

For both dyads:

5. What is the relationship between the peer supervisee's degree of comfort with countertransference disclosure to peer supervisor compared to primary supervisor?
6. What is the relationship between the peer supervisee's likelihood of countertransference disclosure to peer supervisor compared to primary supervisor?

Method

Research Approach

A survey approach was chosen for this non-experimental study. In such an approach data is collected from a sample of individuals by asking questions and then analyzing their responses (Fowler, 1993). Specifically, survey instruments in the form of self-administered questionnaires were used to obtain supervisees' self-reports of attitudes and experiences.

Each research approach includes advantages and disadvantages. Some limitations of a survey approach include (a) potentially inaccurate self-reports, (b) nonresponse bias, (c) inability to clarify participants' questions, (d) lower return rates than questionnaires administered in-person, and (e) lack of in-person debriefing session. However, the potential limitations seemed to be outweighed by the benefits, which include (a) inexpensive cost compared to in-person administration, (b) ease of distribution as information can be collected quickly from a large sample over a broad geographic region, (c) anonymity of participants is allowed, and (d) no interviewer bias (Mitchell & Jolley, 2007).

This study involved a quantitative research design rather than general, descriptive survey research. In the quantitative approach in which the relationships between variables were under investigation, clear hypotheses were formulated, and data were collected that would either provide support or refute the hypothesized relationships between variables (Creswell, 2009). Specifically, a correlational approach was used to study the relationship between supervisory alliance and countertransference disclosure (i.e., comfort and likelihood of disclosure). Correlational research explores the association between

measures of several variables taken simultaneously from the same individual to better understand a more complex feature (Mertens, 2005). Finally, in addition to quantitative methods, this study included a qualitative aspect. Specifically, participants were invited to list factors that influenced their disclosure in peer supervision.

Participants

Participants were students enrolled in clinical and counseling psychology doctoral programs accredited by the American Psychological Association (APA). Participants were required to have a peer supervisor and be currently engaged in supervised clinical experience. Ninety-eight participants responded; however, due to a number of insufficiently complete surveys and some respondents not meeting the specified participant criteria, the final sample included 52 students, 42 females and 9 males. In regards to racial/ethnic identification, 84.6% of participants identified as White (non-Hispanic), 9.6% as Hispanic/Latino, 3.8% as Bi-racial/Multi-racial, and 1.9% as African American/Black. For theoretical orientation, 50% described their orientation as cognitive-behavioral, 17.3% as psychodynamic, 15.4% as humanistic/existential, 5.8% as eclectic/integrated, 5.8% as other, 3.8% as family systems, and 1.9% as don't know/unclear. For their educational experiences, 78.8% were pursuing a Psy.D. and 21.2% were pursuing a Ph.D. Within their doctoral programs, 30.8% were in their third year, 23.1% in their second, 19.2% in their fourth, 13.5% in their first, and 5.8% in their fifth (7.7% indicated "other").

Characteristics of peer supervision. In addition to the background information regarding the participants, it was also important to obtain data on the general characteristics of the peer supervision in which they had been involved. From August

2010 to April 2011, 57.7% of participants reported receiving 6 to 9 months of peer supervision, 25.0% reported less than 3 months, and 17.3% reported 3 to 6 months of peer supervision. In terms of frequency of peer supervision, 57.7% reported receiving 1 to 2 hours per week, 38.5% reported less than 1 hour per week, and 1.9% reported more than 2 hours per week. Demographic characteristics of the 52 participants are presented in Table 1. Peer supervisors' and primary supervisors' demographics are displayed in Tables 2 and 3, respectively.

Instrumentation

A survey instrument was developed to collect data via online administration. The survey included the Working Alliance Inventory-Supervisee Form, the Reaction Disclosure Questionnaire, and a Demographic Questionnaire (*see Appendices B-D*).

Working Alliance Inventory-Supervisee form (WAI-S). This self-report instrument, developed by Bahrick (1990), assesses the strength of the supervisory working alliance. Bahrick adapted the instrument from Horvath and Greenberg's (1989) Working Alliance Inventory (WAI), the most recognized measure of therapeutic alliance (Bernard & Goodyear, 2009). One strength of the WAI is that no items are identified with particular therapy models (Hatcher & Barends, 2006), allowing for a transtheoretical assessment of alliance; this is also the case in the WAI-S. The WAI-S has 36 items with three subscales of 12 items that relate to the alliance components of goals, tasks, and bond. Participants rate how they think or feel about their supervisor for each item using a 7-point Likert-type scale from 1 ("Never") to 7 ("Always").

Seven raters reviewed the 36 items to determine which of the three components of alliance (i.e., goals, tasks, and bonds) were applicable to each item. Reviewers had 97.6%

agreement for items assessing the bond factor, 60% agreement for items assessing the goals factor, and 64% agreement for items assessing the tasks factor (Bahrick, 1990). Although face validity has been established, no other psychometric properties have been tested (Daniel, 2008). Yet, given the importance of the supervisory relationship, numerous studies have utilized this instrument (e.g., Daniel, 2008; Ladany, Ellis, & Friedlander, 1999; Ladany & Friedlander, 1995; Ladany, Lehrman-Waterman, et al., 1999). Permission was given by Bahrick to use and modify the instrument for this study (see Appendix B). Therefore, items referred to "peer supervisor/peer supervision" rather than "supervisor/supervision" on the form completed for the peer supervisor. The directions were also modified to request that participants select the peer supervisor and primary supervisor with whom they spend the most time if they have multiple peer and primary supervisors. The overall working alliance score was the independent variable. For the current sample, Cronbach's alpha for the peer supervisee form was .976 and .982 for the supervisee form.

Reaction Disclosure Questionnaire. This self-report instrument was developed by Daniel (2008) to assess the supervisee's comfort with and likelihood of disclosing countertransference feelings and behaviors to his or her primary supervisor in eight hypothetical countertransference situations. Participants rate their comfort with disclosing their reactions to their clients to their primary supervisor and also how likely they would be to do so. The instrument uses a Likert scale from 1 ("extremely uncomfortable" or "extremely unlikely") to 7 ("extremely comfortable" or "extremely likely"). Hypothetical situations were used to control for variance in participants' prior experiences of

countertransference as well as to reduce the chance of a participant having a negative reaction while responding to the questionnaire.

The items were developed based on existing measures of countertransference (i.e., Inventory of Countertransference Behavior, ICB, Friedman & Gelso, 2000; Countertransference Questionnaire, Betan, Heim, Conklin, & Westen, 2005) and represent frequent manifestations of countertransference across theoretical orientations. On the Reaction Disclosure Questionnaire, countertransference is referred to as "personal reactions" in order to obtain responses from individuals of various theoretical orientations. Face validity was established through a pilot study, but reliability has not been demonstrated (Daniel, 2008).

In this study, likelihood of disclosing reactions and comfort in disclosing were the dependent variables. Permission was given by Daniel to use and modify the instrument for this study (see Appendix C). This investigator changed "supervisor" to "peer supervisor" on the form completed in reference to the peer supervisor. Participants were instructed to select the peer supervisor and primary supervisor with whom they spend the most time if they have multiple peer and primary supervisors. In addition, they were asked to consider their likelihood of and comfort with disclosing in one-on-one interactions. In the current sample, Cronbach's alpha for peer supervisee comfort in disclosing was .937 and for supervisee comfort was .924. Cronbach's alpha for peer supervisee likelihood of disclosing was .952 and was .917 for supervisee likelihood.

Demographic questionnaire. This questionnaire (see Appendix D) was developed by the investigator and consists of questions inquiring about participants' demographic information and experience in supervision. The following information is

requested: the trainee's type of degree program, degree sought, year in program, duration and frequency of both peer supervision and primary supervision received from August 2010 through April 2011, expectations regarding confidentiality of disclosure in peer supervision, and whether negative consequences have occurred from disclosure in peer supervision. In addition, the trainee's theoretical orientation, gender, and race/ethnicity, as well as the peer and primary supervisors' theoretical orientation, gender, and race/ethnicity are requested. The questionnaire has forced-choice items with a blank section for participants to provide supplementary information if the response "other" is endorsed. Blank space also is provided for participants to respond to the question "List two factors that have influenced your disclosure of personal reactions to clients in peer supervision with your peer supervisor." Demographic items were based on information available from the 2009 Association of Psychology Postdoctoral and Internship Centers (APPIC) Match Survey (Association of Psychology Postdoctoral and Internship Centers, 2009) and the APA 2010 Graduate Study in Psychology (Hart, Wicherski, Kohout, & Center for Workforce Studies, 2010).

Pilot Study

A pilot study was conducted to ensure the clarity of questionnaire items and to confirm that the expected survey completion time was 15 minutes. A focus group of four second-year clinical psychology doctoral students, who had peer supervisors, reviewed the survey instrument in hard copy paper format. They assessed the clarity of instructions, content, and wording, as well as determined face validity. Based on the focus group feedback, the questions were formatted in bold font to improve clarity.

Procedure

Recruitment. After receiving approval by the Institutional Review Board (IRB) of the Graduate and Professional Schools at Pepperdine University, hereafter referred to as IRB, recruitment was conducted via email contact with program directors (see Appendix E for recruitment letter). Directors were asked to forward a recruitment letter (see Appendix F) to students in their program via email. Three weeks after the recruitment letter was emailed to program directors, a follow-up email was sent to directors as a reminder to forward the recruitment letter to their students (see Appendix G). Recruitment commenced in May 2011.

There was no available data to determine the actual number of students enrolled in APA accredited clinical and counseling psychology doctoral programs or how many of these students have peer supervisors, as there is great variability in the number of students enrolled in each program and there have been no studies on peer supervision in APA accredited programs. For instance, APA accredited clinical psychology programs have an average of 15 incoming students (Norcross, Ellis, & Sayette, 2010), while APA accredited counseling psychology programs have, on average, 7 incoming students (Norcross, Evans, & Ellis, 2010). During recruitment, program directors at all APA accredited clinical and counseling psychology doctoral programs were emailed the recruitment letter. It is unknown, however, whether directors forwarded the study information to students. Therefore, this study may have resulted in a smaller rate of return than the average response rate of 39.6% for Internet-based surveys (Cook, Heath, & Thompson, 2000).

Protection of human subjects. An application was submitted to the IRB before recruitment to make certain that participants would be protected in accordance with the principles of respect for persons, beneficence, and justice outlined in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The application underwent expedited review because the research did not present more than minimal risk of potential emotional discomfort and no identifying information was to be collected. Potential participants were informed of the purpose of the study, the procedures, possible risks and benefits of participation, right to confidentiality, steps taken to maintain confidentiality, and their right to decline to participate or leave the study at any time. In addition, as an incentive to complete the questionnaires, participants had the opportunity to be entered in a drawing for a $50 gift certificate to Amazon.com. This information was in the introduction to the survey on the website (Daniel, 2008).

Potential risks and benefits. The following risks, identified by Daniel (2008) for her study on supervisory alliance and countertransference disclosure among interns, were applicable to this study. Specifically, some participants may have experienced discomfort if their current alliance with their peer or primary supervisor was not optimal, or they may have been reminded of previous supervisory relationships. Since discussions about alliance should take place in supervision, new negative feelings arising from study participation were not anticipated. Indeed, participants are expected to reflect on alliance and their personal reactions to clients in the context of clinical training (Daniel, 2008). Even though hypothetical situations were provided to prevent emotionally distressing reactions from being triggered by past and present clinical experiences, there was the

possibility that participants might have an uncomfortable reaction. Other risks may have included slight fatigue or inconvenience. If participants did experience any negative reactions, they were directed to discuss them with their peer supervisor, primary supervisor, academic program director, director of clinical training, faculty member, or clinician whom they trust.

Although participants may not have directly benefited from the study, they may have experienced the benefit of reflecting on and gaining greater understanding of their alliance with their peer supervisor and primary supervisor. They may also have benefited from reflecting on and gaining greater understanding of their reactions to clients (Daniel, 2008). This may have improved their ability to manage these reactions, which is a clinical competence. Moreover, it was thought that benefits for clinical training in general and professional psychology might include increased knowledge about peer supervision and the influence that trainees' relationship with their peer supervisors has on their comfort and likelihood of sharing their reactions to clients. This knowledge would contribute to greater understanding of therapists' management of personal reactions, which might ultimately contribute to better client treatment.

Consent for participation. A request for waiver of documentation of consent was submitted to the Pepperdine IRB since the research did not present more than minimal risk, as defined by the Protection of Human Subjects Federal Regulation (2009). At the beginning of the survey, there was a statement of introduction and consent to participate (see Appendix H). Implicit consent was obtained when the participant completed the survey. Participation implied that the participant volunteered to complete

the survey and comprehended the nature of the research as well as the risks and benefits of participation (Daniel, 2008).

Data collection. Instead of paper-and-pencil measures, data was collected with an Internet survey due to the advantages and ease of data collection (Gosling, Vazire, Srivastava, & John, 2004; Kraut et al., 2004), reduced social desirability bias (Gosling et al., 2004), ability to get a substantially larger sample size (Gosling et al., 2004), reduced cost (Hanna, Weinberg, Dant, & Berger, 2005; Kraut et al., 2004), and no need for manual data entry (Hanna et al., 2005). In addition, there is an increasing amount of evidence that results of research on psychological constructs obtained through Internet samples are consistent with those obtained through long-established methods (Gosling et al., 2004). Moreover, research conducted on the Internet does not carry any more risk than traditional methods (Kraut et al., 2004). For these reasons, an online survey was developed for the study.

A link to the website with the measures was included in the recruitment letter to participants. SurveyMonkey, an online service, held the questionnaires. SurveyMonkey reported the results as descriptive statistics, which were sent to a database for additional analysis (Creswell, 2009). SurveyMonkey did not record IP addresses and the data obtained were therefore anonymous. The data will be stored on a USB flash drive and kept by the investigator in a locked file for 5 years; the data files will then be destroyed.

Data Analysis

The data were coded and analyzed using SPSS-19.0. Prior to running analyses, the 14 items on the WAI-S that are reverse scored were modified. The data were screened for accuracy, missing data, outliers, and the assumptions of normality and linearity

(Mertler & Vannatta, 2010). Of the 98 responses, 35 were excluded because they did not complete any or more than one-quarter of the entire survey. The sample size was 63 but 11 more responses were excluded because the participants either indicated they were in a master's program or did not indicate a degree, and one participant indicated enrollment in a school psychology program. The final sample was 52 participants.

The following analyses were used: descriptive statistics, simple regression, and paired sample T-tests. Descriptive statistics were calculated for the participants' demographic characteristics. Simple regression analyses were conducted for research questions 1-4 as they involve a single independent variable (score on the WAI-S) and a single dependent variable (comfort with disclosure or likelihood of disclosure). Paired sample T-tests were used for research questions 5 and 6, which compare continuous variables. Since the WAI-S and Reaction Disclosure Questionnaire are different lengths but both have Likert scales, the statistics were calculated based on the mean item score for both versions of the scales. Finally, because the cells were too small to have meaningful pairs, no post hoc analyses concerning the impact of gender, ethnicity, and theoretical orientation match on supervisory alliance and disclosure were conducted.

Results

Fifty-two completed surveys were obtained in which data analyses were performed. The distribution of each variable related to the research hypotheses was inspected prior to running analyses. The finding of a slight negative skew, in which the majority of participants reported at least a sufficient working alliance, is not surprising given the likely mutual desire to create a positive working relationship. Similarly, it is not unexpected that most participants reported sufficient comfort with and likelihood of disclosing countertransference with both peer and primary supervisors, given that addressing countertransference is a key task of supervision that supervisees seem to value (Falender & Shafranske, 2004). With respect to kurtosis, there was a slightly limited range for reported working alliance with both peer and primary supervisors as well as for reported comfort with and likelihood of countertransference disclosure to peer supervisors. Conversely, there was a slightly wider than normal range for reported comfort with and likelihood of countertransference disclosure to primary supervisors. Although it was found that the data collected did not reflect a normal distribution, the skew and kurtosis were determined to be acceptable in this study and performing further data analyses was warranted.

The two research hypotheses concerning peer supervision were: (a) degree of comfort with countertransference disclosure is positively related to supervisory alliance and (b) likelihood of countertransference disclosure is positively related to supervisory alliance. Research questions also addressed these associations in the primary supervisory relationship as well as comparisons between peer and primary supervisory dyads with

respect to the degree of comfort with and likelihood of countertransference disclosure. The following sections report the results of this study, which supported both hypotheses.

Relationship Between Working Alliance and Countertransference Disclosure

Simple linear regressions were conducted to examine the relationship between working alliance and countertransference disclosure in the peer supervisory and primary supervisory dyads. Results indicated that when working with a peer supervisor, working alliance was positively associated with degree of comfort with disclosure, $\beta = .69$, $p < .001$, $\eta^2 = .481$. Working alliance with the peer supervisor explained approximately 48% of the variance in the degree of comfort, and it was significant, $F\ (1, 50) = 46.35$, $p < .001$. In addition, working alliance was positively associated with likelihood of countertransference disclosure, $\beta = .67$, $p < .001$, $\eta^2 = .451$. Working alliance explained approximately 45% of the variation in likelihood of disclosure, and it was significant $F\ (1, 50) = 41.00$, $p < .001$.

When working with a primary supervisor, it was found that working alliance was positively associated with degree of comfort with disclosure, $\beta = .56$, $p < .001$, $\eta^2 = .312$. Working alliance with the primary supervisor explained approximately 31% of the variance in the degree of comfort, and it was significant, $F\ (1, 50) = 22.68$, $p < .001$. Furthermore, working alliance with the primary supervisor was positively associated with likelihood of countertransference disclosure, $\beta = .48$, $p < .001$, $\eta^2 = .235$, and explained approximately 24% of the variation in likelihood of disclosure, and it was significant $F\ (1, 50) = 15.33$, $p < .001$. Please refer to Table 4 for a summary of means, standard deviations, and intercorrelations, and to Table 5 for a summary of the regression analysis. These analyses suggest that working alliance is positively associated with the degree of

comfort with and the likelihood of disclosing countertransference to both peer and primary supervisors. Even with a small sample, there was a noticeable difference between the amount of variance in the degree of comfort with and likelihood of countertransference disclosure explained by the working alliance in the peer supervisory and primary supervisory dyads.

Dyad Comparisons of Comfort with and Likelihood of Countertransference Disclosure

Paired sample t-tests were conducted to compare peer supervisees' degree of comfort with countertransference disclosure to peer supervisor with primary supervisor, as well as likelihood of countertransference disclosure to peer supervisor with primary supervisor. No significant differences were found between degree of comfort with countertransference disclosure to peer supervisor compared to primary supervisor, t (51) = .35, p = .726, or between likelihood of countertransference disclosure to peer supervisor compared to primary supervisor, t (51) = -.35, p = .727. Although not an initial research question, it should be noted that no significant difference was found between working alliance with peer and primary supervisors t (51) = .05, p = .958. Positive correlations, however, were found between comfort with disclosure to peer supervisor and primary supervisor (r = .70, p = .000) and between likelihood of disclosure to peer supervisor and primary supervisor (r = .72, p = .000). Moreover, there was a positive correlation between working alliance with peer supervisor and primary supervisor (r = .34, p = .014). Please see Table 6 for a summary of the paired sample t-test analysis. These analyses suggest that participants consider peer supervision to be similar to

supervision of record in terms of how they rate the strength of the alliance and how comfortable with and likely they are to self-disclose countertransference.

There were some notable findings on the experience of disclosure reported by participants. In regards to disclosure of information in peer supervision, such as clinical errors, 38.5% expected that the information may be discussed with their primary supervisor, 34.6% expected that the information will be discussed, 13.5% expected it will be discussed only if client safety is involved, and 13.5% expected it will only be discussed with their permission. Furthermore, 80.8% indicated that their disclosure in peer supervision has not resulted in negative consequences from their primary supervisor, 5.8% indicated it has resulted in negative consequences, and 13.5% did not know.

In addition to completion of forced choice items, participants were provided with an opportunity to describe in their own words factors that related to countertransference self-disclosure in peer supervision. Inspection of the write-in responses (total responses = 43) for this qualitative item found that more than half of the responses (n = 25) had a distinctly positive tone, while only a small number (n = 4) were distinctly negative in tone. Furthermore, participants provided responses indicating their "comfort" or feeling "comfortable" with their peer supervisor (n = 5), as well as describing their peer supervisor or the peer supervisory relationship as "supportive" (n = 4) and "nonjudgmental" (n = 5). In addition, the peer supervisor's disclosure of reactions or countertransference (n = 3), a more equal relationship with less of a power differential (n = 3), and the alliance/working relationship (n = 2) were suggested as factors related to their disclosure of countertransference in peer supervision. Responses are displayed in Table 7.

While the data were adequate to investigate the research hypotheses, the findings should be qualified based on two features: the response rate and the finding that the data did not conform to a normal distribution. First, the response rate could not be determined because whether program directors sent the recruitment letter to all students involved in peer supervision was unknown. With a large enough sample, the data may have conformed to a normal distribution. Furthermore, as an exploratory study, it was noted that there were a few participants with outlier (i.e., lower) scores. For the peer supervisory dyad, there were three outliers for both working alliance and comfort with disclosure and two for likelihood of disclosure. The write-in responses provided by these participants were negative in tone and thus consistent with their lower scores. For the primary supervisory dyad, there were two outliers for both working alliance and comfort with disclosure and one for likelihood of disclosure.

Discussion

This exploratory study examined the impact of supervisory working alliance on comfort and likelihood of disclosure of countertransference in peer supervision. This research extends the empirical research conducted by Daniel (2008) and Pakdaman (2011) on the relationship between supervisory working alliance and countertransference disclosure and contributes to efforts to better understand factors that impact countertransference management. In this study, working alliance was found to be positively correlated with degree of comfort with and likelihood of countertransference disclosure to both peer and primary supervisors. These findings are consistent with previous research on the positive correlation between supervisory working alliance and comfort with and likelihood of countertransference disclosure (Daniel, 2008; Pakdaman, 2011). This study was also the first of its kind to examine a process variable (i.e., alliance and countertransference disclosure) within the context of peer supervision, an emerging but little studied training activity.

In developing this study, it was posited that countertransference would be more readily disclosed and addressed by supervisees with their peer supervisors due to the additional support, validation, and connection (Butler & Constantine, 2006) without the threat of evaluation (Benshoff, 1994). However, there did not appear to be significant variances between degree of comfort with or likelihood of countertransference disclosure to peer or primary supervisors or between working alliance with peer and primary supervisors. Furthermore, there were positive correlations between comfort with and likelihood of disclosure to peer and primary supervisors as well as between working alliance with peer and primary supervisors. These findings suggest that participants view

peer supervision similarly to how they view primary supervision, that is, as a generally positive relationship in which they feel comfortable with and are likely to disclose their personal reactions to clients. However, in light of the lack of significant differences in comfort with and likelihood of disclosure and the positive correlations, the impact of the relationship between peer supervisors and primary supervisors on the experience of the supervisee is important to consider. More specifically, clarifying whether the primary supervisor selected the peer supervisor and whether he or she trained and/or supervised the peer supervisor might allow for further explanation of the findings.

Interestingly, the qualities and reasons that participants wrote in as factors influencing their disclosure of personal reactions to clients in peer supervision were remarkably similar to characteristics of the ideal supervisor (e.g., supportive, nonjudgmental, examines countertransference) identified in the literature (e.g., Carifio & Hess, 1987; Ramos-Sánchez et al., 2002). In addition, some participants indicated that a more equal relationship with less of a power differential were factors that influenced their disclosure in peer supervision. These factors are consistent with previous research in which peer supervision was perceived to be less threatening and more informal and comfortable (Benshoff, 1993). This is notable because concerns regarding evaluation and power imbalances have been found to be reasons provided (or related to reasons provided) by supervisees for nondisclosure (Hess et al., 2008; Ladany et al., 1996).

Although the sample size was too small to investigate the impact of gender, ethnicity, and theoretical orientation match on supervisory alliance and disclosure, previous studies have not found significant relationships between matches on

characteristics such as ethnicity (Daniel, 2008), gender, or theoretical orientation (Daniel, 2008; Pakdaman, 2011) and likelihood of or comfort with countertransference disclosure.

Implications for Clinical Training and Professional Psychology

First of all, this study is important because little is known about the format of peer supervision that lies between traditional supervision and consultation with clinical trainees and/or graduate student classmates. This study furthers the understanding of peer supervision, specifically in regards to the clinical competency of countertransference management. Despite a couple of anecdotal comments, there was no evidence that participants were more comfortable disclosing countertransference to their peer supervisors than to their primary supervisors. As such, alliance may be a universal factor, and significant differences between the role of alliance in formal supervision and peer supervision may not exist. It is worth noting, however, that nearly three-quarters of participants indicated they expected that their disclosures in peer supervision would or might be discussed with their primary supervisors. Thus, assumptions about confidentiality (or lack thereof) may be influencing the findings. Indeed, the limits of confidentiality may not be clarified in contractual form in peer supervision, and this seems like an important area to define.

Nevertheless, the findings suggest the importance of building a solid working alliance because supervisees are expected to disclose countertransference (Daniel, 2008). Accordingly, this study contributes to the growing body of literature suggesting the role of alliance in trainee disclosure (e.g., Mehr, Ladany, & Caskie, 2010) and, more broadly, in countertransference management. Indeed, countertransference is harmful to treatment if not properly managed (Falender & Shafranske, 2004), and thus is a requirement for

ethical practice. As successful management of countertransference is beneficial for treatment (Gelso & Hayes, 2001), these findings contribute to the larger body of research on therapists' management of personal reactions, which may ultimately contribute to better client treatment.

More generally, these findings add to the argument that opportunities to supervise (under supervision) should be a part of clinical training. This would boost the integration of knowledge, skills, and values into a level of competence in supervision at the time of licensure (Falender et al., 2004).

Limitations and Recommendations for Future Research

The first and perhaps most substantial limitation of this study was the small sample size. At present, the number of doctoral programs in clinical and counseling psychology with peer supervision is unknown. Therefore, an exploratory study to gather this information would be important, particularly since peer supervision has been described as an increasing trend (Bernard & Goodyear, 2009).

The small sample size may partly be due to the inability to contact participants directly. Similar to Daniel's (2008) study, since it was not known whether program directors forwarded the study information to students, this investigator was unable to determine the response rate. Therefore, no statements about the generalizibility of the results can be made. Timing of recruitment also may have contributed to the small sample size. The second wave of recruitment occurred in June, and this investigator received a number of emails indicating that program directors were on sabbatical. Therefore, they may not have distributed the recruitment letter to students. Additionally, students may have been less willing to complete a survey at the end of the academic term.

Moreover, the small sample size reduced the power; it is unknown whether a statistically significant difference between comfort with and likelihood of countertransference disclosure to peer supervisors compared to primary supervisors would have been detected with a larger total number of cases.

A second limitation relates to nonresponse, which might have been a source of error. Response bias refers to the extent that those individuals who did not respond are significantly different than those who did (Fowler, 1993). Individuals who experienced poor rapport with their peer and primary supervisors may have chosen not to participate. Furthermore, the sample is representative of predominantly White females in clinical psychology doctoral programs, pursuing a Psy.D., who identified their primary theoretical orientation as cognitive-behavioral. A more diverse demographic sample may have led to different results.

Additional limitations relate to the research design and methodology. As this study was non-experimental, causation cannot be inferred from the results; potential third variables (e.g., expectations about confidentiality) might have influenced the relationships found. This study utilized self-report methods, and so inaccurate self-reports involving social desirability bias or response sets (Mitchell & Jolley, 2007), defensive biases, and lack of identification of processes that an observer might recognize (Betan et al., 2005) were issues to consider. With online data collection, the investigator had no control over the physical environment in which participants responded to the survey and no ability to confirm that they were accurately reporting their demographic information (Kraut et al., 2004).

Another limitation relates to the challenges of the instruments themselves. Bahrick (1990) noted that the WAI/Supervision may not be fully sensitive to the range of experiences; participants in her study mostly responded on the high end of the scale, resulting in a ceiling effect. In the current study, the WAI-S may not have allowed for distinction among participants who scored high in alliance. A research base for the WAI-S is needed. It is also unknown whether a ceiling effect exists for the Reaction Disclosure Questionnaire, especially given that there are only 8 items. Therefore, studies that assess actual experiences with countertransference disclosure, rather than hypothetical situations, should be conducted. Perhaps this methodology would detect differences between disclosure in peer supervision and supervision of record. It is recommended that the next wave of research in this area occur at the instrument level.

Given the limited knowledge of peer supervision, there are many areas to investigate in future research. For instance, qualitative studies of peer supervisees' experiences, of variables that factor into countertransference disclosure, and of critical incidents (i.e., key events that impact development as a counselor; Trepal, Bailie, & Leeth, 2010) in peer supervision would all seem to be of value. Due to the high rate of nondisclosure reported by supervisees (Hess et al., 2008; Ladany et al., 1996; Yourman & Farber, 1996), and the finding that many nondisclosures were discussed with a peer or friend in the field (Ladany et al., 1996), nondisclosure in peer supervision seems to be another worthwhile area of research.

In addition to exploratory and qualitative studies, future research might examine the efficacy of peer supervision and how the format meets supervisee needs (Ladany et al., 1996). As Bernard and Goodyear (2009) identified positive client change "as the gold

standard" (p. 301) for outcome criteria in supervision research, investigation of the impact of peer supervision on therapy outcome is recommended. For example, the method of considering the client's symptom reduction, perception of the therapeutic alliance, and motivation for change (Lambert & Hawkins, 2001) could be applied to assess the impact of peer supervision on client progress.

More generally, given the variability in frequency and duration of the peer supervision experiences reported in this study, there is a need for greater understanding of the structure and usage of peer supervision in clinical and counseling psychology doctoral programs. In this study, there was no specification of the nature of the peer supervision on which participants reported (e.g., as a training module), and so it is recommended that future studies request this information. Furthermore, supervision lies on a continuum. For example, individuals at the postdoc level may provide peer supervision or ongoing consultation to practicum students, but this activity is treated as supervision of record. Thus, in some contexts, peer supervision is a hierarchical relationship that does include an evaluative component – whether formal or informal. It is recommended that the qualifier "hierarchical peer supervision" vs. "nonhierarchical peer supervision" be used. Alternatively, individuals in peer supervision may view the relationship as more collegial, which might bring up concerns such as the validity of the peer supervisor's knowledge and boundary issues. Although the resolution of these issues is beyond the scope of this discussion, peer supervision is an emerging area of professional psychology (Bernard & Goodyear, 2009) that should be more clearly defined in future research.

Conclusion

This study investigated the role of alliance on countertransference disclosure in peer supervision as well as provided a preliminary comparison between alliance and such disclosures in peer supervision and the supervision of record. Supervisory working alliance was found to be positively correlated with the degree of comfort with and the likelihood of countertransference disclosure to peer supervisors as well as to primary supervisors. No significant variances were found between degree of comfort with or likelihood of countertransference disclosure to peer or primary supervisors or between working alliance with peer and primary supervisors. These findings add to the larger body of literature on the role of alliance and therapists' management of personal reactions.

References

Akhurst, J., & Kelly, K. (2006). Peer group supervision as an adjunct to individual supervision: Optimising learning processes during psychologists' training. *Psychology Teaching Review, 12*(1), 3-15. Retrieved from http://www.bps.org.uk/dtrp/what-is-the-psychology-teaching-review.cfm

American Psychological Association. (2002). *Ethical principles of psychologists and code of conduct 2002*. Retrieved from http://www.apa.org/ethics/code2002.html

Association of Psychology Postdoctoral and Internship Centers (2009). *2009 APPIC match: Survey of internship applicants. Part 1: Summary of survey results*. Retrieved from http://www.appic.org/match/5_2_2_4_11a_match_about_statistics_surveys_2009a.htm

Bahrick, A. S. (1990). *Role induction for counselor trainees: Effects on the supervisory working alliance* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 9014392)

Barry, P. (2006). Forming and belonging to a peer consultation group for your own mental health and creating a psychotherapy practice that addresses specific topics. *Perspectives in Psychiatric Care, 42*(1)*,* 63-66. doi: 10.1111/j.1744-6163.2006.00051.x

Beck, J. S., Sarnat, J. E., & Barenstein, B. (2008). Psychotherapy-based approaches to supervision. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (pp. 57-96). Washington, D.C.: American Psychological Association.

Benshoff, J. M. (1993). Peer supervision in counselor training. *Clinical Supervisor, 11*(2), 89-102. doi: 10.1300/J001v11n02_08

Benshoff, J. M. (1994, April). Peer consultation as a form of supervision. *ERIC Digest,* 1-6. Retrieved from http://www.eric.ed.gov/PDFS/ED372352.pdf

Benshoff, J. M., & Paisley, P. O. (1996). The structured peer consultation model for school counselors. *Journal of Counseling & Development, 74*(3), 314-318. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Upper Saddle River, NJ: Pearson.

Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry, 162*(5), 890-898. doi: 10.1176/appi.ajp.162.5.890

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-260.

Bordin, E. S. (1983). Supervision in counseling: II. Contemporary models of supervision: A working alliance based model of supervision. *Counseling Psychologist, 11*(1), 35-42.

Bos, S. (1998). Perceived benefits of peer leadership as described by junior baccalaureate nursing students. *Journal of Nursing Education, 37*(4)*,* 189-191.

Bransford, C. (2009). Process-centered group supervision. *Clinical Social Work Journal, 37*(2), 119-127. doi: 10.1007/s10615-009-0200-x

Brown, J. B., Hogg, W., Delva, D., Nanchoff-Glatt, M., & Moore, L. (1999). Peer consultation reflection exercise: Innovative strategy for personal and professional development. *Canadian Family Physician, 45,* 1509-1515. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2328478/pdf/canfamphys00040-0123.pdf

Butler, S. K., & Constantine, M. G. (2006). Web-based peer supervision, collective self-esteem and case conceptualization ability in school counselor trainees. *Professional School Counseling, 10*(2), 146-152. Retrieved from http://www.schoolcounselor.org/content.asp?contentid=235

Caplan, G. (1970). *The theory and practice of mental health consultation*. New York, NY: Basic Books.

Carifio, M. S., & Hess, A. K. (1987). Who is the ideal supervisor? *Professional Psychology: Research and Practice, 18,* 244-250. doi: 10.1037/0735-7028.18.3.244

Chen, E. C., & Bernstein, B. L. (2000). Relations of complementarity and supervisory issues to supervisory working alliance: A comparative analysis of two cases. *Journal of Counseling Psychology, 47*(4), 485-497. doi: 10.1037/0022-0167.47.4.485

Clark, R. A., Harden, S. L., & Johnson, W. B. (2000). Mentor relationships in clinical psychology doctoral training: Results of a national survey. *Teaching of Psychology, 27*(4), 262-268. Retrieved from http://teachpsych.org/top/index.php

Cook, C., Heath, F., & Thompson, R. L. (2000). A meta-analysis of response rates in Web- or Internet-based surveys. *Educational and Psychological Measurement, 60,* 821-836. doi: 10.1177/00131640021970934

Counselman, E. F., & Gumpert, P. (1993). Psychotherapy supervision in small leader-led groups. *Group, 17*(1), 25-32. doi: 10.1007/BF01419603

Counselman, E. F., & Weber, R. L. (2004). Organizing and maintaining peer supervision groups. *International Journal of Group Psychotherapy, 54*(2)*,* 125-143. doi: 10.1521/ijgp.54.2.125.40391

Creswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches*. Thousand Oaks, CA Sage.

Daniel, C. H. (2008). *The relationship between the supervisory alliance and countertransference disclosure among psychology interns* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3324654)

Duan, C., & Roehlke, H. (2001). A descriptive "snapshot" of cross-racial supervision in university counseling center internships. *Journal of Multicultural Counseling and Development, 29*(2)*,* 131-146. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Ellis, A. (2001). Rational and irrational aspects of countertransference. *Journal of Clinical Psychology, 57*(8), 999-1004. doi: 10.1002/jclp.1067

Ellis, M. V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 447-507). New York: John Wiley & Sons, Inc.

Ellis, M. V., Ladany, N., Krengel, M., & Schult, D. (1996). Clinical supervision research from 1981 to 1993: A methodological critique. *Journal of Counseling Psychology, 43*(1), 35-50. doi: 10.1037/0022-0167.43.1.35

Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., . . . Grus, C. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology, 60,* 771-785. doi: 10.1002/jclp.20013

Falender, C. A., & Shafranske, E. P. (2004*). Clinical supervision: A competency-based approach.* Washington, DC: American Psychological Association.

Falender, C. A., & Shafranske, E. P. (2010*).* Psychotherapy-based supervision models in an emerging competency-based era: A commentary. *Psychotherapy: Theory, Research, Practice, Training, 47,* 45-50. doi: 10.1037/a0018873

Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., . . . Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, *3*(4 Suppl), S5-S26. doi: 10.1037/a0015832

Fowler, F. J., Jr. (1993). *Survey research methods* (2nd ed.). Thousand Oaks, CA: Sage.

Freud, S. (1910). The future prospects of psycho-analytic therapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 11, pp. 139-152). Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Friedlander, M. L., & Ward, L. G. (1984). Development and validation of the supervisory styles inventory. *Journal of Counseling Psychology, 31*(4), 541-57. doi: 10.1037/0022-0167.31.4.541

Friedman, S. M., & Gelso, C. J. (2000). The development of the inventory of countertransference behavior. *Journal of Clinical Psychology, 56*(9), 1221-1235. doi:10.1002/1097-4679(200009)56:9<1221::AID-JCLP8>3.0.CO;2-W

Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice, 57*(8), 983-991. doi: 10.1002/jclp.1065

Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., & Rodolfa, E. (2001). Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter? *Journal of Multicultural Counseling & Development, 29*(2), 102-113. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice.* New York, NY: Wiley.

Gelso, C. J., & Hayes, J. A. (2001). Countertransference management. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 418-422. doi: 10.1037/0033-3204.38.4.418

Gosling, S. D., Vazire, S., Srivastava, S., & John, O. P. (2004). Should we trust web-based studies? A comparative analysis of six preconceptions about Internet questionnaires. *American Psychologist, 59*(2), 93-104. doi: 10.1037/0003-066X.59.2.93

Grant, J. (2006). Training counselors to work with complex clients: Enhancing emotional responsiveness through experiential methods. *Counselor Education & Supervision, 45*(3), 218-230. Retrieved from http://www.unco.edu/ces/

Grant, J., & Crawley, J. (2002). *Transference and projection: Mirrors to the self.* Philadelphia, PA: Open University Press.

Greenburg, S. L., Lewis, G. J., & Johnson, M. (1985). Peer consultation groups for private practitioners. *Professional Psychology: Research and Practice, 16*(3), 437-447. doi: 10.1037/0735-7028.16.3.437

Hanna, R. C., Weinberg, B., Dant, R., & Berger, P. D. (2005). Do internet-based surveys increase personal self-disclosure? *Journal of Database Marketing & Customer Strategy Management, 12*(4)*,* 342-356. doi: 10.1057/palgrave.dbm.3240270

Hart, B. M., Wicherski, M., & Kohout, J. L., Center for Workforce Studies (2010). *2010 Graduate Study in Psychology*. Retrieved from http://www.apa.org/workforce/publications/10-grad-study/report-students.pdf

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 292-299. doi: 10.1037/0033-3204.43.3.292

Hayes, J. A. (1995). Countertransference in group psychotherapy: Waking a sleeping dog. *International Journal of Group Psychotherapy, 45*(4), 521-535.

Hayes, J. A., & Gelso, C. J. (2001). Clinical implications of research on countertransference: Science informing practice. *Journal of Clinical Psychology, 57*(8), 1041-1051. doi: 10.1002/jclp.1072

Hess, S. A., Knox, S., Schultz, J. M., Hill, C. E., Sloan, L., Brandt, S., . . . Hoffman, M. A. (2008). Predoctoral interns' nondisclosure in supervision. *Psychotherapy Research,18*(4)*,* 400-411. doi: 10.1080/10503300701697505

Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 365-372. doi: 10.1037/0033-3204.38.4.365

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36*(2), 223-233. doi: 10.1037/0022-0167.36.2.223

Jacobsen, C. H., & Tanggaard, L. (2009). Beginning therapists' experiences of what constitutes good and bad psychotherapy supervision: With a special focus on individual differences. *Nordic Psychology, 61,* 59-84. doi: 10.1027/1901-2276.61.3.59

Johnson, W. B. (2007). Transformational supervision: When supervisors mentor. *Professional Psychology: Research and Practice, 38*(3)*,* 259-267. doi: 10.1037/0735-7028.38.3.259

Kaslow, N. J., & Mascaro, N. A. (2007). Mentoring interns and postdoctoral residents in academic health sciences center. *Journal of Clinical Psychology in Medical Settings, 14*(3)*,* 191-196. doi: 10.1007/s10880-007-9070-y

Kiesler, D. (2001). Therapist countertransference: In search of common themes and empirical referents. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice*, *57*(8), 1053-1063. doi: 10.1002/jclp.1073

Kraut, R., Olson, J., Banaji, M., Bruckman, A., Cohen, J., & Couper, M. (2004). Psychological research online: Report of Board of Scientific Affairs' Advisory Group on the conduct of research on the Internet. *American Psychologist, 59*(2), 105-117. doi: 10.1037/0003-066X.59.2.105

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development, 77*(4), 447-455. Retrieved from http://www.counseling.org/publications

Ladany, N., & Friedlander, M. L. (1995). The relationship between the supervisory working alliance and trainees' experience of role conflict and role ambiguity. *Counselor Education & Supervision, 34*(3), 220-231. Retrieved from http://www.unco.edu/ces/

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*(1), 10-24. doi: 10.1037/0022-0167.43.1.10

Ladany, N., & Lehrman-Waterman, D. (1999). The content and frequency of supervisor self-disclosures and their relationship to supervisor style and the supervisory working alliance. *Counselor Education & Supervision, 38*(3), 143-160. Retrieved from http://www.unco.edu/ces/

Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist, 27*(3), 443-475. doi: 10.1177/0011000099273008

Ladany, N., Walker, J. A., & Melincoff, D. S. (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure. *Counselor Education & Supervision, 40*(4), 263-275. Retrieved from http://www.unco.edu/ces/

Lambert, M. J., & Hawkins, E. J. (2001). Using information about patient progress in supervision: Are outcomes enhanced? *Australian Psychologist, 36*(2), 131-138. doi: 10.1080/00050060108259645

Lewis, G. J., Greenburg, S. L., & Hatch, D. B. (1988). Peer consultation groups for psychologists in private practice: A national survey. *Professional Psychology: Research and Practice, 19*(1), 81-86. doi: 10.1037/0735-7028.19.1.81

Markus, H. E., Cross, W. F., Halewski, P. G., Quallo, H., Smith, S., Sullivan, M., . . . Tantillo, M. (2003). Primary process and peer consultation: An experiential model to work through countertransference. *International Journal of Group Psychotherapy, 53*(1), 19-37. doi: 10.1521/ijgp.53.1.19.42807

Mehr, K. E., Ladany, N., & Caskie, G. I. L. (2010). Trainee nondisclosure in supervision: What are they not telling you? *Counselling and Psychotherapy Research, 10*(2)*,* 103-113. doi: 10.1080/14733141003712301

Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (2nd ed.). Thousand Oaks, CA: Sage.

Mertler, C. A., & Vannatta, R. A. (2010). *Advanced and multivariate statistical methods* (4th ed.). Glendale, CA: Pyrczak.

Minkle, B., Bashir, A. S., & Sutulov, C. (2008). Peer consultation for mediators: The use of a holding environment to support mediator reflection, inquiry, and self-knowing. *Negotiation Journal, 24*(3), 303-323. doi: 10.1111/j.1571-9979.2008.00186.x

Mitchell, M. L., & Jolley, J. M. (2007). *Research design explained* (6th ed.). Belmont, CA: Thomson Wadsworth.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979). *Belmont report: Ethical principles and guidelines for the protection of human subjects of research*. Retrieved from http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.htm

Norcross, J. C., Ellis, J. L., & Sayette, M. A. (2010). Getting in and getting money: A comparative analysis of admission standards, acceptance rates, and financial assistance across the research-practice continuum in clinical psychology programs. *Training and Education in Professional Psychology, 4*(2)*,* 99-104. doi: 10.1037/a0014880

Norcross, J. C., Evans, K. L., & Ellis, J. L. (2010). The model does matter II: Admissions and training in APA-accredited counseling psychology programs. *The Counseling Psychologist, 38*(2)*,* 257-268. doi: 10.1177/0011000009339342

Page, B. J., Pietrzak, D. R., & Sutton, J. M. J. (2001). National survey of school counselor supervision. *Counselor Education and Supervision, 41*(2), 142-150. Retrieved from http://www.unco.edu/ces/

Pakdaman, S. (2011). *Supervisory alliance and countertransference disclosure of psychology doctoral students* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3487995)

Patton, M. J., & Kivlighan Jr., D. M. (1997). Relevance of the supervisory alliance to the counseling alliance and to treatment adherence in counselor training. *Journal of Counseling Psychology, 44*(1), 108-115. doi: 10.1037/0022-0167.44.1.108

Porter, N. (2009). Feminist and multicultural underpinnings to supervision: An overview. *Women & Therapy, 33*(1-2)*,* 1-6. doi: 10.1080/02703140903404622

Protection of Human Subjects Federal Regulation, 46 C. F. R. §102 (2009).

Ramos-Sánchez, L., Esnil, E., Riggs, S., Wright, L. K., Goodwin, A., Touster, L. O., . . . & Rodolfa, E. (2002). Negative supervisory events: Effects on supervision satisfaction and supervisory alliance. *Professional Psychology: Research and Practice, 33,* 197-202. doi: 10.1037//0735-7028.33.2.197

Remley, T. P., Benshoff, J. M., & Mowbray, C. A. (1987). A proposed model for peer supervision. *Counselor Education and Supervision, 27*(1), 53-60. Retrieved from http://www.unco.edu/ces/

Renko, M., Uhari, M., Soini, H., & Tensing, M. (2002). Peer consultation as a method for promoting problem-based learning during a paediatrics course. *Medical Teacher, 24*(4), 408-411. doi: 10.1080/01421590220145789

Schreiber, P., & Frank, E. (1983). The use of a peer supervision group by social work clinicians. *Clinical Supervisor, 1*(1)*,* 29-36. doi: 10.1300/J001v01n01_04

Shafranske, E. P., & Falender, C. A. (2008). Supervision addressing personal factors and countertransference. In C. A. Falender & E. P. Shafranske (Eds.)*, Casebook for clinical supervision: A competency-based approach* (pp. 97-120). Washington, DC: American Psychological Association.

Spice, C. G., & Spice, W. H. (1976). A triadic method of supervision in the training of counselors and counseling supervisors. *Counselor Education and Supervision, 15*(4)*,* 251-258.

Stanard, R. P., & Hughes, J. T. (2008). Using peer supervisors in counselor education training: Research findings. *Perspectives in Peer Programs, 21*(1)*,* 1-11.

Thomas, J. T. (2007). Informed consent through contracting for supervision: Minimizing risks, enhancing benefits. *Professional Psychology: Research and Practice, 38*(3)*,* 221-231. doi: 10.1037/0735-7028.38.3.221

Todd, W. E., & Pine, I. (1968). Peer supervision of individual psychotherapy. *The American Journal of Psychiatry, 125*(6), 780-784.

Trepal, H. C., Bailie, J., & Leeth C. (2010). Critical incidents in practicum supervision: Supervisees' perspectives. *Journal of Professional Counseling: Practice, Theory, and Research, 38*(1)*,* 28-38.

Wagner, C. A., & Smith, J. P., Jr. (1979). Peer supervision: Toward more effective training. *Counselor Education and Supervision, 18*(4)*,* 288-293.

Wilkerson, K. (2006). Peer supervision for the professional development of school counselors: Toward an understanding of terms and findings. *Counselor Education & Supervision, 46*(1), 59-67. Retrieved from http://www.unco.edu/ces/

Yourman, D. B., & Farber, B. A. (1996). Nondisclosure and distortion in psychotherapy supervision. *Psychotherapy: Theory, Research, Practice, Training, 33,* 567-575. doi: 10.1037/0033-3204.33.4.567

Zins, J. E., Ponti, C. R., & Murphy, J. J. (1992). Peer-mediated professional development groups for special services practitioners. *Special Services in the Schools, 6*(3)*,* 179-193. doi: 10.1300/J008v06n03_10

Table 1

Participant Demographics (*N* = 52)

Characteristic	*n*	*%*
Gender		
Female	42	80.8
Male	9	17.3
Other	0	0.0
Missing	1	1.9
Racial/ethnic identification		
African American/Black	1	1.9
Asian/Pacific Islander	0	0.0
Hispanic/Latino	5	9.6
Native American/Alaskan Native	0	0.0
White (non-Hispanic)	44	84.6
Bi-racial/Multi-racial	2	3.8
Other	0	0.0
Primary theoretical orientation		
Cognitive-behavioral	26	50.0
Family systems	2	3.8
Humanistic/existential	8	15.4
Psychodynamic	9	17.3
Other	3	5.8
Eclectic/integrated[a]	3	5.8
Don't know/unclear[a]	1	1.9
Type of doctoral program		
Clinical	49	94.2
Counseling	3	5.8
Other	0	0.0
Degree sought		
Ph.D.	11	21.2
Psy.D.	41	78.8
Other	0	0.0

[a] The categories *Eclectic/integrated* and *Don't know/unclear* were created following an inspection of the narrative responses.

(continued)

Characteristic	*n*	%
Year in doctoral program		
First	7	13.5
Second	12	23.1
Third	16	30.8
Fourth	10	19.2
Fifth	3	5.8
Other	4	7.7
Months of peer supervision		
Less than 3 months	13	25.0
3 to 6 months	9	17.3
6 to 9 months	30	57.7
Frequency of peer supervision		
Less than 1 hour per week	20	38.5
1 to 2 hours per week	30	57.7
More than 2 hours per week	1	1.9
Missing	1	1.9
Months of supervision		
Less than 3 months	4	7.7
3 to 6 months	6	11.5
6 to 9 months	42	80.8
Frequency of supervision		
Less than 1 hour per week	9	17.3
1 to 2 hours per week	37	71.2
More than 2 hours per week	6	11.5
Expectations for disclosure		
Will be discussed with your primary supervisor	18	34.6
May be discussed with your primary supervisor	20	38.5
Will be discussed only if client safety is involved	7	13.5
Will only be discussed with your permission	7	13.5
Negative consequences for disclosure in peer supervision		
Yes	3	5.8
No	42	80.8
Unknown	7	13.5

Table 2

Peer Supervisor Demographics

Characteristic	*n*	*%*
Gender		
Female	41	78.8
Male	11	21.2
Unknown	0	0.0
Other	0	0.0
Racial/ethnic identification		
African American/Black	1	1.9
Asian/Pacific Islander	4	7.7
Hispanic/Latino	2	3.8
Native American/Alaskan Native	0	0.0
White (non-Hispanic)	43	82.7
Bi-racial/Multi-racial	2	3.8
Unknown	0	0.0
Other	0	0.0
Primary theoretical orientation		
Cognitive-behavioral	22	42.3
Family systems	3	5.8
Humanistic/existential	3	5.8
Psychodynamic	14	26.9
Other	5	9.6
Eclectic/integrated [a]	1	1.9
Don't know/unclear [a]	4	7.7

[a] The categories *Eclectic/integrated* and *Don't know/unclear* were created following an inspection of the narrative responses.

Table 3

Supervisor Demographics

Characteristic	*n*	*%*
Gender		
Female	29	55.8
Male	23	44.2
Unknown	0	0.0
Other	0	0.0
Racial/ethnic identification		
African American/Black	1	1.9
Asian/Pacific Islander	1	1.9
Hispanic/Latino	1	1.9
Native American/Alaskan Native	0	0.0
White (non-Hispanic)	47	90.4
Bi-racial/Multi-racial	1	1.9
Unknown	1	1.9
Other	0	0.0
Primary theoretical orientation		
Cognitive-behavioral	20	38.5
Family systems	3	5.8
Humanistic/existential	5	9.6
Psychodynamic	17	32.7
Other	2	3.8
Eclectic/integrated [a]	4	7.7
Don't know/unclear [a]	0	0.0
Missing	1	1.9

[a] The categories *Eclectic/integrated* and *Don't know/unclear* were created following an inspection of the narrative responses.

Table 4

Summary of Means, Standard Deviations, and Intercorrelations for Scores on the Working Alliance Inventory for Supervision and the Reaction Disclosure Questionnaire

Variable	*M*	*SD*	1	2	3	4	5	6
Peer Supervisory Dyad								
1. Working alliance	5.18	1.06	--	.694***	.671***			
2. Comfort	5.12	1.31	.694***	--				
3. Likelihood	5.22	1.33	.671***		--			
Primary Supervisory Dyad								
4. Working alliance	5.17	1.12				--	.559***	.484***
5. Comfort	5.07	1.17				.559***	--	
6. Likelihood	5.27	1.14				.484***		--

Note. 1 = Working alliance with peer supervisor; 2 = Comfort with countertransference disclosure to peer supervisor; 3 = Likelihood of countertransference disclosure to peer supervisor; 4 = Working alliance with primary supervisor; 5 = Comfort with countertransference disclosure to primary supervisor; 6 = Likelihood of countertransference disclosure to primary supervisor

*** $p < .001$

Table 5

Summary of Regression Analysis

Variable	R^2	B	β	*p*
Peer Supervisory Dyad[a]				
Comfort with disclosure	.481	.860	.694	<.001
Likelihood of disclosure	.451	.846	.671	<.001
Primary Supervisory Dyad[b]				
Comfort with disclosure	.312	.581	.559	<.001
Likelihood of disclosure	.235	.493	.484	<.001

[a] IV is WAI-Peer

[b] IV is WAI-Supervisee

Table 6

Differences Between Comfort with and Likelihood of Disclosure and Working Alliance (WA) in Peer and Primary Supervisory Dyads

	Peer		Primary			
Variable	*M*	*SD*	*M*	*SD*	*t*(51)	*p*
Comfort	5.12	1.31	5.07	1.17	.35	.726
Likelihood	5.22	1.33	5.27	1.14	-.35	.727
WA	5.18	1.06	5.17	1.12	.05	.958

Table 7

Attitudes and Experiences Influencing Disclosure in Peer Supervision

Response[a]	Valence	Primary Contents
1. I feel my peer supervisor is an unpleasant person who lacks empathy. I also feel that she is bigoted and narrow minded.	-	
2. I primarly work in the transference, without disclosing my personal reactions to Pts, to a supervisior, the tx is doomed		
3. comfort wanting to seek support to manage these reactions	+	comfort, supportive
4. supervisor's openess and focus	+	
5. Orientation of program - behavioral. Not focused on tranference/ countertranference. Type of clients – inpatient/severe vs. outpatient/behavioral medicine.		
6. Experiences with self-disclosure that met ethical guidelines. Review of ethical guidelines, recommendations, and vignettes that permit self-disclosure.		
7. supervisor's acceptance and patience	+	
8. Comfortable with supervisor, particular topics	+	comfortable
9. similar age, similar training level		more equal relationship
10. comfortable working relationship	+	comfortable, working relationship

[a] This table consists of verbatim responses. One response included additional comments about study methodology that have been omitted here as this was not the intent of the table.

(continued)

Response[a]	Valence	Primary Contents
11. feedback, feeling better that I am making the right choices	+	
12. 1. rift in agreement/understanding about appropriate ways of dealing with the issue(s) 2. felt sense of insensitivity and/or ignorance in regard to many issues	-	
13. Peer supervisor is encouraging and supportive.	+	supportive
14. I don't feel judged I feel supported	+	nonjudgmental, supportive
15. Supervisor's gender.		
16. Having an understanding and accepting relationship with my peer supervisor Feeling a sense of safety (nonjudgmental, caring, supportive, protective) with my peer supervisor	+	nonjudgmental, supportive
17. -peer supervisor has a non-judgmental attitude -I usually am seeking help with the case, and sharing my reactions to the client is important in my orientation	+	nonjudgmental
18. her nonjudgmental attitude and the development of a professional working alliance between us	+	nonjudgmental, alliance
19. Mutual respect, desire to improve work as a clinician	+	
20. High value placed on process at internship site. Peer supervisor models behavior.	+	

[a] This table consists of verbatim responses. One response included additional comments about study methodology that have been omitted here as this was not the intent of the table.

(continued)

Response[a]	Valence	Primary Contents
21. Mistrust, differing clinical experiences/ theoretical orientation	-	
22. 1. Peer supervisor's approach to supervision 2. Level of discomfort with peer supervisor	-	
23. If I am aware of them and I am making attempts to correct them.		
24. Unsure of what is appropriate to disclose Concern about privacy, information being shared elsewhere		
25. Friendships Inability to hold my information		
26. Trust Supervisor's expertise	+	
27. being less afraid of consequences (than with primary supervisor) feeling less intimidated	+	more equal relationship, less of a power differential
28. - If I think my personal reactions are impacting the treatment, I am more likely to bring it up - If my personal reactions are influencing my current degree of comfort/competence in taking the role of a therapist, then I am more likely to bring it up		
29. discomfort with revealing counter-transference feelings due to personal issues -when I choose to disclose I do it in hoping that supervision will provide paths to take with client		

[a] This table consists of verbatim responses. One response included additional comments about study methodology that have been omitted here as this was not the intent of the table.

(continued)

Response[a]	Valence	Primary Contents
30. 1. The reaction of the peer supervisor to the topic discussed. 2. The peer supervisors own countertransference and how this impacts her view of the clinical therapy		peer supervisor's disclosure
31. comfort with supervisor	+	comfort
32. professional growth help with handling situation	+	
33. assistance with managing counter-transference. wanting to provide the best services I can offer to clients.	+	
34. My peer supervisor is very experienced and kind.	+	
35. 1. I feel that if I am trying to hide these feelings, these are the feelings that are most important to be disclosed in supervision. 2. My peer supervisor is understanding and non-judgmental.	+	nonjudgmental
36. Comfortability with peer supervisor her disclosure to me	+	comfort, peer supervisor's disclosure
37. any time that I think my feelings may negatively affect how I relate to my client		
38. 1) perceived openness of supervisor 2) how personal the reactions are, i.e., I may be slightly less willing to disclose if my reactions to a client are of a personal/embarrassing nature, e.g., sexual attraction.	+	

[a] This table consists of verbatim responses. One response included additional comments about study methodology that have been omitted here as this was not the intent of the table.

(continued)

Response[a]	Valence	Primary Contents
39. It is ethically what should be done as a trainee and also I only learn when I discuss my mistakes.		
40. 1. my own fear of looking bad--this generalizes to most situations for me 2. less of a power differential makes me more likely to disclose in this relationship	+	less of a power differential
41. 1. wanting the peer supervisor to feel that I am a good supervisee 2. to learn about normative counselor reactions		
42. 1) feeling as though the peer supervisor would be able to relate 2) knowing the peer supervisor has previous experience with a type of client or issue	+	
43. I felt that my peer supervisor was more transparent in sharing her reactions with me. My peer supervisor was more likely to share her clinical experiences, even those where she felt that she made errors.	+	peer supervisor's disclosure

[a] This table consists of verbatim responses. One response included additional comments about study methodology that have been omitted here as this was not the intent of the table.

APPENDIX A

Literature Review Tables

Supervision – Overview of Theory

This table provides an overview of supervision. Findings from literature reviews and theoretical discussions indicate that supervision is indispensible in the training of mental health professionals. It occurs in counseling, social work, and psychiatry in addition to professional psychology. Supervision is a hierarchical relationship between a more senior member of a profession and a more junior member that serves the functions of overseeing the quality of clinical services and building competence in the supervisee. A competency-based model of clinical supervision has been developed. Unlike consultation, the supervisor bears ethical and legal responsibility for the supervisee's work. Relationship may be the most important aspect of supervision, out of which the supervisory alliance is formed. Supervisee-supervisor theory and research has drawn on client-therapist relationship research. Literature on supervision process and outcomes has grown out of the move to demonstrate efficacy in professional psychology.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Bernard & Goodyear (2009)	• Reviews and evaluates supervision models, interventions, and research • Includes content areas necessary for the Approved Clinical Supervisor (ACS) credential and attends to core supervision	• Literature review/ theoretical discussion o Integrates literature from psychology, counseling, family therapy, psychiatry, and social work	• N/A	• N/A	• Working definition: "Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship o is evaluative and hierarchical, o extends over time, and o has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a

	competencies stated by the Association of Psychology Postdoctoral and Internship Centers (APPIC) supervision task group				gatekeeper for those who are to enter the particular profession" (p. 7). • Supervision is essential to the training of mental health professionals. o Visible in accreditation and licensure statues, in international scope of literature, and growing number of supervision books. • A conceptual model of supervision consists of *Parameters of Supervision, Supervisee Developmental Level, and Supervisor Tasks.* • Relationship may be the most crucial aspect; supervisory alliance is important. o Working alliance grew out of psychodynamic theory but now accepted by most therapists – pantheoretical. • Supervisor-supervisee theory and research has drawn on client-therapist relationship research. o Modify most recognized measure of therapeutic alliance (Horvath & Greenberg, 1989) or develop instrument explicitly for supervision (e.g., Efstation et al., 1990). • Can infer connection between quality of supervision and client outcome. • The supervisory relationship is complex. • Individual, developmental, and cultural differences affect the supervisory relationship. • 3 ranges to view relationship: (1) supervisory triad (2) supervisory dyad, (3) and individual contributions of supervisee and supervisor to the quality and effectiveness of the relationship (dynamic processes, e.g., supervisee attachment and supervisor countertransference). • Three studies (Ladany et al., 2001; Spelliscy, 2007; Chen & Bernstein, 2000) demonstrate that supervisor's interpersonal style predicts supervisory alliance. Attractive and

					Interpersonally Sensitive styles appear to be more predictive; Task-oriented style is only associated with agreement on task component of working alliance. • Supervisors in training programs and clinical sites may avoid evaluation. • Supervisees often experience anxiety due to uncertainty regarding expectations and roles. o Educating about these through discussions and audio/video modeling may be useful. o *Role induction* shown to be effective with clients in counseling (p.182). • Consultation o Consultation and supervision involve assisting the beneficiary to be more effective as a professional; for advanced trainees, supervision may become consultation. o Consultation can be a single event and is typically sought more voluntarily. o Consultation does not involve evaluation. • Peer supervision groups are continuous, nonhierarchical arrangements that reduce isolation and burnout, are important for continual professional development, and do not involve formal evaluation. • Peer supervision is a developing trend. • Supervision-related research has a shorter history than counseling and psychotherapy research, which dates from around end of World War II (Garfield, 1983). o Volume has steadily increased, but still much room for growth in volume and quality. o Overuse of outcome measure of supervisee satisfaction. Weak association with supervisee skills, attitudes, and cognitions. Analogy to pastry shop: customers who are leaving confirm they liked pastries and would

					return, which is different than analyzing the nutritional content of pastry consumed.
Caplan (1970) (chapter)	• Defines and presents characteristics of mental health consultation • Categorizes types of mental health consultation	• Theoretical discussion	• N/A	• N/A	• Consultation is "a process of interaction between two professional persons – the consultant, who is a specialist, and the consultee, who invokes the consultant's help in regard to a current work problem with which he is having some difficulty and which he has decided is within the other's area of specialized competence" (p.19). • Differences from supervision: o Supervisor is senior member of same profession; consultant is often member of different profession. o Supervision is a continuing process; consultation involves several interactions resulting from present work issue and is sought on occasion. o Supervisor has admin responsibility for supervisee's work and is professionally responsible for clients' care; consultant typically is from outside the institution, does not have responsibility for consultee's work or client care. o Supervision is a hierarchical relationship; consultation is a "coordinate relationship" (p.22) without a power differential. o Consultee is not obligated to accept consultant's suggestions. o Consultation does not include personal/private material of consultee. o Goal is to improve consultee's management or understanding of the work difficulty and to enhance competence to handle similar issues. • Types of mental health consultation: (a) client-centered case consultation, (b) consultee-centered case consultation, (c) program-centered

					administrative consultation, (d) consultee-centered administrative consultation.
Falender & Shafranske (2004)	• Presents a framework for identification and development of specific competencies in trainees and supervisors	• Literature review/ theoretical discussion	• N/A	• N/A	• A competency-based model of clinical supervision is presented. • Competencies support the supervisee's integration and application of knowledge, skills, abilities, and values, which are formed into competencies and evaluated through formative feedback and summative assessments. • Four superordinate values are believed to be fundamental to supervision and clinical work: integrity-in-relationship, ethical values-based practice, appreciation of diversity, and science-informed practice. • Supervision has the critical functions of assuring the integrity of clinical services and building competence in the supervisee. • Outcomes: o quality management o learning of how to apply knowledge, theory, and clinical procedures to solve problems o socialization into profession o enhancement of supervisee self-assessment and self-efficacy o training in supervision practice o supporting professional development resulting in competency as psychologist o enabling supervisee to become a colleague • The "supervisory alliance is, to a great extent, the result of the nature and quality of the relationship that is formed between the supervisor and supervisee (p. 4). • Move to empirically show efficacy within professionally psychology has resulted in body of literature on supervision process and outcomes

					• Supervisee report is foundation for most of the research; research has no link to treatment efficacy or other variables that would seem to be positively influenced by exceptional supervision. • Countertransference (CT) may be considered to be all personal responses of therapist, or more narrowly, the reactions originating from the therapist's transference - unconscious conflicts and needs. • Addressing CT is key task of supervision; supervisees seem to value it. • Strong supervisory alliance that takes into account personal values and factors provides best foundation for exploring CT. • Supervisory relationship can help trainees understand their responses to clients and develop skills to manage them instead of acting out on them. • CT cannot be completely eradicated; objective is to use CT within the therapeutic and supervisory relationships to further treatment. • Exploring CT involves revealing personal experiences, attitudes, values, which may elicit anxiety and shame. • Examination of CT combined with continued assessment of skills may lead to feelings of vulnerability and intensified self-criticism. • Must maintain boundary between supervision and psychotherapy o promoting exploration of personal issues threatens integrity of supervisory alliance and is not helpful to supervisee or client o personal issues that arise during discussion of processes/interactions in particular client's treatment are considered in terms of the case o referring to psychotherapist appropriately

					manages CT so that it does negatively impact client's treatment.

Supervision – Overview of Empirical Studies and Compilations

An overview of empirical studies and compilations on supervision is provided in this table. Findings from two meta-analyses indicated that the overall quality of supervision research in the 15 years prior to 1997 was inadequate. Specifically, there were many statistical and methodological threats, High Type I and II error rates, and medium effect sizes. Most of the investigations were found to be unrigorous and exploratory, and there had been few replication studies.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Ellis, Ladany, Krengel, & Schult (1996)	• Assesses status of clinical supervision research since 1981 based on standards of scientific rigor • Assesses whether methodology quality has improved based on suggestions in Russell, Crimmings, & Lent's (1984) review	• Meta-analysis with illustration of clinical supervision study • Studies evaluated on 49 threats to validity • Statistical variables were calculated (*N*, effect size, statistical power, and per comparison and experimentwise error rates)	• Methodological evaluation variables: 49 potential threats to validity ○ Cook & Campbell's (1979) 33 threats to validity in 4 classes (statistical conclusion, internal, construct, external) ○ Wampold, Davis, & Good's (1990) 4 threats to	• 144 studies • Articles by journal: *Journal of Counseling Psychology* (*n*=38; 29.0%), *The Clinical Supervisor* (*n*=28; 21.4%), *Counselor Education and Supervision* (*n*=19; 14.5%) and *Professional Psychology: Research and Practice* (*n*=17; 13.0%) and 20 journals that published 3 or	• At time of study, there had been at least 32 reviews of empirically based supervision studies. • Quality of supervision research is inadequate. ○ Statistical and methodological threats are numerous and significant. ○ High Type I and II error rates ○ Medium effect sizes ○ Several new measures have been developed but finding psychometrically feasible measures is a substantial barrier. ▪ Instruments from psychotherapy research adapted for supervision; change a few words (e.g., "client" → "supervisee") • Designs have shifted to ex post facto field studies instead of experimental or quasi-experimental; compromised conceptual and methodological rigor and hypothesis validity. • Recommendations for designing and conducting a feasible supervision study are provided (see p.

			hypothesis validity ○ Russell et al.'s (1984) 12 methodological threats – 6 threats to internal validity, 6 to external validity ○ 8 supplemental variables	fewer supervision articles (e.g., *Journal of Consulting and Clinical Psychology* *n*=27; 19.1%). • Publication year: 1981 (*n*=5; 3.8%), 1982 (*n*=8; 6.1%), 1983 (*n*=14; 10.7%), 1984 (*n*=14; 10.7%), 1985 (*n*=8; 6.1%), 1986 (*n*= 13; 9.9%), 1987 (*n*=7; 5.3%), 1988 (*n*=9; 6.9%); 1989 (*n*=10; 7.6%), 1990 (*n*=7; 5.3%), 1991 (*n*= 12; 9.2%), 1992 (*n*=10; 7.6%), 1993(*n*=14; 10.7%) • Design: Ex post facto (no RA and IV not manipulated; 72.9%), experimental (RA and manipulated IV; 8.3%), quasi-experimental (no RA and	45-47). • Limitations: several criteria had little or no variability (e.g., markedly brief training period), which implies they did not apply; criteria may have been defined so that they prohibited detection of design variations; 2 criteria had lower interrater agreements (mid to upper .70s); no comparison group, selection bias – estimates may be too optimistic.

				manipulated IV; 8.3%), case studies (4.9%), scale development and validation (*n*=8; 5.6%). 47% had cross-sectional designs with tests of longitudinal or developmental inferences • Participants in studies: supervisees (79.9%), supervisors (53.5%), clients (9.0%) • Included peer supervision studies	
Ellis & Ladany (1997)	• Presents an integrative review of clinical supervision research (inferences about supervisees and clients) that (a) systematically evaluates the scientific rigor of the studies, (b) reinterprets the results (if needed) in consideration of conceptual and	• Meta-analysis • Studies evaluated on 37 threats to validity and 8 additional variables (e.g., identifying limitations of research) • Statistical variables were calculated (N, effect size, statistical power, and per	• Replicated Ellis, Ladany, Krengel, and Schult's (1996) methodology • Methodological evaluation variables: 37 potential threats to validity ○ Cook & Campbell's (1979) 33 threats to validity in 4	• 104 studies • Articles by journal: Journal of Counseling Psychology (n=30; 31.6%), The Clinical Supervisor (n=18; 19.0%), Counselor Education and Supervision (n=13; 13.7%, Professional Psychology:	• In general, quality of research in 15 years prior to 1997 is substandard. ○ Majority of investigations were found to be unrigorous and atheoretical (exploratory) and had limited control over alternate explanations of the data or threats to validity of data or results. • Few replication studies. • Clinical supervision may be more complex than represented in existing theories. • Lack of testing supervisory theory. • Lack of clinical supervision-specific measures and psychometric testing; should empirically establish feasibility of measures for supervisory context that were adapted from another context.

	methodological limitations, and (c) organizes and reviews the studies based on the examined inferences (regarding supervisory relationship, matching in supervision, supervisee development, supervisee evaluation, and client outcome) to address limitations of prior reviews of clinical supervision research and to emphasize the theory-testing type of research. • Codes fundamental assumptions or inferences about supervisees and clients and organizes review based on these inferences	comparison and experimentwise error rates)	classes (statistical conclusion, internal, construct, external) ○ Wampold, Davis, & Good's (1990) 4 threats to hypothesis validity	Research and Practice (n=14; 14.7%), Psychotherapy (n=4; 4.2%), and 12 other journals (e.g., Journal of Consulting and Clinical Psychology (n=16; 16.8%) with 3 or fewer relevant articles on supervision • Publication year: 1981 (n=4; 4.2%), 1982 (n=3, 3.2%), 1983 (n=9; 9.5%), 1984 (n=9, 9.5%), 1985 (n=5, 5.3%), 1986 (n=11; 11.6%), 1987 (n=6; 6.3%), 1988 (n=9; 9.5%), 1989 (n=6; 6.3%), 1990 (n=6; 6.3%), 1991 (n=10; 10.5%), 1992 (n=6; 6.3%), 1993 (n=8; 8.4%), 1994 (n=2; 2.1%) 1995 (n=1; 1.1%)	• Recommend 2 measures of supervision: Role Conflict and Role Ambiguity Inventory (RCRAI; Olk & Freidlander, 1992) and Relationship Inventory (Schact, Howe, & Berman, 1988) see p. 489 • Primary inference about supervisory relationship: relationship components are related to supervisee outcome (e.g., supervisee skills). • "…the quality of the supervisory relationship is paramount to successful supervision. What constitutes a high-quality relationship, however, is largely untested and equivocal" (p. 495). ○ Suggest that applying knowledge about counseling relationships to supervision w/o accounting for the differences in supervisory relationship, such as evaluation, may contribute to lack of clarity about supervisory relationship. ○ Inferences about Supervisory Working Alliance: Efstation, Patton, & Kardash (1990) and Ladany & Friedlander (1995). Strengths: Large sample sizes (Ns>123) and effort to measure a construct modified from therapy to supervision. Methodological weaknesses: new measures with initial psychometric data, threats to internal validity due to lack of randomization and failure to control for potential third variables. • Use of Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990) would be unwise until psychometric properties of supervisee and supervisor forms are improved, theoretical inferences clearly tested and cross-validated with larger, more representative sample. ○ Nonparallel trainee (SWAI-T) and supervisor (SWAI-S) forms; internal consistency reliabilities all below .77 except for SWAI-T Rapport .90; within forms, scales are moderately to highly intercorrelated and some items are

				• Design: Ex post facto research (no RA and IV not manipulated; 72.1%), experimental (RA and manipulated IV; 6.7%), quasi-experimental (no RA and manipulated IV; 9.6%), case studies (4.8%), test construction with validity data (6.7%) • Included peer supervision studies	loaded considerably on more than one scale; SWAI-T and SWAI-S Rapport scales minimally correlated as well as the Client Focus scales on trainee and supervisor forms; small within dyad correlations of SWAI and Supervisory Styles Inventory (Friedlander & Ward, 1984); data suggests that 2 SWAI forms assess different constructs. • Limitations: no clear criteria for determining whether a study's data and results are interpretable; lack of hypothesis validity due to descriptive purpose; conclusions only as good as the research from which they were made.

Peer Supervision/Consultation Groups & Structured Peer Consultation/Peer Supervision Models for Other Disciplines – Theoretical Contributions

This table presents theoretical contributions and models on peer supervision/consultation groups from the fields of nursing, psychiatric nursing, and mediation. Peer consultation/supervision groups were described as providing support, assistance with decision-making and problem-solving, and opportunities for learning, as well as other benefits.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Barry (2006)	• Addresses issues in	• Recommendations	• N/A	• N/A	• P/MH APRNs may become isolated if they

	private practice for advanced practice psychiatric/mental health nurses (P/MH APRNs)	for establishing peer consultation groups			work in private practice, which may limit growth. • Continuing peer group meetings can protect against isolation. • Numerous APRNs have established peer consultation groups of 5 – 10 members to discuss complex cases on a recurring basis. • The group provides support and collaborative problem-solving regarding clinical assessment, treatment planning, decision-making, and treatment report writing for HMOs.
Claveirole & Mathers (2003)	• Reports findings from implementation of peer supervision system with mental health nursing lecturers	• Model discussion	• Diary recording and notes made by facilitator during study meetings	• 11 nurse lecturers in university setting; 4 supervision pairs and 1 triad	• Peer supervision was considered to have value in terms of support, decision-making and prioritizing, managerial assistance, problem-solving and productivity. • Direct educational value of peer supervision was not indicated by participants. • Other info of interest: Clinical supervision is now part of mainstream mental health nursing
Hart (1990)	• Provides recommendations for building peer consultation for nurses into clinical settings • Describes potential benefits of peer consultation	• Theoretical discussion	• N/A	• N/A	• Peer consultation refers to a process in which a nurse speaks with colleagues to solve a clinical or administrative problem. • Peer consultation o promotes learning of nursing skills and knowledge o provides support o provides a means to review practice o encourages professional interdependence o acknowledges group members' expertise o reduces feelings of isolation o increases self-confidence and self-esteem o shapes professional identity o decreases conflict and builds group power
Minkle, Bashir, & Sutulov	• Describes mediators'	• Model illustration	• N/A	• Mental Health Issues in	• Peer consultation uses reflective practices to advance learning and can provide support for a

(2008)	experiences of peer consultation group • Explains how the holding environment promotes peer consultation groups' use of reflective practices			Mediation Study Group (MHIMSG) – (approximately 12 m and w); professionals of different disciplines (law, mental health, business, etc.) who use various mediation models/styles	mediator to engage in self-reflection in regards to challenging cases. • The goal is that "the mediator eventually internalizes the reflective process" (p. 321). • Group members gain fresh views, insights, and meta-perspective (i.e., awareness of one's bodily state, thoughts, and feelings and their influence on attitudes and behavior). • Group members experienced professional development through focusing on knowledge and skills, self-awareness, interpersonal dynamics, communication, culture, et cetera. • Developing a holding environment that offers a safe, confidential space is necessary for successful group consultation process.
Morgan (2006)	• Explains consultation module of Adult Psychiatric Mental Health Graduate Program at UMASS Lowell	• Literature review with illustration	• N/A	• N/A	• Consultation Activities ○ Psychiatric/Mental Health NP students (P/MHNP) take on consultant roles and Gerontological NP students (GNP) and Family NP students (FNP) take on consultee roles for 1st class with questions on cases of medical patients with potential psychiatric problems. ○ GNP and FNP students then take on consultant roles and P/MHNP students take on consultee roles for cases of psychiatric patients with complex medical problems. • Students' self-esteem and role mastery may be increased more by positive feedback from peers than from faculty. • Consultation activity serves as a model for collaboration among advanced practice nurses in the field.

Peer Supervision/Consultation Groups & Structured Peer Consultation/Peer Supervision Models for Other Disciplines – Empirical Studies and Compilations

Major findings from empirical studies and compilations on peer supervision/consultation groups and structured peer consultation/peer supervision models in healthcare disciplines (i.e., nursing, radiology, and medicine) are presented in this table. Qualitative and pre-experimental approaches were used in this research. Common perceived benefits of peer supervision/consultation included (a) providing an opportunity for increasing clinical knowledge and skills, (b) encouraging interaction and the development of communication and interpersonal skills, and (c) promoting critical thinking and reflection on practice.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Bos (1998)	• Describes nursing students' perceptions of benefits of peer leadership	• Qualitative study • Content analysis	• Self-evaluation following clinical time as peer leader – asked to "describe your strengths and areas for improvement. Describe what you learned and what you would do differently if given another opportunity"	• 12 junior baccalaureate nursing students in surgical unit of teaching hospital in Midwest	• Perceived benefits were practice in prioritizing care, improvement of critical thinking, technical, and management skills, and awareness of peer resources. • Peer leadership involves peer teaching and supervision. • Peer leadership promotes intrinsic motivation by providing a non-evaluative opportunity to increase the knowledge and skills for building clinical judgment. • Peer leadership also promotes cognitive flexibility.

			(p.190).		
Brown, Hogg, Delva, Nanchoff-Glatt, & Moore (1999)	• Explores family medicine teachers' experience of Peer Consultation Reflection Exercises (PCRE)	• Qualitative study; key informant interviews and 1 hour focus group	• Five key informant interviews addressing: overall perception of PCRE experience, value of PCRE, barriers and facilitators to participating in or learning, transferability of PCRE to own workplace	• 10 family medicine teachers who attended the 1996 Annual Meeting of the College of Family Physicians of Canada's Section of Teachers	• PCRE was valued for the opportunity for feedback and for learning new perspectives on academic problems. PCRE was also valued for its empowering nature. • Learning was facilitated by a climate of safety, openness, and respect, experienced leaders, and relative anonymity of participants. • A barrier to learning was the formal structure of PCRE. • Transferring PCRE to other settings necessitates having experienced leaders and confidentiality. • Limitations of study: sample was self-selected, only 1 focus group • Other info of interest: PCRE was adapted from family therapy intervention of the reflecting team; the peer reflecting team has been used with groups of peers, residents, and students for managing administrative, educational, clinical, and research challenges. o PCRE is different from traditional continuing education in medicine. • Steps in PCRE: o Introductions of participants o Presenter (selected by group) describes his/her challenge o Participants ask questions of presenter; 1 question allowed at a time; 2-3 rounds of questions o Participants form reflecting team to discuss challenge. Presenter observes the discussion. o Presenter reflects on recommendations/comments. o Steps (except for step 1) are repeated with next presenter.

Lang, Sood, Anderson, Kettenmann, & Armstrong (2005)	• Presents the incorporation of rotating peer supervision model (microteaching) into a communication skills course for radiology trainees	• Pre-experimental one-group pretest-posttest design	• Preassessment Survey – 18 questions in which trainee rates level of comfort in a real-world scenario (wording based on State Trait Anxiety Inventory; STAI; Spielberger, 1983); also indicate expectations and communication skills h/she would like to enhance • Initial video-taped role play of challenging situation to establish baseline skills • Web-based course with 10 modules of communication skills: encouragement, matching, distance vs. closeness, sensory term preferences, showing	• 20 radiology trainees (11 m, 9 w) - residents and fellows	• Rotating peer supervision is "a process in which students teach other students and themselves about teaching through observation, analysis, and evaluation of their own teaching, as well as that of their colleagues" (p. 904). o Armstrong (1974) initially developed concept for teacher trainees. o Method has been used for years in medical education leadership programs. o "Microteaching exercise" now used for term "rotating peer supervision." • At least 1 behavior on the checklist improved for 8 residents, worsened for 1, and remained high for the others. • Microteaching promotes reflection on practice experience and is part of practice-based learning. • Microteaching is a means to integrate communication and interpersonal skills (core competencies of the Accreditation Council of Graduate Medical Education (ACGME) into residency and fellowship programs.

			perception of control, negative suggestions, instructions, pacing and leading, eye movement, and eye contact. • Microteaching exercises – groups of 4 to 9 trainees with faculty facilitator (videotaped) • Outcome assessment – performance on video and microteaching video measured with checklists for 10 behaviors in Web course		
Renko, Uhari, Soini, & Tensing (2002)	• Explores whether difficulties in tutorial group sessions of problem-based learning (PBL; e.g., limited participation, lack of cohesion, and withdrawal) could be prevented with a peer consultation model	• Pre-experimental design (one group, post-test only)	• Open discussion after each session • Questionnaire with 6 open-ended questions on student's opinion and understanding of the objectives, most significant issues, benefits and limitations of the method, differences	• 49 fifth-year medical students in a 10-week pediatrics course	• *Peer consultation* is "based on collaborative small group working and peer tutoring" (p.408). • Peer consultation model divided the tutorial group into three subgroups of presenters, facilitators, and observers, with 2-3 members each. Students changed groups between sessions to rotate through the roles. • Peer consultation model involved each student taking responsibility for a case, which prevented lack of participation, interaction, and cohesion. • Medical students reported that the consultation model compelled them to carefully define the problem, assisted with developing communication skills and recognizing

			compared with prior experiments in problem-solving, own learning about his/her problem-solving strategies and which role provided the most learning.		challenging issues from diverse perspectives, and provided an opportunity to assess their own problem-solving strategies. • Consultation method appears to encourage collaborative student learning

Peer Supervision/Consultation groups for Clinical & Counseling Psychology, Psychiatry, School Psychology, and Social Work – Theoretical Contributions

Theoretical contributions on peer supervision/consultation groups in psychology (i.e., clinical, counseling, and school), social work, and psychiatry are outlined in this table. These model illustrations and theoretical discussions suggest that peer consultation groups for professionals provide: (a) support; (b) a forum for processing countertransference, as well as addressing ethical, legal, and professional matters; and (c) an opportunity to improve critical thinking.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Variables/ Instruments	Sample	Major Findings
Greenburg, Lewis, & Johnson (1985)	• Explains importance of peer consultation groups for clinicians in private practice • Describes peer consultation group's composition, goals,	• Theoretical discussion with case illustration	• N/A	• 6 members (5 psychologists, 1 social worker) – all White, upper-middle-class females; various theoretical	• Peer consultation groups are a resource for information and a setting for addressing legal, ethical, and professional matters. • Peer consultation groups offer a regular opportunity to identify and attend to negative emotions and threats to objectivity. • While it is a task-oriented group, processing

	content, and process			orientations; meet for 4 hr 1x month, unstructured sessions	is involved. • Practicing professionals, like trainees, should examine negative feelings and conflicts. • Clinicians in private practice are at risk for burnout and stress from isolation. • Goals of group include: o Offer support/assistance in handling difficult cases and stresses of private practice o Provide objectivity for processing countertransference • Share information (regarding referral sources, techniques, seminars, etc.)
Granello, Kindsvatter, Granello, Underfer-Babalis & Moorhead (2008)	• Describes how a peer consultation model can be utilized to expand supervisor cognitive development	• Literature review and model illustration	• N/A	• Supervisory peer consultation group – 4 members (university faculty member, doctoral student supervisor, on-site supervisor, and faculty member/ethics chair for state counseling association)	• Expanding members' perspectives and improving critical thinking might be chief benefit of supervisory peer consultation group. o Discussions enabled members to view difficult cases from diverse perspectives and increase knowledge of supervision complexity. • Other info of interest: supervisee development models have grown in past few decades; models of supervisor development have not.
Markus et al. (2003)	• Describes use of experiential model for peer supervision and consultation of group therapy o Countertransference defined as "any or all reactions of a therapist to a patient or therapy	• Model illustration and theoretical discussion	• N/A	• 9 members from same department of a medical center who met for 1 hr sessions biweekly for 1 year - experienced group clinicians	• Group experiential model utilizes primary process to direct, explain, and resolve countertransference. • Shared risk-taking and vulnerability are advantages of an experiential model. • Dual professional relationships and established friendships may have complicated the model implementation.

	group" (p. 20)			in National Registry of Certified Group Psychotherapists; various disciplines in mental health (psychology, nursing, social work) and theoretical orientations; group had rotating leadership	• This model requires that members have technical skills, understanding of group process, and awareness of one's own psychodynamics.

Peer Supervision/Consultation groups for Clinical & Counseling Psychology, Psychiatry, School Psychology, Social Work – Empirical Studies and Compilations

This table presents empirical findings, primarily from descriptive studies and case illustrations, on peer supervision/consultation groups in psychology (i.e., clinical, counseling, and school), social work, and psychiatry. Peer supervision/consultation groups tend to be leaderless and heterogeneous in many aspects such as gender, amount of experience, and theoretical orientation. They have many benefits such as providing forums to receive support, increase knowledge and skill development, learn new perspectives on treatment strategies, explore countertransference, and work on professional development. It is

suggested that peer supervision should be referred to as peer consultation, due to the lack of evaluation and responsibility for others' clients. Although many positive outcomes have been reported, information has come mostly from anecdotal accounts.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Variables/ Instruments	Sample	Major Findings
Benshoff (1994)	• Reviews research on peer consultation for counselors	• Literature review	• N/A	• N/A	• Consistent counseling supervision by a qualified supervisor is often not readily available to counselors, despite the fact that it is acknowledged that supervision is essential for professional development. • *Peer supervision* or *peer consultation* refers to peers collaborating for mutual gain. o Relationship is non-hierarchical and non-evaluative. • Peer *consultation* may be a more suitable term to refer to "a process in which critical and supportive feedback is emphasized while evaluation is deemphasized" (para 2). • Individuals utilize their helping skills to assist one another in becoming more effective professionals. • Focus is on assistance with achieving goals, unlike in traditional supervision where the focus is on evaluation, • Advantages of peer consultation: o Increased interdependence on colleagues o Less dependency on supervisors o Greater responsibility for self-assessment of skills and assessment of peers' skills o Greater responsibility for increasing own professional development o Increased self-confidence and self-

					direction ○ Improvement in supervision and consultation skills ○ Utilization of peers as models ○ Freedom to select the consultant ○ Absence of evaluation ○ Feeling of empowerment • SPCMs ○ regular consultation dyads, typically 1x week or biweekly ○ specific structure for every session with focus on certain tasks but permit some adaptation ○ activities include: goal-setting, case consultation, tape review, discussion of theoretical orientation, etc. • Peer consultation necessitates that counselors are inspired, dedicated to meeting regularly, and open to providing and receiving support and feedback. • There is a need to identify adequate outcome measures.
Counselman & Weber (2004)	• Discusses factors believed to influence success or failure of peer supervision groups (PSGs) • Provides guidelines for creating and maintaining PSGs • Considers how a leaderless structure benefits or hinders consultation task	• Literature review	• N/A	• N/A	• A leaderless peer supervision group (PSG) is a common arrangement for therapists who have fulfilled formal training. • PSGs should be labeled consultation groups because members do not have direct responsibility for others' clients. • PSGs typically have five or six members who share leadership tasks. • PSGs are appealing to therapists for continuing consultation and support, networking, and combating burnout/isolation. • PSGs provide interpersonal learning experiences and parallel process learning. • Many PSGs do not survive.

					• A PSG must share leadership functions such as adhering to the contract, gatekeeping, and addressing group processes (e.g., competition and shame).
Lewis, Greenburg, & Hatch (1988)	• Explores the degree of participation among private practitioners in peer consultation groups • Provides an overview of the characteristics of groups or group members	• Descriptive study Data analysis: chi-square analysis and analysis of variance (ANOVA)	• Survey, 30 questions • About members - age, gender, geographic area, theoretical orientation, view of supervision experiences during graduate training, years of psychotherapy experience, specialty area (e.g., clinical psychology), practice setting, main professional activity • About groups – how formed, length of time in existence, size, gender composition, theoretical composition, type of leadership, meeting place, frequency of meeting, range of	• 480 psychologists in private practice listed in *The National Register of Health Service Providers in Psychology*; certified or licensed at independent practice level in state, with training and experience in providing direct health care services	• 23% of the sample currently were members of peer consultation groups, 24% had previously belonged, and 61% wanted to belong if one were available. • Groups tended to be small (6 members), informal, and leaderless. • Majority (93.5%) met at least once per month. • Most groups are heterogeneous in theoretical orientation, gender, and amount of experience. • Typical member is a 46-year-old male with a doctorate in clinical psychology who has been in private practice for 11 years in metropolitan region; full-time solo practitioner with office in professional building; primarily practices individual therapy but also provides marital-family therapy and consultation-diagnostic services; a generalist. • Top motivations for joining: (1) receiving suggestions for problematic cases (2) discussing ethical concerns (3) countering isolation. • Groups serve as informal, voluntary peer review to discuss cases, professional concerns, and ethical decisions.

			group members' experience, time allocated to various activities, process variables (e.g., degree of structure), members' needs and whether they have been met		
Logan (1997)	• Describes development and process of peer consultation group for school counselors	• Case illustration	• N/A	• N/A	• Peer consultation groups may offer: o Case consultation o Problem solving o Support o Useful feedback o Materials and resources • The group initially focused on sharing resources; case consultation regarding dealing with difficult cases followed. • Group members worked on professional development.
Page, Pietrzak, & Sutton (2001)	• Explores degree of participation among school counselors in administrative and clinical supervision, their views of supervision goals, and their intent to be a certified clinical supervisor.	• Descriptive study	• Survey, revised version of Sutton & Page's (1994) questionnaire to assess school counselors' views of clinical supervision • *Peer supervision* defined as: "a planned meeting with one or more colleagues; the sole purpose of the meeting is	• 267 American School Counseling Association members • Typical respondent: married woman with master's degree in counseling and 7.92 years of school counseling experience. Work	• 13% of counselors currently had individual clinical supervision from a licensed counselor (28%), guidance director (21%), professor of counselor education (12%), other school counselor (12%), school psychologist (11%). • 11% had group clinical supervision. • 29% had peer supervision – weekly (49%), every other week (15%), monthly (23%), less than once per month (13%). • 2 goals rated most important for clinical supervision: "taking appropriate action with client problems" and "developing skills and techniques" (p. 148).

			clinical supervision" (p.144).	setting: elementary school (47%), middle school (24%), high school (29%)	
Schreiber, & Frank (1983)	• Discusses the development and structure of peer supervision group of social workers	• Literature review with illustration	• N/A	• N/A	• Benefits of a peer supervision group for social workers include: a forum for reflection on therapeutic work, awareness of countertransference, a setting to revisit familiar experiences, a process of peer review, and a setting to communicate new information in the field.
Todd & Pine (1968)	• Describes peer supervision group experience of psychiatrists who conducted long-term therapy with difficult patients	• Case study	• N/A	• 10 psychiatrists (4 continuing for entire 13 years of the group)	• Peer supervision group offered learning that had not been acquired through training, supervision, or personal psychotherapy. • Group discussion moved from general to more personal. Discussions of difficult transferences paved the way for explorations of countertransference (CT). • Interactive and supportive environment enabled exploration of CT. • Peers provided alternative perspectives and different treatment strategies/interventions, which improved therapist's coping and therapeutic effectiveness. • Group also supported members through personal issues that influenced their work. • Group promoted informal consultation, which appeared to reduce discussion of patients in social situations. • Members struggled with the degree to which they questioned the presenter's issues that factored into CT.

Wilkerson (2006)	• Reviews how peer supervision has been defined for school counselors • Synthesizes a definition of peer supervision • Introduces current models that match the definition • Presents overview of outcome research for these models	• Literature review	• N/A	• N/A	• Although most school counselors report desire for clinical supervision, few have it. • Peer supervision has been proposed as alternative to clinical supervision. • *Peer* connotes relationship between equals, unlike Bernard & Goodyear's (2009) definition of supervision. • New definition of peer supervision: "a structured, supportive process in which counselor colleagues (or trainees), in pairs or in groups, use their professional knowledge and relationship expertise to monitor practice and effectiveness on a regular basis for the purpose of improving specific counseling, conceptualization, and theoretical skills" (p. 62). • 5 ways peer supervision differs from clinical supervision and consultation: ○ (1) collegial, peer relationship between individuals of same profession (not hierarchical as in clinical supervision and not interdisciplinary as in consultation models) ○ (2) accountability with monitoring and giving feedback (not evaluative as in clinical supervision) ○ (3) more counselor-centered orientation rather than client-centered in consultation ○ (4) standard, ongoing format rather than isolated event due to specific clinical concern ○ (5) structure with goal setting, direction, and monitoring to promote professional growth • 2 models fit new definition: Spice & Spice (1976) and Remley, Benshoff, & Mowbray (1987)

					○ emphasize case presentation and audio/videotaped sessions ○ emphasize work in session, which promotes accountability and efficacy ○ can be modified for group format • No evidence implies that Remley et al. (1987) or Spice & Spice (1976) models contribute to better outcomes for school counselors or their clients. • Excluding descriptive report, there is no data to suggest that peer supervision should "be valued above and beyond" (p. 65) no supervision. • Recommendations: ○ Distinguish peer supervision from clinical supervision and peer consultation. ○ Use new definition in investigation of present level of school counselors' participation in peer supervision. ○ Conduct empirical studies to evaluate viability and efficacy of peer supervision models.
Yeh, Chang, Chiang, Drost, Spelliscy, Carter, & Chang (2008)	• Explored the development, content, and process of online peer supervision group (OPSG) for counselor trainees	• Descriptive study	• Process measure: Chang, Yeh, & Krumboltz's (2001) 16 category taxonomy of verbal response modes (VRMs) to categorize utterances in the posts on electronic bulletin board • Content measure: 6	• 16 (all w) counselor trainees in counseling psychology master's program at Northeastern graduate school who were at off-campus internship – Age range: 23-47; SES: middle to upper-middle class;	• OPSG seems to be a practical way to provide support for counselor trainees. • Participants reported feeling open, comfortable, and confident in using OPSG and its anonymous system. ○ Openness may have been influenced by lack of hierarchical, evaluative supervisory relationship. • Responses to posted messages were considered to be applicable to and helpful for addressing participants' concerns. • Nearly 75% of messages were responses to another participant's, which supports the conclusion that peers interacted/responded to each other's questions.

			content codes of case conceptualization, counseling techniques, ethics, interpersonal issues, professional identity, and supervision • Demographic questionnaire • Online Peer Supervision Group Questionnaire (OPSGQ) – 16 items with 7 point Likert-type scale; 4 subscales: Confidence, Comfort, Openness, Preference for Anonymity; 2 open-ended questions on helpful/unhelpful features of group	Racial/ethnic background: 11 White, 2 Asian, 2 Latina, 1 Black	• Professional identity, therapeutic techniques, and case conceptualization were the topics most discussed. • A large proportion of messages consisted of self-disclosure (experiential or informational) and guidance. • Limitations: small sample size, counselors from 1 program, lack of non-verbal cues with online format may have led to miscommunications
Zins & Murphy (1996)	• Identifies peer support groups' (PSGs) contributions to enhance school psychologists' professional practice	• Descriptive study	• PSG, based on Kirschenbaum & Glaser (1978) is defined as "a small group (two or more persons)	• 490 members of the National Association of School Psychologists (NASP); all	• Almost 64% of respondents endorsed PSG involvement at some time during their careers; slightly less than 50% currently participating. • Over 93% indicated at least moderate interest in joining a PSG. • Doctoral and non-doctoral level school

	• Explores features of successful groups		of professionals who meet periodically to learn together and support each other in areas of common professional interest" (p. 63); separate from clinical supervision • National survey: assessed past or current PSG involvement, number of years involved, frequency of meetings, particular benefits of participation in the group (selected from list), variables perceived as important to group's success (open-ended), and degree to which would like to become involved if not in a PSG	major geographic areas and demographic characteristics represented proportionally to NASP membership (e.g., greater than 62% female, 76% non doctoral level, 91% school-employed)	psychologists had high percentage of involvement. • PSGs were considered to be beneficial for professional development. • Greatest benefits reported to be in knowledge and skill improvement and job enthusiasm. • Enthusiastic and committed members, structured meetings, convenient places/times to meet, administrative assistance, similar professional interests and goals, and environment of openness, respect, and trust were associated with effective groups.
Zins, Ponti, & Murphy (1992)	• Describes nature of the peer support group for	• Literature review	• N/A	• N/A	• *Peer-mediated learning experiences* have been referred to as *peer consultation, peer review*,

	special services practitioners in schools • Outlines strengths and weaknesses of group • Provides guidelines for practice, research, and training				and *peer supervision* in the literature. • *Peer-mediated professional development* takes place in a collaborative and supportive atmosphere, includes group problem solving and critical feedback, and upholds quality and ethical practice. o *Peer review groups* – utilize case presentations, review, and problem solving and have a more narrow concentration; clinical supervisors may participate. o *Peer support groups* – utilize case reviews, didactics, group problem solving, community visits; participants typically have equal professional status. • Peer support group (PSG) is defined as a small group of practitioners with similar interests and goals who gather regularly to learn, solve problems, and receive/provide support for professional development (Kirschenbaum & Glazer, 1978). • PSGs provide monitoring of professional activities and feedback. • Rationale for peer-mediated professional development includes: efficacy of peer-influenced learning, quality assurance (increasing competence), and opportunity to reduce isolation and burnout and increase networking. o PSGs often used by various helping professionals (e.g., Lewis, Greenberg, & Hatch, 1988). o Less empirical research on PSGs than on other professional development (e.g., clinical supervision); majority is anecdotal accounts of activities of peer groups and outcomes. o Positive outcomes reported by members:

					improvement in practice, more networking opportunities, increased job enthusiasm, greater participation in professional organizations, assistance with problematic situations, and reduced isolation (e.g., Lewis et al., 1988; Schreiber & Frank, 1983). • Guidelines: o Goals: to exchange information, receive help and support o Composition: most effective functioning with 8 to 12 members with rather diverse professional backgrounds, education and practice experiences and theoretical orientations but still have a sense of cohesion. o Operation: get administrative approval, hold meetings regularly with definite agendas, share and rotate leadership, utilize learning formats such as case consultation, discussion of written material, peer observation, site visits, problem-solving, and outcome evaluation. • PSGs may be an excellent addition to clinical supervision.

Structured Peer Consultation/Peer Supervision Models for Counseling Psychology, School Counseling – Theoretical Contributions

This table presents the theoretical contributions to structured peer consultation and peer supervision models that have been developed for counselors and counselor trainees. Peer supervision for both counseling and school psychology was developed to promote more peer interdependence. The peer dyad and peer group formats have been used for counselors, while peer dyad, peer triad, peer group, and web-based peer group formats have been used for counselor trainees. All models identified involve clear structure, a

systematic procedure, and feedback. Other typical aspects of the models are goal setting, case presentation, videotape review of sessions, and rotation of roles between supervisor/consultant and supervisee/consultee.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Variables/ Instruments	Sample	Major Findings
Borders (1991)	• Introduces approach for conducting peer group supervision	• Model description	• N/A	• N/A	• This model builds on prior methods (i.e., Spice & Spice, 1976; Wagner & Smith, 1979) and was developed to realize these objectives: o Involve all group members o Assist members in providing direct, objective feedback o Develop members' cognitive counseling skills o To be modifiable according to counselor experience level o Provide a structure for supervising counseling sessions (individual, family, group) o Train in methods that counselors can internalize for self-monitoring o Offer a systematic procedure that can be used by supervisors of varying levels of experience. • 3 to 6 counselors and a trained supervisor; meet weekly or biweekly; 1.5-3 hours. • Steps (1) Counselor raises questions about client or taped session and asks for specific feedback. (2) Peers select (or are assigned) roles, tasks, or perspectives for viewing the tape. (3) Counselor shows selected taped segment. (4) Peers provide feedback. (5) Supervisor serves as moderator and/or

					process observer to aid the discussion. (6) Supervisor provides summary of feedback and discussion. • This model has been used with students (practicum and intern) and experienced counselors but its effectiveness has not been empirically studied • Peer supervision groups are encouraged for counselors throughout their careers.
Remley, Benshoff, & Mowbray (1987)	• Introduces a peer supervision model for counselors	• Model discussion	• N/A	• N/A	• Administrative supervision occurs in nearly all settings that offer counseling; mainly a management duty that does not attend to process of counseling. • Factors to consider when selecting peer supervisor: trust (most significant), training and experience level, theoretical foundation, work setting, sex of supervisor. • Model: 10 1-hr sessions with a clear structure. 1. Background info and goal setting o (e.g., discuss orientation/perspective and training experiences) o self-assessment of skills by each peer o goal-setting o contract for 9 sessions 2. Oral case presentations o Each peer presents a case with which having difficulty o Swap audio or videotapes for review prior to 3rd session 3. Review tape for 1st counselor o 1 peer is supervisee, other is supervisor who offers + and – feedback and asks about interventions 4. Review tape for 2nd counselor o Repeat process from session 3 o Select issue for next session; both will read 2 journal articles on topic

					5. Discuss readings and reactions 6. Evaluation of process o Review goals, process effectiveness, current issues, exchange tapes to review 7-8. Review 2nd tape for each counselor 9. Case presentations & issues 10. Evaluation of experience o Includes discussion of whether to repeat sessions 2-10 for more supervision. • Conclusion: peer supervision offers "an opportunity to monitor their practice on a regular basis for the purpose of improving specific clinical counseling skills" (p. 59) as well as improving professional self-confidence.
Spice & Spice (1976)	• Introduces a triadic model of peer supervision	• Model discussion	• N/A	• N/A	• Students rotate roles at each session. o Supervisee: presents sample of work (e.g., case report, audiotape) o Commentator: reviews sample before session and provides feedback at session. o Facilitator: attends to here-and-now dialogue and attempts to intensify effect • Skills developed through processes of: o Case presentation o Critical commentary ▪ Initial focus on the positive to build supervisee self-confidence ▪ "Suggestions for improvement" (p.254) (a) supervisee's goals for counseling session, (b) progress toward goals in session (c) alternative ways to achieve goals ▪ Dialogue when supervisee accomplishes goals in different way than how commentator would have o Meaningful dialogue o Intensifying of here-and-now process ▪ Can highlight a parallel process

					• Eventually blend roles/processes into individual supervisory approach. • Adaptation for supervision training: supervisee presents samples of h/h supervision sessions.
Wagner & Smith (1979)	• Describes peer supervision model for counselor-trainees	• Model discussion	• N/A	• Counselor-trainees in master's counseling program	• Definition: "a process in which counselors-in-training help each other become more effective and skillful helpers by using their relationships and professional skills with each other" (p. 289) • Peer supervision facilitates student accountability for self- and peer assessment. • Peer supervision facilitates independence and interdependence among students for professional and personal development. • Professional and personal issues (e.g., group management, client resistance, and primary supervisory relationship) have been worked on in peer supervision sessions. • Model o Main goal was to build emotional support system that continued beyond university supervisor. o Rotation system, 1h/week: peer supervisee (presents issue), peer supervisor (helper role) o Counselor educator also acts as peer supervisor and supervisee. o One supervisory dyad is observed by other students and counselor educator at group supervision seminar. ▪ Session is videotaped. ▪ One observer (coach) has remote control device so can speak to peer supervisor from control room. • Results of model o Professional growth o Supervision goals were clarified and

					prioritized o More self-direction o Importance of modeling o Supervision as a collaborative experience ▪ Take on more responsibility for learning ▪ Ask for help ▪ More concentration on interpersonal conflicts between each other o No experimental evidence exists that demonstrates either rotating or continuing peer dyads is more beneficial. ▪ Rotating + work w/variety of diverse individuals with different skills and experience levels; may clarify personal style and issues by distinguishing behavioral patterns across dyads. ▪ Continuing for semester or year + relationship issues may arise and can work through conflicts; potential for profound sharing; but counselor educator may need to choose the dyads b/c some pairs may be self-protecting. • Limitations (according to this author): results only based on student feedback and observation of students – no systematic evaluation. • Other information: o Professional development continues throughout one's life and demands self-assessment, ongoing education, and evaluation. o Peer supervision promotes attitudes and behaviors integral to life-long professional growth. o Peer supervision was formulated as aspect of

					training that might promote more peer interdependence. ▪ Fraleigh & Buchheimer (1969) and Kendall (1972) proposed that peer supervision may decrease dependency on authorities, enhance responsibility for self and peer assessment, and show that professional growth by supervision can exist outside of academic programs.

Structured Peer Consultation/Peer Supervision Models for Counseling Psychology, School Counseling – Empirical Studies and Compilations

The following table presents findings from empirical studies and compilations on structured peer consultation and peer supervision models developed for counselors and counselor trainees. Overall, peer supervision was considered to be valuable and to provide helpful feedback, despite the lack of significant increase in counseling effectiveness reported in an experimental study. Peer support was identified as a beneficial outcome in all seven of the studies. Limitations of these studies included small sample sizes and lack of generalizability.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Variables/ Instruments	Sample	Major Findings
Agnew, Vaught, Getz, & Fortune (2000)	• Describes findings from evaluation of long-term clinical	• Qualitative program evaluation	• Job Satisfaction Blank; (JSB, Hoppock, 1935)	• 32 school professionals - (director of	• Peer group supervision program was considered to be valuable for professional and personal development.

	supervision program for school counselors in suburban Virginia school district		• Counselor Burnout Semantic Differential Scales (Cummings & Nall, 1983) • Researcher-developed semantic differential scales (Agnew SDS; Agnew, 1998) – 9 adjective pairs of 7 concepts - 3 measuring program effects: skill gains, professional changes, and counseling relationships; 4 measuring program strengths and weaknesses: peer clinical supervision, peer supervision sessions, supervision feedback, administrative support • Anonymous responses • Structured	guidance and counseling, 16 current elementary school counselors, former elementary counselor, 12 elementary school principals, 2 assistant principals); all counselors female; mean years of experience for counselors 11.7 years	• Nearly all participants credited positive counseling skills, professionalism, and personal gains/changes to the peer clinical supervision program. • Counselors reported high job satisfaction and low levels of burnout. • Counselors perceived that peer feedback was the main reason for increased counseling skills. • Counselors identified personal gains of increased confidence, comfort with job, and professional validation due to the program. • Peer support was the program strength most often reported. o Peer support increased counselors' sense of validation (professional and personal) and decreased feelings of isolation. • Limitations: qualitative approach limits validity due to lack of control over extraneous variables.

			interviews		
Akhurst & Kelly (2006)	• Develops and implements a structured peer supervision group (PSG) based on the Structured Group Supervision model (SGS; Wilbur, Roberts-Wilbur, Morris, Betz & Hart,1991) • Compares the contributions and limitations of PSG to traditional, individual supervision • Identifies strategies that may facilitate learning in the models	• Qualitative study, using grounded theory (Glaser, 1992)	• Group's dialogic processes vs. processes in traditional dyadic supervision • Participants' evaluation of their PSG experiences and comparison to their individual supervision (ISV) experiences • Data collection: trainees' written reflections of previous supervision experiences and audio recordings of PSG and ISV sessions, focus group discussion, and individual participant interviews	• 9 trainee psychologists in university-based services	• The models offer different forms of interaction and potentially add to trainee development in distinct ways. • PSG provides a less hierarchical, more focused, supportive, and empowering experience. • Important considerations for peer group supervision identified in the literature confirmed by the study: o Group size (9 participants) appeared practical, although (6 to 7) would most likely have facilitated more PSG cycles. o Having members of equal status seemed helpful because they were dealing with similar issues. o Rotating role of facilitator managed the leadership, with mixed success. o Goals were restricted by Request-for-Assistance (RFA) statement, and most were achievable. o Main goal of supporting the presenter was attained. o The structure was beneficial to participants. o The PSG interactions seemed to be most helpful when RFA was task-focused. o Participants seemed to need more training in facilitation skills, and more explicit connection between clinical cases and theoretical framework was recommended. o Participants were motivated to participate in full cycle of ten sessions. o No form of evaluation was included. o Organizational aspects supported PSG. • Having both supervision models in training program may enhance trainees' learning by providing: more opportunities to reflect on

					cases, encouragement of trainees to take more active role in forming their understandings, a move towards increased autonomy, and environments that optimize support while challenging trainees' constructions of meaning. • Strategies that may facilitate learning: (themes) learning through speaking, learning as conveying information or as constructing meanings, moving from supervisor authority to intern autonomy, shifting between support and challenge, making the implicit more explicit, shifting between the interpersonal and the intrapersonal. • Limitations: restricted number of participants, some were not accessible for more follow-up interviews; one setting; time frame of less than six months, and methodology used.
Benshoff (1993)	• 1st study: Identifies peer supervision outcome variables and benefits • 2nd study: Investigates the efficacy of Structured Peer Supervision Model (SPSM; Benshoff, 1989) - 7-session version of Remley, Benshoff, & Mowbray's (1987) model, a structured program of consultation sessions in which students switch	• 1st study: descriptive • 2nd study: experimental, pretest-posttest control group design with random assignment to treatment group Data analysis: t-test, 2 (treatment group) x 2 (experience level) ANOVA	• 1st study: ○ Shortened version (3-4 session) of SPSM used to determine trainees' responses to the model ○ Evaluation form with seven open-ended questions to assess aspects of peer supervision • 2nd study: ○ SPSM (experimental group only)	• 1st study: 81 master's level counseling students, specializing in school and community counseling, mainly White females, age 25-44 years • 2nd study: 87 master's level counseling students enrolled in practicum or internship courses, largest number specializing in school counseling;	• 1st study: ○ Trainees perceived peer supervision to be beneficial for building counseling skills and techniques and enhancing understanding of concepts. ○ Peer supervision offered support, encouragement, and useful feedback that promoted learning. ○ Peer supervision was perceived to be different than other supervision - less threatening, and more informal and comfortable. • 2nd study: ○ Participants who engaged in peer supervision did not rate themselves significantly higher on counseling effectiveness than those in traditional supervision only. ○ Although results were not significant, descriptive data tentatively confirm the usefulness of peer supervision for counseling

	roles of supervisor and supervisee - in furthering counselor trainees' professional development		○ Counselor Evaluation Rating Scale (CERS; Myrick & Kelly, 1971) – 27 items, Likert-type scale, 13 items for counseling skills, 13 items for evaluating supervision behavior; administered pre- and posttest to each group ○ Demographic questionnaire	(14 m, 66 w), majority 25-44 years	trainees at master's level. ○ Limitations: 1st study – abbreviated version of SPSM limits ability to generalize responses to full SPSM model; 2nd study – small sample size, counseling effectiveness may be difficult to observe in only seven sessions, inadequate sensitivity of the CERS, use of CERS for self-report may have constricted potential significance of results, and supervised counseling effectiveness may not have been the optimal criterion measure.
Benshoff & Paisley (1996)	• Examines school counselors' responses to participation in structured peer consultation model	• Pilot study of structured peer consultation model	• Structured Peer Consultation Model for School Counselors (SPCM-SC) - adaptation of model for peer consultation (Remley et al., 1987) shown to be valuable for counselor trainees; counselors work in dyads for nine, 90-minute sessions every other week • Assessment of	• 20 School counselors for kindergarten – 12th grade; (3 m, 17 w); age 24-59 years	• SPCM-SC may assist school counselors in receiving feedback on their counseling. • Participants agreed the SPCM-SC had assisted them in understanding and enhancing their consultation skills and in helping them understand and apply counseling concepts, skills, and techniques. • Participants indicated that peer consultation had given them support, encouragement, and ideas; they considered it to be worthwhile. • Participants liked the structure of the model but had varying preferences for amount of structure in sessions. • Since participants found tape review of sessions to be helpful, later SPCM-SC training sessions focus more on critique of counselor performance. • Limitations: small sample size, volunteer participants, limited experience with model,

			Peer Consultation Model (APCM) scale - 16 items with 6-point Likert-type scale to assess responses to and satisfaction with peer consultation • Small group feedback session		and need for instruments to assess various parts of the model.
Butler & Constantine (2006)	• Investigates effectiveness of a 12-week, Web-based peer supervision group in increasing school counselor trainees' collective self-esteem (i.e., positive feelings from school counselor identification) and written case conceptualization skills	• Quasi-experimental; pretest/posttest, assigned to conditions based on convenience • Data analysis: t-test, multivariate analysis of variance, univariate analysis of covariance (ANCOVA), multivariate analysis of covariance (MANCOVA), Follow-up ANCOVAs	• Collective Self-Esteem Scale (CSES; Luhtanen & Crocker, 1992) – 16 item, 7-point Likert-type instrument to measure self-esteem in relation to belonging to certain social groups. Four subscales: private, public, membership, and importance to identity. CSES items revised to indicate school counselor social group membership • Case conceptualization vignette - asked	• 48 school counselor trainees in master's degree program • Web-based peer supervision group: 5 m, 19 w. Age range: 24-37 years. Racial/ ethnic composition: 15 White Americans, 4 African Americans, 3 Asian Americans, 2 Latino Americans. • Control group: 6 m, 18 w. Age range: 23-40 years. Racial/ ethnic composition: 16 White Americans, 3 African Americans, 3 Asian Americans,	• Participants in Web-based peer supervision group reported significantly higher collective self-esteem and achieved significantly higher case conceptualization and treatment scores than did those did in the control group. • Positive sense of collective identity might act as a safeguard against professional burnout. • When in-person group supervision is not feasible, Web-based peer supervision may be an appropriate alternative for school counselor trainees. • Peers, who may be dealing with similar professional issues, may provide additional support, validation, and connection. • Limitations: assigned to conditions by convenience, small sample size, majority of sample was White and female.

			to write at least 3 sentences about the perceived etiology of the student's issues and at least 3 sentences describing an effective treatment plan; case conceptualization ability evaluated by examining degree of cognitive processes of differentiation and integration • Short demographic questionnaire	and 2 Latino Americans. • No trainees reported prior counseling experience	
Coban & Demir (2007)	• Investigates effect of Structured Peer Consultation Program on school counselor burnout	• Quasi-experimental; pre-test post-test nonequivalent control group design • Data analysis: one-way analysis of covariance (ANCOVA)	• Maslach Burnout Inventory (Maslach & Jackson, 1982) – 22 item instrument, 5 point Likert type scale assessing dimensions of emotional exhaustion, depersonalization, and personal accomplishment;	• 19 school counselors in Gaziantep city, Turkey • Assignment to groups based on practicalities of group membership (i.e., mutual availability) ○ Experimental group – 8 counselors (4 m, 4 w)	• Structured Peer Consultation Program was effective in reducing all three dimensions of school counselors' burnout. • Participants reported gaining positive counseling skills as well as making professional and personal gains. • Peer supervision offered support, ideas, encouragement and was viewed to be worthwhile. • Structured Peer Consultation Program from Benshoff and Paisley (1996), revised by Fallon and Lambert (1998) as Revised Restructured Peer Consultation Model for School Counselors, was modified for Turkish version

			Turkish version developed by Ergin (1992); for current study: Cronbach Alpha (n=55); Internal reliability for subscales: 0.86 for emotional exhaustion, 0.70 for depersonalization, 0.72 for personal accomplishment	○ Control group – 11 counselors	into 5 sessions of group meetings for 90 min. ○ Session 1: goal setting ○ Sessions 2-3: presentations of cases contributing to burnout ○ Session 4: coping strategies ○ Session 5: evaluation and termination
Crutchfield & Borders (1997)	• Investigates whether peer-group clinical supervision has a positive impact on school counselors' effectiveness, specifically on ○ Perceptions of job satisfaction ○ Perceptions of counseling self-efficacy ○ Counseling effectiveness • Examines which of 2 models is most helpful ○ Structured Peer Consultation Model for School	• Quasi-experimental; pretest-posttest design • Data analyses: one-way analyses of covariance (ANCOVAs) for dependent counselor variables; three-way analysis of variance for dependent variable of client behavior change	• 1st group: SPCM-SC (Benshoff & Paisley, 1996) • 2nd group: SPGS (Borders, 1991) • [Dependent variables] • Job Satisfaction Blank (JSB; Hoppock, 1977) – 4 items, 7-point Likert scale • Counseling Self-Estimate Inventory (COSE; Larson et al., 1992) – 37 item self-report questionnaire with 6-point Likert type scale to measure	• 29 school counselors (5 m, 24 w), majority (83%) had master's degree as highest degree; worked in elementary and middle schools, 2 worked in high schools; Age range 25-56; all White • Assignment to groups based on practicalities of group membership (e.g., geographic location) ○ 1st treatment group (dyadic) ○ 2nd treatment group (peer-group)	• Neither peer dyad nor peer group supervision had significant effect on job satisfaction, self-efficacy, or counseling effectiveness. • Each situation demonstrated movement in preferred direction; treatments had small but pervasive impacts. • Qualitative evaluation indicated that supervision sessions were perceived to be helpful. ○ 90% found feedback and support to be most helpful ○ Gains were described in colleague support and feedback on approach, skills, and perspective-taking • Participants in dyads reported support to be most helpful, while those in groups reported feedback on techniques and skills as most helpful. • Possible explanations for findings: instruments may not have been appropriate for school counselors or did not measure behaviors that did change (e.g., conceptualization ability) -

	Counselors (SPCM-SC; Benshoff & Paisley, 1996) ○ Systematic Peer Group Supervision (SPGS; Borders, 1991) – assigns roles (e.g., counselor, student, teacher) to group members to respond to counselor supervisee's questions after review of tape (see p. 222)		counseling self-efficacy • Counseling effectiveness: ○ Index of Responding Empathy Scale (IRE; Gazda et al., 1984) – 10 item scale, write out empathic response to helpee statement ○ Counselor Behavior Analysis Scale (CBA-Long; Howard, Nance, & Myers; 1987) – 24 item (only 2nd 12 items used) self-report measure of counselor flexibility and adaptability ○ Teacher Report Form (TRF; Achenbach, 1991) –	○ unstructured control group	intervention period may have been too brief (2.5 months). • Limitations: lack of true random assignment, small sample size → limited generalizability; only self-report

			assesses client change; standardized measure of teacher's perception of students' adaptive functioning and difficulties (internalizing or externalizing problems) in school • Post-Session Helpfulness Questionnaire, adapted from Client Post-Session Questionnaire (Hill, 1989) – for exploratory purpose		

Mentoring – Empirical Study

This table presents the findings from a descriptive study on mentoring relationships in clinical psychology graduate programs. Ph.D students were more likely to have been mentored than Psy.D students. Graduates of a department of psychology within a university or college were more likely to have been mentored than those of a school of professional psychology within a university or

college or a freestanding professional psychology school. However, Psy.D students rated their mentor relationship more positively and were more satisfied with their programs than Ph.D students.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Clark, Harden, & Johnson (2000)	• Describes mentoring relationships in clinical psychology graduate programs o Mentoring is defined as " a personal relationship in which a more experienced (usually older) individual acts as a guide, role model, teacher, and sponsor of a less experienced (usually younger) protégé. A mentor provides the protégé with knowledge, advice, challenge, counsel and support in the protégé's pursuit of	• Descriptive study	• Survey – demographic information, whether had faculty mentor in clinical psychology doctoral program (or reason had not), demographic data on mentor, information about initiation and length of relationship, general evaluation of relationship, ratings of functions in the relationship, three most important personality characteristics of mentor, ratings of any negative qualities, gender-	• 787 American Psychological Association members and associates living in U.S. who received a PhD or PsyD in clinical psychology in 1994, 1995, or 1996 (30% m, 70% w) Age range 27-84 yrs, mean age 38 yrs; Racial/ethnic composition: European American (87%), Hispanic (4%), African American (2%), Asian/Asian American (2%), American Indian (<1%), Other (4%); Degree: PhD (69%), PsyD (31%); setting in	• PhDs were more likely to have been mentored than PsyDs; graduates of a department of psychology within a university or college were more likely to have been mentored than those of a school of professional psychology within a university or college or a freestanding professional psychology school. o May be due to larger student-faculty ratios, shorter time for degree completion, and less faculty-student research collaboration in PsyD programs • PsyDs rated mentor relationships more positively and were more satisfied with their program than PhDs. o Less emphasis on research, more emphasis on providing acceptance, encouragement, and support in PsyD program mentoring • Mentored respondents reported greater satisfaction with their program than nonmentored did. o 32% of nonmentored indicated faculty did not have time, 30% indicated mentoring was not provided or encouraged at program. • 79% of males had male mentors, 21% had female mentors. • 54% of females had male mentors, 46% had female mentors. • No gender differences for likelihood of being mentored and satisfaction with mentor

	becoming a full member of a particular profession" (p. 263).		related and ethical issues, importance of mentor relationships in training, and total level of satisfaction with the program from which they received degree	which doctorate earned: department of psychology within a university or college (54%), school of professional psychology within a university or college (15%), freestanding school of professional psychology (32%) • Response rate 79%	relationships. • 62% of mentors were male. o Typical faculty mentor is male, 16 years older than protégé, described as supportive, intelligent, having wisdom and behaving ethically, and being warm, caring, and attractive interpersonally. • Protégé or both protégé and mentor initiated majority of mentor relationships. • Majority reported no negative experiences; 25% reported that mentor was not as available as they wanted. • Results imply that faculty-student mentoring is advantageous for graduate students. • Limitations: retrospective, self-report data; reliability and validity were not established for the survey; only individuals who completed doctorates were included in sample. • Other info of interest: o There is limited empirical data on mentoring relationships in graduate psychology training.

Countertransference (CT) – Theoretical Contributions

The following table provides the psychoanalytic and psychodynamic origins of, as well as later theoretical contributions to, the concept of countertransference. Currently, countertransference can refer to all of the therapist's reactions that arise out of interacting with the client rather than to only the therapist's transference based on his or her unconscious conflicts. Other theoretical perspectives

recognize the inevitability of countertransference, which can be detrimental to therapy if not acknowledged and managed. The ability to use countertransference to further treatment is part of the clinical competence of awareness of personal factors and their impact on therapy. Although countertransference has been defined in numerous ways, a structural theory and a framework for empirical investigation have been developed.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Ellis (2001)	• From a REBT perspective, presents effective and destructive features of CT • Provides recommendations for clinical practice	• Theoretical discussion with case illustration	• N/A	• N/A	• CT is nearly inevitable. • CT originates in biology and social learning, consisting of prejudiced thoughts, emotions, and behavior. • Recommendation: experiment with CT instead of looking at it in terms of *absolutes, shoulds*, or *musts*.
Shafranske & Falender (2008)	• Presents a process model to address CT in supervision	• Book chapter with illustration	• N/A	• N/A	• Personal experiences form the basis of interpersonal competencies in clinical practice. • Aspect of clinical competence is awareness of personal factors, their impact on therapy, and the ability to utilize CT to further treatment. • Exploration of personal reactions and the effect on treatment is based in theoretical framework of personal factors, CT responses, and mutually created enactments. • CT definition: o all of therapist's personal reactions to client that arise out of their interactions o reactions may be considered therapist's unconscious transference or therapist's experience of client's projected mental

					contents • CT is a personal factor that impacts therapy and may increase therapist's reactivity, which may lead to extreme affect, failure to reflect, and possibly engagement in unplanned behaviors. • Supervisory working alliance must exist to attend to supervisee's CT and personal factors. • CT conceptual model can be used to identify states of mind that arise in therapist and to explore influence of personal factors. • Model based on Bouchard, Normandin, and Seguin's (1995) categories of mental states/activities that were developed out of the CT Rating System (Normandin & Bouchard, 1993), empirical research o Objective-Rational state: therapist's perceived objective observation; personal factors are not visible and do not lead to changes in therapist's state of mind or behavior o Reactive state: therapist's experience shaped by CT; states of mind and behavior are not typical for the therapist o Reflective state: therapist re-enters state of mind from the session and opens his or her subjective experience to observation 4 processes facilitated by supervisor 1. Emergence 2. Immersion 3. Elaboration 4. Interpretation •
Freud (1910)	• Presents overview of the state of psychoanalysis • Explains that progress in	• Paper presented at Second Psycho-Analytical Congress	• N/A	• N/A	• Briefly addresses CT as a technique, which stems from patient's influence on analyst's unconscious. • CT should be acknowledged and defeated.

	psychoanalysis will come from increased knowledge and continued development of technique, as well as greater authority				• Analyst cannot work with a patient more than he has addressed and worked through his own complexes and resistances.
Grant (2006)	• Describes a psychotherapy course in a transtheoretical masters program in counseling psychology that builds competence in trainees for working with severely disturbed clients	• Course description	• N/A	• N/A	• Course is based on psychodynamic theory. • Competencies: • (1) Developing and repairing the alliance. • (2) Understanding and using transference and countertransference. o Goal is to teach trainees the process of becoming aware of and understanding their responses so that they can utilize them constructively o Teach trainees to use their responses to clarify the client's patterns • (3) Utilizing personality structure in case conceptualization. • Theory is linked to experiential training; students practice with clients who are role-played by actors or staff. • Most therapists in practice are integrative or eclectic. • The three competencies can be utilized in any counseling program.
Hayes (1995)	• Synthesizes, critiques and expands literature on CT in group psychotherapy • Presents CT literature in 5 components:	• Literature review and theoretical discussion	• N/A	• Articles and books referenced in PsycLit 1974-1993 with keywords "countertransference" and "group" and articles	• CT literature does not have a theoretical framework for research. • Suggests organized study of CT - origins, triggers, manifestations, effects, and management factors. o Origins –from unresolved conflicts (e.g., authority/power issues, need for approval, family issues.

	origins, triggers, manifestations, effects on process and outcome, and management.			published before 1974 referenced in sources • CT defined as "therapists' cognitive, affective, and behavioral reactions to clients that are grounded in therapists' unresolved intrapsychic conflicts" (Gelso & Carter, 1985; Grotjan, 1953) (p. 521-522).	○ Triggers – from group composition and stage. ○ Manifestations – (e.g., affect screening, distort perceptions, showing favoritism) should consider with origin and trigger; might have another cause (e.g., skill deficit) ○ Effects – on process and outcome not yet investigated. ○ Management – (1) prevent CT (2) increase chance that CT could be used beneficially; self-awareness is critical, (e.g., have co-therapist, supervision). • Critique ○ CT is mostly unconscious, so can be difficult to determine for certain that reactions are from CT. ○ Construct entails blind spots; should not rely on self-report exclusively. ○ Manifest differently: (e.g., CT of withdrawal or overactivity if have unresolved conflict with same-sex intimacy) → attempt to obtain behavioral, affective, and cognitive manifestations.
Heimann (1950)	• Addresses analytic candidates' tendency to be fearful and/or guilty of feelings toward patients and therefore to avoid emotional responses to patients and to be detached • Proposes that analyst's emotional reactions (CT) is one of most significant	• Theoretical discussion	• N/A	• N/A	• CT is common. • CT originates from patient's transference. • Analyst who has worked through own infantile conflicts can carry patient's id, ego, superego, and objects projected by patient. • Interpretations will be unproductive if analyst does not check in with his feelings. • Attending to own emotional reactions protects analyst from becoming a "co-actor" (p. 83) in patient's re-enactment.

	instruments for work; a means into patient's unconscious • Defines countertransference as "all the feelings which the analyst experiences towards his patient" (p. 81)				
Kiesler (2001)	• Presents framework for empirical investigation of CT	• Theoretical discussion	• N/A	• N/A	• Due to different labels and concepts for CT, theoretical and clinical works on CT have not been integrated. • CT is destructive when it is not noticed or labeled (kept out of conscious awareness). • Subjective CT: stimulated by therapist's unresolved conflicts. • Objective CT: elicited mainly by client. • "Real" therapist responses: therapist's experiences and behaviors that would be considered normative based on healthy client-therapist interactions. • CT can be observed when therapist's behaviors and experiences with client in session deviate from baseline of experiences and behaviors with o Subjective CT: other clients or the same client; his or her therapist, supervisor or colleagues; or significant others o Objective CT: colleagues' baseline or client's significant other's baseline to the client • Kiesler's approach to CT is based on interpersonal theory. • Intervention:

					○ 1. Therapist stops reinforcing client's maladaptive pattern of interpersonal behavior. ○ 2. Therapist shares his or her emotional experience of the interaction with the client.
Racker (1953)	• Presents theory that pathological aspect of CT is an manifestation of neurosis	• Theoretical discussion	• N/A	• N/A	• Analyst is interpreter and object of unconscious processes. • CT that is pathological is referred to as CT neurosis. • Oedipus complex is the origin of CT neurosis. ○ Each male patient symbolizes the father and each female symbolizes the mother. ○ Neurotic CT arises when patient's situation and personality interact with the analyst's current (inner and external) situation. ○ Patient is a screen for analyst's internalized objects. ○ "The analyst's feeling of annoyance with the patient is always, in part at least, neurotic" (p. 322); Patient's resistance is frustrating to the analyst realistically and touches on infantile frustrations. • Must attend to how neurotic CT influences the analyst's conceptualization, interpretations, and responses. • Compulsiveness (and underlying anxiety) of the need to provide an interpretation can alert analyst to neurotic CT.
Racker (1957)	• Extends discussion on CT as means to understand patient's inner life • Explores CT influence on	• Theoretical discussion	• N/A	• N/A	• CT may interfere with therapeutic work. • CT that is repressed results in inadequate analysis of transference. • CT is related to dynamics in the patient. • 2 types of CT • Concordant CT - analyst has partial

	analyst's actions				identification with patient's experience. ○ Identification with the patient is the foundation for empathy. • <u>Complementary CT</u> - partial identification with patient's objects. • Analyst's response is like that of the object; patient interacts with analyst as projected internal object.
Reich (1951)	• Presents theory of CT	• Theoretical discussion with case illustrations	• N/A	• N/A	• Analyst's unconscious is an instrument for understanding the patient. • Analyst must be object of patient's transference; analyst must be neutral toward patient. • CT is the analyst's unconscious feelings; analyst's transference to patient. ○ "the effects of the analyst's own unconscious needs and conflicts on his understanding or technique" (p. 26). • CT can be detrimental. • CT phenomena ○ Acute (Identification with patient, related to content of patient material) ▪ Easier to manage ○ Permanent (Generalized, analytic relationship) ▪ Sign of analyst's neurotic/character problems) ▪ Analysis is the solution
Renik (1993)	• Presents implications for technique with regards to analyst's subjectivity	• Theoretical discussion	• N/A	• N/A	• Therapist's (analyst's) personality (i.e., values, beliefs, peculiarities) influences treatment. • Analyses are interactions between aspects of patient and analyst. • General view is that awareness of personal reactions and motivations is helpful, abundant source of information. ○ CT enactment is not helpful. • Awareness of personal motivation follows

					observation of own behavioral expression of the motivation (slight tension affects analyst's, for example, tone of voice, choice of words vs. silence) ○ Awareness of CT is always after CT enactment. • Accepting analyst's subjectivity suggests that CT enactment does not have to be avoided. • Analyst cannot uphold absolute objectivity. • Analyst's actions influenced by "personal motivations of which we cannot be aware until after the fact" (p. 560); subjectivity of technique cannot be avoided.
Sandler (1976)	• Presents theory of CT	• Theoretical discussion	• N/A	• N/A	• Patient enacts a role and forces a matching role onto analyst. • Analyst's thoughts, feelings, and visible reactions are "role responsiveness" (p.45) and make CT a valuable tool. • Analyst's response is "a compromise formation between his own tendencies and his reflexive acceptance of the role which the patient is forcing on him" (p. 46). • Not all CT originates in the patient. • Analyst may gain awareness of CT after acting on thoughts and feelings.
Tummala-Narra (2004)	• Discusses the dynamics of race and culture in the supervisory relationship • Provides supervisor recommendations for addressing cultural aspects in a safe manner	• Theoretical discussion with clinical illustrations	• N/A	• N/A	• Integrating cultural diversity issues in supervision is an aspect of clinical competence; capacity to explore culture is a clinical competency. • Recently, exploration of race and culture in transference and countertransference has brought up question of how an individual's psychic reality is shaped by cultural identities and social contexts. • Supervisor and therapist's mishandling of power may lead to reenactment of discrimination

					experiences. • Extent to which supervisory relationship is viewed as safe by both supervisee and supervisor impacts whether and how diversity issues will be addressed. • A selective exploration of race, culture, class, etc. may be a barrier to addressing diversity. • Supervisor recommendations include: gaining cultural knowledge, initiating a dialogue on race and culture, practicing multicultural education, and addressing transference responses.
Winnicott (1949)	• Explores hate in CT • Develops concept of objective CT to assist analysts and psychiatrists working with psychotic and anti-social patients	• Theoretical discussion	• N/A	• N/A	• Objective CT refers to "the analyst's love and hate in reaction to the actual personality and behaviour of the patient" (p. 70). • Analyst must be aware of CT so can examine objective responses, such as hate for these individuals. • Patient induces these feelings in analyst like he or she does in others. • Analyst should uphold objectivity.

Countertransference (CT) – Empirical Studies and Compilations

This table provides findings from empirical studies and compilations on countertransference, now considered to be an unavoidable, mutually constructed aspect of therapy. Countertransference origins, triggers, and manifestations (affective, behavioral, and cognitive) have been identified. Several instruments have been developed to measure countertransference. In a study with former trauma clients, it was found that clients perceived therapists' reactions and generally indicated more satisfaction when therapists discussed the reactions. Both negative and positive countertranference have been shown to relate to working alliance. Furthermore,

countertransference has been determined to be more complex than only positive or negative reactions; eight countertransference manifestations were found in clinicians working with clients with personality disorders.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Betan, Heim, Conklin, & Westen (2005)	• Develops an instrument to measure CT; presents data on reliability and factor structure • Investigates relation between CT and patient personality pathology o CT defined as therapists' affective, behavioral, and cognitive responses to patients	• Instrument development – RQ 1 • Correlational study – RQ 2	• Clinical Data Form – measures demographic information on clinicians and demographic, diagnostic, and etiology information on patient. • Axis II diagnosis – clinicians rate each criterion of DSM-IV Axis II diagnoses (randomly ordered) as present or absent; gives categorical diagnosis and dimensional measure • Countertransference Questionnaire – 79 item therapist report; measures CT phenomena (thoughts,	• 181 clinicians - 141 psychologists and 40 psychiatrists (106 m; 75 w) from random national sample of psychiatrists and psychologists from the American Psychiatric Association and American Psychological Association membership registries with 3 years or more of postlicensure or postresidency experience who engaged in 10 hrs per week or more of direct patient treatment; Setting: private practice (80.1%);	• Factor analysis uncovered 8 CT manifestations: (1) overwhelmed/disorganized (coefficient alpha = 0.90), (2) helpless/inadequate (coefficient alpha= 0.88), (3) positive (coefficient alpha= 0.86), (4) special/overinvolved (coefficient alpha =0.75), (5) sexualized (coefficient alpha=0.77), (6) disengaged (coefficient alpha=0.83), (7) parental/protective (coefficient alpha=0.80), (8) criticized, mistreated (coefficient alpha=0.83) • Second factor analysis ruled out psychoanalytic or psychodynamic orientation as alternative explanation for factor structure. • Cluster A disorders were significantly associated with criticized/mistreated factor; Cluster B with overwhelmed/disorganized, helpless/inadequate, sexualized, disengaged factors and negative association with positive factor; Cluster C with parental/protective factor. • Composite portrait of CT responses to patients with narcissistic personality disorder involves feeling angry, annoyed, resentful, mistreated, et cetera, independent of clinician orientation. • Factor structure provides more complex view of CT – not simply positive or negative. • Instrument provides standardized method for describing CT experiences; improves on information obtained from case studies. • Significant relationship between CT factors and personality disorder criteria implies that CT

			emotions, and behaviors), written in language so can be used by clinicians of various theoretical orientations	hospital (31.5%); forensic (8.3%); clinic (7.7%); or school (5.0%); Theoretical orientation: psychodynamic (40.3%); eclectic (30.4%); cognitive behavioral (20.4%) • Patient sample – (approximately 50% m, 50% w); Average age: 40.5 years; Caucasian (92.8%); SES: upper class (16.6%), middle class (56.4%), working class (24.3%), poor (2.8%); Average length of treatment 19 months, median 13 months; Most common diagnoses: major depressive disorder (49.2%), dysthymic disorder (37.6%), generalized anxiety disorder	responses arise in clear, predictable patterns. • Psychologists had significantly higher response rate (3:1) than psychiatrists but found no differences between the samples of patients. • Limitations: self-report measures (e.g., bias), diagnostic data was not gathered independently of clinician's CT response reports; response rate of 10%, small sample size. • Other info of interest: quantifying CT enables clinicians to refine and systematize self-reflection and for those who do not focus on CT, a means to obtain information that may be important for diagnosis and therapeutic process.

				(25.4%), adjustment disorder (24.9%)	
Cutler (1958)	• Investigates effects of CT on therapist's perceptions of own and client's in-session behavior, and on efficacy in working with client material that taps own areas of conflict. • Investigates whether: ○ Therapist will over or underreport content related to own needs/conflicts vs. non conflictual content ○ Therapist's responses to client behavior that is conflictual for therapist will be viewed as less adequate than responses to nonconflictual material. • Identifies areas of conflict for	• Correlational study	• Rating scale with adjectives developed from "Circle" interpersonal coding (Freedman, Leary, Ossorio, & Coffey, 1950) – identifies areas of therapist conflict • Criterion variable for therapeutic efficacy - Therapists' responses coded as Task-oriented or Ego-oriented ○ Task-oriented: facilitate therapy ○ Ego-oriented: defensive responses when material touches on therapist's conflict areas, reduces therapy efficacy	• 2 therapists who had different neutral and conflict areas ○ Therapist 1: 3 years grad training in clinical psychology, > 300 hours of therapy experience, had personal psychoanalysis, current site: college counseling center ○ Therapist 2: 2nd year grad student in clinical psychology, < 50 hours therapy experience, no personal psychotherapy, current site: VA facility	• Significant discrepancies between therapist self-rating and judges' rating indicated existence of conflict. • Trainee-therapists' interventions judged to be inadequate when client's material tapped therapist's unresolved conflicts. • Experience and level of self-insight are positively related to tendency to engage in task-oriented behavior, as opposed to ego-oriented behavior. Suggests that can use supervision, training, and personal psychotherapy experience to increase therapeutic benefit for client. • Other areas of interest: ○ Long been acknowledged that therapist's personality is one of most significant variables in therapy.

	therapist. • *Countertransference* defined as "the transference reactions of the therapist to his patient" (p. 349)				
Dalenberg (2004)	• Assesses trauma survivor clients' perceptions of therapist CT • Discusses how client and therapist anger may be addressed to assist complex trauma client	• Qualitative study; discussion of selected findings from Trauma Research Institute Trauma Countertransference Study (Dalenberg, 2000)	• Structured interview	• 132 former trauma therapy clients – (38 m, 94 w); Racial/ethnic composition: Caucasian (68%), Hispanics (16%), Black (12%); trauma discussed: childhood abuse (52%), assault, loss, rape (10%); Average length of treatment: 27.41 months; therapist orientation: cognitive-behavioral (34%), analytic (53%), humanistic (13%); most therapists were female (54%); classified as nondisclosing	• Clients' most frequently reported sources of anger were interpretations (specifically, blaming), therapist disbelief or minimization, sudden shifts in boundaries, and disputes about "manipulation." • Clients perceive CT reactions. • Most common source of client-reported angry CT (therapist inappropriate anger) was when client confronted therapist - from dispute over approach or personal anger; also due to client's lack of change or failure to follow therapist suggestions. • Clients generally indicated more satisfaction when therapist discussed reaction. Least satisfied clients indicated that therapist exhibited "no real response," which "was interpreted as lack of care" (p.442). • Mostly nondisclosing therapists were more likely to have incident of explosive anger or disclosure than therapists who more frequently disclosed CT reactions. • Client-reported satisfaction and perceived positive therapy outcome were related to view that therapist engaged in self-reflection and internal struggle to stay connected to client to further treatment. • Limitations: origin of reaction is assumed b/c therapists were not interviewed.

				therapists (35%)	• Other area of interest: mainstream therapies consider timing and technique of CT disclosure instead of previous methods of suppressing or overcoming CT.
Friedman & Gelso (2000)	• Develops Inventory of Countertransference Behavior (ICB), a measure of supervisor's perception of supervisee's CT behavior in session o Determines whether items on ICB reflect CT o Determines whether CT behavior can be categorized as over- or underinvolvement • *Countertransference behavior* defined as "therapist's inability to manage or control unresolved issues so that these issues manifest themselves during treatment" (p. 1222)	• Scale construction • Convergent Validation • Data analyses: exploratory factor analysis	• ICB o Version sent to experts – 32 items, Likert-type format, rate degree to which items reflect CT behavior as defined in this study o Version sent to supervisors - 32 items, 5-point Likert-type scale, rate extent to which supervisee's in-session behavior toward client demonstrated specific behaviors (but items did not refer to behavior as CT); items hypothesized to signify overinvolvem	• Experts on CT - 11 doctoral level psychologists (9 m, 2 w); 8 counseling, 3 clinical; Average age: 48; all Caucasian; Average supervisory experience: 18 years • Supervisors – 126 psychologists and counselor-educators (72 m, 52 w, 1 gender not specified), randomly selected from Association for Counselor Education and Supervision (ACES) member list; Average age: 49; Racial/ethnic composition: 114 White, 6 African American, 2 Asian/Pacific Islander, 1	• Measure assesses 2 domains of CT behavior: Negative CT and Positive CT (rather than hypothesized overinvolvement and underinvolvement). o Negative CT: inappropriate behaviors, critical or not affirming o Positive CT: approaching client but inappropriately informal or personal, overly supportive, seems to have merging, dependent features. • Total scale and both subscales found to have high internal consistency. • Supervisees' positive and negative CT were positively correlated with one-item measure of CT behavior and negatively correlated with measure of CT management ability. • Therapist's behavior that meets own needs avoids client issues; probable base in therapist's unresolved conflicts • Limitations: 48% return rate may imply self-selection bias; small sample size; potentially inflated correlations b/c of method variance (all self-report by one individual); no investigation of discriminant validity. • Other areas of interest: o Freud originated the term countertransference (1910/1959). Reactions were not objective; distortions due to therapist's own conflicts. Recommended that therapists overcome them b/c perceived as obstacle to treatment. • + and – CT can both exist → ambivalent

			ent and underinvolvement; higher scores indicate higher levels of CT behavior • Countertransference Index (CT; Hayes, Riker, & Ingram, 1997) – 1 item measure with 5-point Likert scale, rate degree to which therapist's in-session behavior signifies unresolved conflict, CT • Countertransference Factors Inventory – Revised (CFI-R; Latts, 1996) – 40 item measure of 5 qualities hypothesized to be components of CT management: empathy, self-insight, self-integration, anxiety management, conceptualization	Biracial, 2 "Other"; Degree: 105 doctoral, 16 master's, 4 "other," 1 did not specify degree; Average supervisory experience: 13 years; Theoretical orientation: cognitive behavioral (36%), humanistic/existential (30%), other (e.g., systems; 24%), psychodynamic (8%); did not indicate (2%); Average number of times met with supervisee: 15.86	condition.

			ability; refer to therapist behavior in therapy setting • Demographic questionnaire		
Gabbard (2001)	• Reviews the evolution of CT theory • Presents contemporary psychoanalytic model of CT	• Literature review with clinical illustration	• N/A	• N/A	• Historical Overview - CT moved from limited concept of therapist's transference to patient to mutually constructed event that permeates treatment. o Freud ▪ CT described as analyst's transference to patient ▪ *Narrow* perspective ▪ CT a problem to be overcome o Heimann ▪ *Totalistic* perspective ▪ Although viewed CT as helpful info, did not promote therapist disclosing feelings with patient o Winnicott (1949) ▪ *Objective* form of CT – therapist's reaction to patient is same as others' reactions ▪ Less emphasis on therapist's conflicts; more on patient's behavior that provokes certain reactions • Important Concepts o Projective identification – writers and clinicians often use term differently, various meanings ▪ Term developed by Melanie Klein ▪ Klein's P.I. is fantasy where patient projects into therapist part of the patient's self that has been split off; process is intrapsychic because does

					not have to change how therapist feels or acts ▪ If analyst was affected, analyst needed more analysis. ▪ Klein did not agree with Heimann's perspective because she thought patients might be held responsible for analyst's issues. ▪ Bion (1955), British colleague, proposed interpersonal piece to P.I. - P.I. like his model of infant-mother and patient-analyst interaction as container-contained. - Infant projects unbearable affects by projecting into mother; mother contains and metabolizes them so that infant can reinternalize them. - An "explicitly interpersonal interaction" (p. 985), not just unconscious fantasy ▪ Some American analysts, like Ogden, saw interpersonal piece of P.I.; in explaining projected contents, Klein used preposition "into" instead of "onto" ▪ Generally, contemporary Kleinians recognize that CT may signal patient's effort to stimulate feelings in therapist that patient is not able to bear. ▪ P.I. process "requires a 'hook' in the recipient of the projection to make it stick" (p. 986); therapist's repressed self or object representations surface due to pressure by patient.

					○ Role-responsiveness – concept developed by Joseph Sandler (1976), contemporary Freudian ▪ Patient unconsciously brings out internal object relationship w/in transference; therapist plays role from patient's inner world ▪ P.I. is defensive process (a) unwanted part of self is split off and projected into object representation (b) object representation is externalized as therapist experiences pressure to step into role through patient's mostly unconscious verbal and nonverbal tactics ○ CT enactment – refers to interconnected transference-CT events therapist is not consciously aware of ▪ American analysts, ego psychological approach ▪ Narrow perspective of CT ▪ nonverbal manifestations (e.g., changing body posture) ▪ Ego psychologists concur that analyst is compelled to become transference object, but emphasize more input from analyst's conflicts than Kleinians. ▪ "Enactment by definition implies an action" (p. 988). ○ Constructivist and Relational Theories – stress mutuality, 2 subjectivities ▪ Constructivist - Enactments are continuously occurring. - Analyst's actual behavior affects patient's transference.

					- Transference and CT are interconnected and constructed mutually. ▪ Relational - Analyst is more vulnerable because CT and real attributes are out in open for patient. • Current Model o CT viewed as jointly created event between patient and therapist. o Psychoanalytic theorists of different approaches have come together to view CT as created in part by therapist's internal object relations and in part shaped by feelings generated by patient. ▪ Weight given to input differs with theory o Patient will try to make therapist into transference object; therapist must determine how to remove him or herself from projected role or enactment. o CT is considered to be unavoidable o Analyst or therapist as blank screen with total neutrality is not a practical concept anymore. o Minor CT enactments can offer useful information regarding dynamics recreated in therapy. o Self-disclosure of CT may be beneficial in certain instances, but some patients will be overwhelmed or burdened by disclosure. o Mutuality does not mean symmetry; power differential between therapist and patient. ▪ CT should be contained, processed, and explored in supervision or consultation.

Gelso & Hayes (2001)	• Examines empirical literature that addresses treatment outcomes of CT management • Describes 5 factors essential for CT management	• Literature review	• N/A	• N/A	• 10 studies have investigated effects of CT, starting with Cutler (1958) • Acting out of CT impedes therapy, but effective management of CT is beneficial. • Therapist should develop skills of anxiety management, empathy, self-insight, self-integration, and conceptualization. o *Self-insight* – awareness and understanding of own feelings. o *Self-integration* – intact, healthy character structure; ability to keep healthy boundaries. o *Anxiety management* – ability to tolerate and understand anxiety so does not negatively impact response to client. o *Empathy* – identify with other's experience; enables therapist to attend to client's needs. May be aspect of sensitivity to own reactions. o *Conceptualization ability* – use of theory to understand client dynamics and therapeutic relationship. ▪ Theoretical framework/conceptualization <u>without</u> awareness of CT may result in more CT behavior. • Applying these skills is critical for successful management of CT. • Little research addresses CT management directly related to distal outcome. o *Distal* refers to "effects of treatment on indices of client behavior at the end of treatment . . . assessed at various points after termination" (p.419) • Alliance is weakened when therapists demonstrate CT behavior, according to Ligiero & Gelso (2002) and Rosenberger & Hayes

					(2001). Relationship of CT behavior to WA implies that CT may prevent successful outcome. • More research should address CT management and distal outcomes, as well as how CT management works and influences therapy. • Other areas of interest: provides brief background on views of CT; all definitions include therapist's reactions, based on feelings, to client. o Internal experience or verbal/nonverbal behavior o Internal viewed to be helpful if utilized to understand client o Viewed as harmful if therapist acts out in treatment (attending to own needs instead of client's)
Hayes & Gelso (2001)	• Presents clinically-centered synthesis of CT research • Organizes results into categories of origins, triggers, manifestation, management, and effects (Hayes, 1995).	• Literature review	• N/A	• CT research from past 50 years; excludes studies that defined CT construct differently than Gelso & Hayes's (1998) definition - "therapists' reactions to clients that are based on therapists' unresolved conflicts" (p.1042)	• "CT is an occupational hazard" (p. 1050) • Most research on negative features and consequences. • No research on beneficial effects, how to use CT to further therapeutic relationship. (e.g., experience of being wounded to assist work). • (1) Origins o Therapist's unresolved conflicts o May be viewed as developmental; origins in issues from childhood • (2) Triggers • CT is chronic or acute o Acute CT occurs sporadically and is not typical of therapist. o Chronic CT occurs often with many clients and may be typical for therapist; almost any trigger provokes chronic CT. o Triggers and origins interact; individual differences in therapist influence what

					becomes CT trigger o Client attributes ▪ Client reminds therapist of someone significant in h/h life o Therapy content ▪ Most empirical focus ▪ Therapist's unresolved issues elicited by session information ▪ CT behavior viewed as self-protecting response for therapist o Therapy process ▪ How interact, what happens ▪ During session or over course of sessions • (3) Manifestations • Internal & external CT are related – internal reactions not managed will probably produce CT behavior, nearly all CT behavior has covert thoughts and feelings • Certain affective responses, behaviors, and cognitions commonly occur across clients. o Affective ▪ <u>Anxiety</u> – signal of danger, response when unresolved conflicts are provoked; most empirical attention ▪ Anger, boredom, nurturance, sadness, inadequacy o Cognitive ▪ <u>Distortion</u> – fundamental to CT, most investigated of cog manifestations o Behavioral ▪ <u>Avoidance</u> /withdrawal, under-involvement – most research ▪ Over-involvement • (4) Management o 1. Reduce likelihood of CT reactions

					▪ assumption: fewer unresolved conflicts = fewer CT reactions ▪ myth: good therapists do not have CT or overcome CT ▪ optimal level of CT ○ 2. Minimize negative effects of CT on therapy ○ CT behavior that is acted on is likely to be harmful ○ outline for reflection: reflect back on CT manifestations, triggers, then origins ○ Factors of Self-insight and Self-integration for management ▪ Self-insight – recognition of own unresolved conflicts ▪ Self-integration – extent of resolution ○ Research needed on how to discuss CT reactions with client in therapeutically beneficial manner ▪ Clinical experience: for insight; discussing CT reactions can counteract power imbalance, deepen therapeutic alliance, provide sense of universality to client • (5) Effects on Tx Outcome ○ Intermediate ▪ WA negatively correlated with CT; many studies have demonstrated that if strong WA is not developed, successful therapy is unlikely ○ Distal – limited research to confirm that unmanaged CT negatively affects outcome
Ligiero & Gelso (2002)	• Investigates relationship between CT behavior and WA,	• Correlational study	• Short form of Working Alliance Inventory for	• 50 therapist trainees (13 m, 37 w) – 27 master's level	• Negative CT was related to lesser quality of working alliance. ○ Negative CT behaviors may inhibit development of working alliance; behaviors meet therapist's

	therapist attachment style and WA, and therapist attachment style and CT behavior.		Therapists (WAI-Therapist; Tracey & Kokotovic, 1989) – 12 items, adapted from Horvath & Greenberg's (1989) 36-item instrument, measures therapist's perceived strength of working alliance • WAI-Observer – measures supervisors' perception of strength of working alliance • Relationship Questionnaire (Bartholomew & Horowitz, 1991) –adapted from Hazan & Shaver's (1987) adult attachment measure • Countertransference Index (Hayes, Riker, & Ingram, 1997) – measure of concurrent validity for ICB • Inventory of	counseling, 23 doctoral level counseling or clinical psychology; Average experience 1.76 years; Primary orientation: psychodynamic/psychoanalytic (24%), humanistic/existential (38%), cognitive/behavioral (32%), other (6%); master's students mainly supervised by doctoral students; doctoral students mainly supervised by psychologists in practice and faculty. • 46 supervisors – (17 m, 29 w); Primary orientation: psychodynamic/psychoanalytic (46%), humanistic/existential (24%), cognitive/behavioral (28%), other	needs, not the client's → less likely to agree on tasks, goals and form bond. • Positive CT was related to weak bond of working alliance, rated by supervisors. • CT behavior was associated with disagreement between supervisor and therapist on bond strength. • Attachment style was not related to working alliance or CT behavior. • Results imply that managing CT behavior may positively influence supervisor's rating of supervisee (Daniel, 2008). • Awareness of CT behavior may lead to accurate understanding of client and alliance. • Limitations: cannot prove causal relationship; trainee therapists; ICB's psychometric properties need more investigation; brief therapy; many supervisors were doctoral students. • Information of interest: ○ WA is essential to psychotherapy and impacts treatment outcome; consider how alliance can be developed or damaged. ○ Operational definition of CT is still being developed. ○ CT behavior is detrimental when unconsciously acted out. ○ CT behavior vs. CT feelings (internal reactions that are recognized can be helpful in understanding client).

			Countertransference Behavior (ICB; Friedman & Gelso, 2000)	(2%).	
Rosenberger & Hayes (2002a)	• Examines effects of client's in-session material on CT • Explores potential moderating role of CT management	• Case study	• Adjective Check List (ACL; Gough & Heilbrun, 1983) – endorse adjectives if describe individual (oneself or other); 15 subscales on Murray's (1938) need-press theory of personality • Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) – only total score • Counselor Rating Form – Short version (CRF-S, Corrigan & Schmidt, 1983) – 12 items, 3 subscales measure therapist attractiveness, expertness, and trustworthiness • Session Evaluation	• Client – 21 yrs, single, White, female; college student at university counseling center; diagnosis of MDD, single episode, mild • Therapist – 34 yrs, White female, licensed (for 3 yrs) psychologist	• Conflict-related material was positively related to working alliance but inversely related to therapist's avoidance behavior. o Note: therapist demonstrated limited avoidance behavior overall. o Low avoidance behavior and inverse relationship to conflict-related material may be influenced by gender. o Therapist seemed to keep sessions easy, on surface level so as not to harm the TA when client brought up material that tapped therapist's unresolved issues • Therapist perceived herself to be less attractive and expert the more client spoke about issues associated with therapist's unresolved conflicts (she was aware of); perceived herself to be less trustworthy the more client spoke about issues associated with conflicts she was unaware of. • CT management related to therapist's perceived social influence attributes (attractiveness, expertness, trustworthiness) and to therapist and client ratings of session depth. • CT management may help build TA. • Effective CT management may further session depth. o Ability to manage own defensive activity may lead to more intense attention to client. • 1st study to include all components of Hayes's (1995) model of CT (Rosenberger & Hayes, 2002b) • Limitations of study: single case design lacks external validity, validity of ACL and others to identify unresolved conflicts; moderate interrater

			Questionnaire (SEQ; Stiles & Snow, 1984) – 24 bipolar adjectives to measure session depth and smoothness – assesses session impact • Countertransference Factors Inventory – Revised (CFI-R; Gelso, Latts, Gomez, & Fassinger, 2002) – 21 items measure therapist's management of CT; state aspects in session with certain client • Brief Symptom Inventory (BSI; Derogatis, 1993) – 53 items, 5-point scale to measure client sx/distress pre and post-treatment		reliability. • Other information: general agreement on CT's clinical significance although controversy over definition and conceptualization has existed since first identification. ○ Interaction of therapist and client factors; therapist's conflict-related issues and client factors likely to stimulate issues.
Rosenberger & Hayes (2002b)	• Presents definitions of CT construct • Reviews analogue and field studies published since last	• Literature review	• N/A	• Research reviewed has moderate definition of CT	• Freud first described CT in 1910 (Freud, 1910/1959) • Historical definitions of CT *(see table and citations p. 265)* ○ (1) Classical – analyst's unconscious,

	major CT review published in 1977 • Discusses themes, limitations, therapy implications, and suggestions for future research				neurotic responses to client's transference ▪ not helpful to therapy; must be overcome ▪ Freud (1910/1959), Reich (1951) o (2) Totalistic – all reactions (unconscious and conscious) to client ▪ Heimann (1950) o (3) Moderate – reactions rooted in counselor's unresolved conflicts ▪ majority of empirical studies in past 20 years from this position ▪ unmanaged CT reactions will negatively impact therapy ▪ Gelso & Carter (1985), Gelso & Hayes (1998) • Comprehensive, testable theory of CT had been lacking. o Hayes's (1995) structural theory now provides framework for reviewing and synthesizing research • CT is abstract, challenging to operationalize and measure. o Majority of empirical research has used analogue methodology, stresses internal rather than external validity. • CT has been viewed as avoidance behavior (Bandura, Lipsher, & Miler, 1960), over-or under emphasis on emotionally threatening client material (Cutler, 1958), or counselor's withdrawal of involvement (Yulis & Kiesler, 1968). • Analogue research o Since last review, more thorough operational definitions of CT manifestation (including affective and cognitive, not only behavioral) o Improved methodology: video instead of audiotapes as client stimuli; counselors

					produce own verbal responses rather than select among written responses. o Managing CT involves awareness of feelings combined with ability to utilize theoretical perspective (Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987) o Managing CT involves anxiety management and self-integration (Gelso, Fassinger, Gomez, & Latts 1995; Van Wagoner, Gelso, Hayes, & Diemer, 1991). o Design still has limited external validity. • Field research o Utilized fairly nonintrusive, discreet data collection (e.g. videotaping) o Only a few field studies • Cognitive manifestations: distorted perceptions of client, incorrect recall of client data, defensive mental actions, blocked understanding, indecision, and modifications in treatment planning. • Affective manifestations: state anxiety (lab studies), anger, boredom, nurturance, and sadness (field studies). • Behavioral manifestations: avoidance or withdrawal. • Origin of reaction should be explored to establish whether CT based (or, e.g., due to skill deficit). • Overall self-awareness and clear theoretical framework may help manage CT to decrease likelihood of avoidance behavior. • Less reliance on laboratory studies; need for more field experiments, observational studies, and interviews. • Limitations of studies: counselor-trainees usual participants – more experienced counselors may

					display CT another way or be better at managing CT; limited investigation of cultural differences (e.g., race, ethnicity, sexual orientation) triggering CT. • Suggestions for future research: include individuals of diverse cultural heritage; use Hayes's (1995) theory to construct research questions or connect results to literature.

Therapeutic Working Alliance – Theoretical Contributions

Theoretical contributions to the therapeutic working alliance are provided in this table. The therapeutic working alliance was originally a psychoanalytic concept that has been applied to many therapy models. Client and therapist develop a therapeutic alliance that involves an agreement on goals, agreement on tasks, and development of a bond. Strength of the working alliance is a main factor in therapeutic change. Working alliance is not the same as the therapeutic relationship; rather, alliance is the extent to which therapist and client engage in purposeful collaborative work.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Bordin (1979)	• Reviews and further develops the psychoanalytic concept of the working alliance • Applies working alliance to a range	• Theoretical discussion	• N/A	• N/A	• Working alliance is central to the change process. • Client and therapist continuously create therapeutic alliance that involves 3 interrelated aspects: agreement on goals and tasks, and development of bond. • Therapeutic modalities differ in the types of

	of psychotherapy models				working alliances. • Efficacy of tasks in moving toward goal depends on therapist's ability to connect the task to client's difficulties and desire to change. • Strength of working alliance is main factor in change; due to match between client and therapist's personalities and the requirements of the working alliance. • Amount of change from working alliances is a function of their strength.
Bordin (1994) (chapter)	• Reviews and clarifies theory of working alliance • Provides clinical applications • Explains the purpose of therapeutic tasks and "basic science" approach to psychotherapy research	• Theoretical discussion	• N/A	• N/A	• Conceptualization built from Greenson's (1967) idea of the real relationship and alliance; echoes Otto Rank (1945) and Carl Rogers' (1951) view that client has active role in change process. • Identifying and agreeing on change goal is a fundamental process to building initial working alliance and gaining strength to prevail through strains and ruptures. • Mutually agreed-upon goals can be empowering to client looking for change.
Hatcher & Barends (2006)	• Clarifies alliance theory • Expands function in psychotherapy research	• Theoretical discussion	• N/A	• N/A	• Many view alliance as identical to the overall therapeutic relationship. o Loses conceptual connections and becomes atheoretical. • According to Bordin (1979, 1980, 1994), alliance refers to extent to which therapist and client engage in purposeful, collaborative work. o Alliance is not equal to the therapeutic relationship. Theory prompts the question, "In what way, and to what extent, does this relationship reflect, embody, and assist the participants' purposive, collaborative work?"

					(p. 294). o Alliance is not at the same conceptual level as the components of therapy; it is a feature of the overall therapy and its components. o Researchers tend to make working alliance theory concrete, but "alliance is actualized when technique engages clients in purposive work" (p. 294). • Bordin's working alliance theory can be critiqued. o Client actively contributes to negotiation of the alliance. o Examination of bond component should be related to the purposeful work of therapy. ▪ The question is whether there is an optimal level of bond for constructive work. • Alliance should be evaluated within context of purposeful, collaborative work for a specific treatment. o Alliance measures should be modified by omitting items with weaker links to purposeful work and adding more relevant items. o Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is one measure that has a comprehensive rationale for the items. ▪ Several strengths such as having no items connected to particular therapy models ▪ Limitations include failing to address managing disagreement and including items on bond scale that are not connected to purposeful work. o No alliance measure effectively describes shared investment in specific tasks of treatment.

Empirical studies and compilations on the therapeutic alliance are presented in this table. Research has shown that the quality of the working alliance has been steadily associated with positive outcomes for therapy, and the strength of association seems to hold across theoretical orientation. The working alliance, however, is not an intervention or sufficient condition but a vehicle that supports and interacts with strategies in the treatment. Several alliance measures have been developed.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Hatcher & Barends (1996)	• Investigates patients' responses to alliance measures • Utilizes exploratory factor analysis to further understanding of patients' perspective of alliance • Utilizes patients' estimate of improvement variable to test factors' importance	• Correlational study • Exploratory factor analysis	• Penn Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983) – 11 items, 6 point Likert-type scale; 2 subscales: (a) Helping Alliance - degree to which patient views therapist as providing, or able to provide necessary help and (b) Collaboration – degree to which patient experiences therapy as	• 231 outpatients (83 m, 148 w); Age range: 18-65 yrs, median 27 yrs; Diagnostic issues: majority had anxiety, depression, relationship difficulties and mild character disorders; Marital status: single (76%), married (15%), divorced/separated (9%); Racial/ethnic background: White (95%), African American (1.5%), Hispanic	• Presence of strong general factor (i.e., patient's overall tendency to give alliance high or low rating) was found due to high correlation between 3 measures. • Joint factors found were: (1) Confident Collaboration, (2) Goals and tasks, (3) Bond, (4) Idealized Relationship (i.e., sense of useful collaboration with therapist and level of disagreement with therapist), (5) Dedicated Patient, (6) Help Received (i.e., outcome items). • Confident Collaboration and Idealized Relationship (with general factor removed) were related to patients' estimate of improvement. o Confident Collaboration is the extent to which patients feel confident in and dedicated to a process that seems to be hopeful and helpful. o Patients consider the essence of the alliance to be purposeful, mutual collaboration. • Alliance measures should be revised. o The above-mentioned 2 dimensions are not

			collaborative • Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) • California Psychotherapy Alliance Scales (CALPAS; Gaston, 1991; Marmar, Horowitz, Weiss, & Marziali 1986; Marmar, Gaston, Gallagher, & Thompson, 1989) – 24 counterbalanced items, 7 point Likert-type scale referring to most recent therapy session; this study modified items to pull for ratings for entire therapy; 4 subscales that focus on client and therapist separate contributions and degree of mutual agreement on goals and strategies of therapy: (a) Patient Working Capacity (PWC), (b) Patient Commitment (PC), (c) Working Strategy Consensus (WSC), (d) Therapist	(1.5%), Asian (1%), unidentified (1%); Education: majority were in college or had graduated; Length of treatment: 2-274 sessions of psychodynamic therapy, M=51, range of <1 month to 4 yrs; Session frequency: 1x week (46%), 2x week (48%), 3x week (6%) • 65 therapists – had 1 to 9 of participant patients; Experience: therapists with > 8 months but < 1 yr (36% of patients), therapists with > 2 yrs but < 3 (21%), therapists with > 3 years but < 4 (13%); therapists with >4 but < 5 yrs (6%), therapists with > 5 yrs	part of the theoretical structures of these alliance measures. o Additional items should capture therapist's attempt to engage the patient in work of therapy. o Bond should be conceptualized to include patient's space to express positive and negative affects and therapist's capacity to facilitate these expressions. o Some items addressing goals and tasks could be omitted due to high correlations. o Items from HAQ should not be included in alliance research because they do not discriminate alliance components; help received measures outcome. • Other info of interest: o This study is an extension of prior research on patient-therapist agreement on alliance (Hatcher, Barends, Hansell, & Gutfreund, 1995) that used confirmatory factor analysis of therapists' and patients' global scores on WAI, CALPAS, and HAQ to confirm a model of shared-view factor and 2 unique factors for patients and therapists. o Shared-view factor from prior study was significantly correlated with Confident Collaboration and Idealized Relationship. • Limitations: range of therapist experience (therapists with less experience may be less competent with techniques); sample was primarily White, middle class.

			Understanding and Involvement • Patient's Estimate of Improvement to Date (EI) – synthesis of standardized patient ratings on 2 separate self-report measures of improvement to date; administered with other measures (proximal outcome)	(24% of patients)	
Horvath (2001)	• Presents findings from two decades of research on therapeutic alliance.	• Meta-analysis	• N/A	• 90 clinical investigations	• "Two decades of empirical research have consistently linked the quality of the alliance between therapist and client with therapy outcome. The magnitude of this relation appears to be independent of the type of therapy and whether the outcome is assessed from the perspective of the therapist, client, or observer" (p. 365"). • Therapist and client's perceptions of alliance often become similar over time in successful tx. • Early alliance is slightly better predictor than alliance in midstage. o Initially, developing alliance is more important than technique. o Ask for client's view of alliance, negotiate goals. • Client factors affecting alliance: severity of issue, type of impairment, and quality of attachment or O.R. • Therapist's skills and personal factors affecting alliance: o Communication skills, empathy, openness, personality, therapist-client complementarity, and collaboration (critical aspect of alliance).

					○ Inconsistent relationship between therapist training level and quality of alliance. ○ Probably, therapists with more experience/skill build better alliances with severely disturbed clients. • History ○ Origins in Freud's (1912-1913) works on relation between client and therapist. ○ Awareness of therapy elements shared across orientations renewed interest in alliance. ○ Luborksy (1976) and Bordin (1975) broadened alliance from psychodynamic formulation; alliance essential to all helping relationships, did not use exclusively psychodynamic ideas (e.g., transference). ○ Alliance instruments developed; operational definitions have varied.
Horvath & Greenberg (1989)	• Presents development and initial validation of self-report instrument the Working Alliance Inventory (WAI), based on Bordin's (1980) theoretical framework, for measuring quality of alliance – general variables influencing extent of successful counseling outcome • Describes 3 studies that use WAI to	• Scale development and validation • Instrument development and pilot study • Clinical trials	• Instrument development – item generation, rated on 5-point Likert scale degree to which item was relevant to working alliance and then classified item as referencing goals, tasks, or bond component. • Study 1 – predictor variables ○ WAI ○ Empathy scale of Relationship Inventory (RI; Barrett-Lennard, 1962) – measures	• Instrument development ○ Ratings by experts - 7 experts on working alliance ○ Ratings by professionals – 21 registered psychologists from local psychological association roster (randomly selected) ○ Pilot test – 29	• WAI demonstrated some evidence of being an effective, initial predictor of successful counseling outcome. • High scale correlations suggest that components may not be completely distinct. • WAI has adequate reliability. • Preliminary support for validity: evidence of ○ convergent validity of WAI scales ○ discriminant validity of Goal scale ○ concurrent validity (e.g., Empathy more closely related to working alliance concept, especially Bond scale, than to Social Influence components). ○ predictive validity (e.g., Task scale significantly greater predictor of client-based outcome than Empathy or CRF scales). • Other areas of interest: overview of 3

	predict indexes of counseling outcome • Addresses instrument reliability, validity, and relations between components of alliance		1 of 3 therapist-provided facilitative conditions essential for change, according to Rogers ○ Counselor Rating Form (CRF; LaCrosse & Barak, 1976) – only clients completed - measures Strong's (1968) social influence theory formulation of variables of attractiveness, trustworthiness, and expertness ○ Outcome variables: ○ Adaptation of Client Posttherapy Questionnaire (CPQ; Strupp, Wallach & Wogan, 1964) – outcome measure of client progress: satisfaction, perceived change, and	graduate students in counseling psychology program participating in peer counseling exercise • Clinical trials ○ Study 1 – 29 counselor-client dyads in short-term counseling (<15 sessions); Counselors – experienced professionals; theoretical orientations: client-centered, analytic, Jungian, behavioral, cognitive. Clients – adults; Age range 19-65; in counselors' caseload or had sought counseling on fee for service basis	theoretical approaches to nonspecific variables and more in-depth info on Bordin's working alliance. ○ Emphasizes mutuality and interdependence of client-counselor relationship. • Working alliance is not an intervention or sufficient condition; it is a vehicle that supports and interacts with particular strategies.

			perceived adjustment ○ Therapist Posttherapy Questionnaire (TPQ) – measures relationship between counselor's perception of working alliance and view of outcome • Study 2 ○ Empathy Scale of RI – clients only ○ CRF ○ Task scale of WAI ○ Outcome measures for client: ○ Scale of Indecision (SI; Osipow, Carney, & Barak, 1976) ○ State-Trait Anxiety Inventory (STAI; Speilberger, Gorsuch, & Lushene, 1970)	○ Study 2 – Clients - 31 adults who responded to advertisement providing counseling to individuals experiencing personal conflict in exchange for participation in research; 6 Counselors with 2-7 years experience with Gestalt method ○ Study 3 – 25 client-counselor dyads Clients: voluntary participants • Counselors: from variety of settings (gov. agencies, university clinics, private practice); theoretical orientations: client-centered, gestalt, psychodynamic,	

			○ Target Complaint (TC; Battle et al., 1966) ○ Outcome measures for counselor: Therapist's Target Complaint questionnaire (TTC; Greenberg & Webster, 1982) • Study 3 – predictor variables ○ WAI – revised version; 36 items (12 for each alliance component) with 7-point Likert scale ○ CRF ○ Empathy Scale of RI ○ Outcome variables: ○ CPQ ○ STAI ○ TC Tennessee Self Concept Scale (TSCS; Fitts, 1965) – pre and post-treatment measure of self-image	behavioral, cognitive-behavioral and rational emotive	
Horvath &	• Examines the	• Literature review	• N/A	• N/A	• Collaboration is at the center of the alliance (a

Greenberg (1994) (introduction to book)	research, theory, and application of the working alliance; addresses the definition of the alliance, measurement issues, relationship of the alliance to outcome, and alliance as an intervention.				safe environment; development of relationship may reveal client's past and present relational issues). • Research shows that a good alliance is associated with positive outcomes for therapy. • Measures early on in therapy show strong relation between alliance and outcome; quality of alliance grows more indicative of the possibility of later success by 3rd-5th session. • Midstage of alliance needs to be clarified conceptually and clinically.

Supervisory Working Alliance – Theoretical Contributions

The following table presents the theoretical contributions to the supervisory working alliance, a concept adapted from the therapeutic working alliance. The supervisory working alliance is a collaboration for change that is founded on mutually agreed-upon goals and methods to accomplish them. The emotional bond is built through working together toward the goals. The amount of change in the supervisee was proposed to be due to building and repairing the working alliance.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Bordin (1983)	• Adapts working alliance concept to supervision	• Theoretical discussion	• N/A	• N/A	• Supervision process is similar to counseling process. • Supervision relationship is a "working alliance."

					• Alliance refers to relationship between supervisor and trainee. • Working alliance is a collaboration for change; founded on mutually agreed-upon goals (e.g., competence in specific skills) and methods to accomplish them; emotional bond is built through working together toward the goals. • Goals of supervision: mastering of skills, expanding one's understanding of clients, increasing one's self-awareness and awareness of the therapy process, overcoming obstacles that inhibit learning and mastery; deepening understanding of theory, identifying a stimulus for research, and maintaining service standards. • Change goals refer to thoughts, feelings, and actions; types of goals indicate different types of alliances. • Tasks are the methods. • Bonds involve feelings of liking, caring, and trusting; combinations of goals and tasks vary in the amount of liking, caring, and trusting necessary to maintain the collaboration. • Bonds lie between teacher and student, therapist and patient. • Trainees should clearly comprehend supervision objectives. • Important to agree early on about tasks and goals; bonding component may form more slowly. • Agreement on tasks and goals of therapy and a constructive bond assure a strong working alliance. • Alliance may influence outcome of

					supervision and trainee's development as clinician. • Proposed that the amount of change in supervisee is due to building and repairing the working alliance.

Supervisory Working Alliance and Related Factors – Empirical Studies and Compilations

Findings from empirical studies and compilations on the supervisory working alliance and related factors are presented in this table. Several measures of supervisory working alliance have been developed. Of the studies reviewed, six used the WAI/Supervision (Bahrick, 1990) and four used the SWAI (Efstation, Patton & Kardash, 1990). An additional study used the WAI but whether it was modified for supervision was not indicated. Supervisory working alliance has been related to the client's perception of therapeutic alliance, supervisor style (i.e., highly attractive, highly interpersonally sensitive, and moderately task-oriented), supervisee satisfaction, greater supervisor self-disclosure, discussions of cultural factors in supervision, and supervisee comfort with and likelihood of countertransference disclosure. Supervisory working alliance has been negatively related to supervisee role conflict and ambiguity, supervisees' perception of counterproductive supervision events, and greater amounts of supervisor ethical violations as perceived by supervisees. Furthermore, in a peer supervision model, both members of the dyad had similar, positive perceptions of the alliance.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Bahrick (1990) (dissertation)	• Investigates the effects of an audio-taped role induction procedure on the supervisory relationship • Develops an instrument to assess the working alliance in supervision	• Experimental study (attention-control group design with pretest, posttest, and post-posttest measures) • Data analysis: t-test, analysis of covariance, repeated measures analysis of covariance, Pearson Correlation Coefficients, multivariate repeated measures analyses of covariance	• The Working Alliance Inventory/Supervision – assess strength of supervisory working alliance; adaptation of Horvath & Greenberg's (1985) Working Alliance Inventory for measuring strength of working alliance in a counseling relationship; 36 items, 7-point Likert-type scale, 3 subscales of 12 items that relate to the supervisory working alliance components of goals, tasks, and bonds • Semantic differential technique (Osgood, Suci, & Tannenbaum, 1958) – assess trainees' evaluation of supervision • Supervisory Emphasis Rating Form (Lanning, 1986) – assess agreement on areas of emphasis in supervision	• 17 trainees (4 m, 13 w) in first or second year of counseling psychology graduate program, enrolled in practicum • Role Induction procedure group (n=10) • Attention- Control group (n=7) • 10 supervisors – 9 advanced graduate students with master's degrees and 1 faculty member (3 m, 7 w)	• None of the hypotheses were supported (role induction would lead to more positive evaluations of supervision, strengthen the alliance, and increase congruence of trainee/supervisor pairs in perceived areas of emphasis). • Role induction procedure produced statistically significant correlations between supervisor and trainee evaluations of supervision, the global working alliance, and goals and tasks subscales. • Correlations were not maintained at end of supervision. • More positive evaluation of supervision is associated more with congruence on bond scale (affective) than with congruence on goals and tasks scales (cognitive). • Inter-rater reliability of the Working Alliance Inventory/Supervision was established: 97.6% agreement for items assessing the bonding factor, 60% agreement for items assessing the goals factor, and 64% agreement for items assessing the tasks factor. • The Working Alliance Inventory/Supervision presents the question, "to what degree do supervision tasks and goals make sense, and to what extent are you collaborating on these in supervision?" (p. 72). • Limitations: content and format of the role induction procedure, small sample size,

					participants' varying amounts of previous experience, individual supervisor effects, ceiling effects of instruments.
Carifio & Hess (1987)	• Surveys, classifies, and integrates theory and research on "ideal" supervisor o Describes personal and individual characteristics of supervisors o Describes training techniques o Describes approaches and methods utilized	• Literature review	• N/A	• Studies of traditional, individual supervision of graduate students or mental health professionals • Excluded: studies of more structured supervision, teaching, and counseling techniques	• Ideal supervisor has similar characteristics as ideal psychotherapist. Varies level of expression of characteristics according to situation. o Respect o Empathy o Concreteness with presentation o Genuineness o Flexibility o Concern o Openness o Self-disclosure • Ideal supervisor has knowledge of and experience with psychotherapy and supervision. o Sets clear goals with supervisee in an open discussion o Utilizes various teaching techniques and methods of data collection and presentation such as brainstorming, role play, modeling, and guided reflection o Avoids doing psychotherapy in supervision • Ideal supervisor is supportive and noncritical. o Utilizes social influence processes (trustworthiness, attractiveness, expertness) such as systematic and direct feedback. o Is not too direct or passive. • Controlling for or measuring numerous variables that may affect supervision is challenging.

Chen & Bernstein (2000)	• Combines examination of supervisory working alliance with process construct of complementarity over initial 3 weeks of supervision o Investigates whether supervision issues addressed differ depending on strength or weakness of working alliance o Investigates whether a relationship exists between strength of working alliance and extent of complementarity in dyad's communication o Investigates relation between complementarity and	• Research-informed case study (Soldz, 1990) – individual cases chosen, based on quantitative criteria, for analysis from between-groups design; to obtain process and outcome data	• Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) • Critical Incidents Questionnaire (CIQ; Heppner & Roehlke, 1984) – free response questionnaire that asks both supervisor and supervisee to describe a critical incident in most recent supervision session, what made it a critical incident, and when it occurred in the session. • Supervisory Issues Questionnaire (SIQ, developed for this study) – 10, 5-point Likert type items that measure participant's perception of importance of Ellis's (1991) 10 supervisory issues: supervisory relationship, competence, purpose and direction, emotional awareness, personal issues, autonomy, professional ethics,	• 10 supervision dyads – supervisor a counseling psychology doctoral student in a clinical supervision course, supervising (weekly) a master's level counselor trainee; main theoretical orientations (dynamic, cognitive behavioral, humanistic-existential and interpersonal); all White o 7 Supervisors (1 m, 6 w); Age range 30-45 years; Prior supervision experience: average of 4 supervisees o 10 Supervisees (1 m, 9 w); Age range: 25-50 years; in 1st counseling practicum; 9 had no prior	• There is some support for: o Sequential order of issues/themes in trainee professional development. Issues of competence, emotional awareness, supervisory relationship, and purpose and direction were identified more frequently. ▪ Low-WA dyad rated personal issues theme as most critical; High-WA rated as 4th ▪ Inadequate attention to supervisory relationship combined with too much exploration of personal issues in initial stages may impede development of healthy working alliance or damage a weak relationship. o Greater complementary interaction in high vs. low-alliance dyad. o Relationship between complementarity and satisfaction with supervision. ▪ When supervisor and supervisee agree on content focus, supervisee is less likely to have resistance to supervisor's lead. • Dyad with a stronger alliance perceived supervisor style to be highly Attractive, highly Interpersonally Sensitive, and moderately Task-oriented. o Results in line with Friedlander & Ward's (1984) high-high-moderate profile on Attractiveness, Interpersonal Sensitivity, and Task Oriented styles,

	supervisor and supervisee satisfaction with supervision. • Examines the efficacy of research-informed case study design for research in supervision process and outcome		personal motivation, individual differences, and theoretical identity • Topic Determination/Initiation Coding System (TDCS; Tracy, 1981,1988,1991) – measures complementarity through ratings of interpersonal interactions in audio recording; high complementarity when one participant's efforts to initiate topics are accepted/followed by other participant • Relational Communication Coding System (RCCS; Ericson & Rogers, 1973; Rogers, 1979) – identifies patterns of interpersonal communication; 3 indexes of dependence, domineeringness, and dominance (success rate of participant's attempt to increase control); Dominance	individual counseling experience • High-WA dyad o Supervisor – 30 years old, female, 2nd year counseling psychology doctoral student; orientation: psychodynamic, interpersonal, and systems; prior supervision of 4 counselor trainees o Supervisee – 25 year old, female 1st year master's counseling, orientation: humanistic-experiential and interpersonal; no previous counseling experience • Low-WA dyad o Supervisor – 29 year old, female, 3rd year counseling psychology	and Carifio & Hess's ideal supervisor (1987) (see p. 493) • Dyad with weaker alliance perceived supervisor style to be moderate on 3 dimensions. • Limitations: did not focus on participant characteristics (e.g., age, supervisory experience) which might account for results; small sample pool; little evidence for validity of some of the measures for supervision (rather than counseling) context; • Other information of interest: *complementarity* influenced by o interpersonal personality theory (Sullivan, 1953) – one individual meets the other's need in an interaction, which helps relationship development o relational communication (Jackson, 1959) – complementary communication involves unequal status • Supervision is a "dynamic, bidirectional process" (p. 486).

			is the measure of complementarity • Session Evaluation Questionnaire, Form 4 (SEQ; Stiles & Snow, 1984a) 24, 7-point bipolar adjective pairs with 4 subscales: Depth, Smoothness, Positivity, Arousal; measures immediate influence of session • Revised Supervisory Alliance Inventory (SWAI; Patton, Brossart, Gehlert, Gold, & Jackson, 1992) – measures level of supervisory working alliance; 2 separate forms for supervisor and supervisee	doctoral student; orientation: cognitive and interpersonal; no prior supervision experience ○ Supervisee- • 39 year old, female, 2nd year master's level student in counseling; orientation: cognitive behavioral and systems; no prior counseling experience	
Daniel (2008) (dissertation)	• Examines the impact of supervisory alliance on psychology interns' disclosure of countertransference in clinical supervision and self-reported comfort in doing so • Examines the	• Correlational study – RQ 1 • Causal-comparative – RQ 2 • Data analysis: descriptive statistics for determining participant characteristics; correlational analyses between	• Working Alliance Inventory-Supervisee form (Bahrick, 1990) • Reaction Disclosure Questionnaire (developed by Daniel) – self-report instrument that measures supervisee comfort in disclosing countertransference behaviors and feelings to supervisor through	• 175 clinical, counseling, and school psychology interns at pre-doctoral internship sites, members of the Association of Psychology Postdoctoral and Internship Centers (APPIC)	• A strong supervisory working alliance is positively associated with the likelihood of countertransference disclosures to supervisors, as well as supervisee comfort level in disclosing. • Strength of alliance mediates comfort and likelihood of disclosure. • A strong supervisory working alliance is slightly correlated with likelihood of and comfort level with disclosing sexualized countertransference reactions. • Supervisees self-reported being more likely to disclose countertransference

	effects of gender, ethnicity, and theoretical orientation and the supervisee-supervisor match between these characteristics, as well as sexual orientation of the intern, type of degree program, and theoretical orientation on comfort with and disclosure of countertransferenc e	mean total score of WAI with variables of overall comfort in disclosing, overall likelihood of disclosing, comfort in disclosing sexualized countertransferenc e, and likelihood to disclose sexualized countertransferenc e; univariate analyses of variance of other variables	8 hypothetical scenarios of countertransference situations; Likert scale 1(extremely uncomfortable) to 7 (extremely comfortable), maximum total points of 56 (high comfort with disclosing) • Demographics questionnaire		reactions if there is a strong working alliance, despite not feeling comfortable in doing so. • Similarities between supervisee and supervisor on gender, ethnicity, or theoretical orientation were not found to influence the probability of or comfort with disclosures.
Efstation, Patton, & Kardash (1990)	• Constructs an instrument to measure trainees' and supervisors' perceptions of the relationship in counseling supervision • The supervisory working alliance is defined as the "set of actions interactively used by supervisors and trainees to facilitate the learning of the trainee" (p. 323)	• Scale construction • Data analysis: factor analyses, reliabilities, convergent and divergent validity	• Supervisory Working Alliance Inventory (SWAI) – 30 supervisor and 30 trainee items in 7-pt Likert response style; asked to indicate degree to which item activity was characteristic of their trainee or supervisor • Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) – 33 items in 7-pt Likert scale; measures extent to which supervisor or	• 185 supervisors – (114 m, 69 w, and 2 gender unidentified) mean age 41.96 yrs; doctoral level psychologists from university counseling centers, outpatient clinics, U.S. Veterans Administration Medical Centers, and state and private psychiatric hospitals; most had psychodynamic, cognitive	• Supervisory alliance is important. • Three supervisor factors (Client Focus, Rapport, and Identification) and two trainee factors (Rapport and Client Focus) were revealed by factor analysis. • SWAI scores were shown to have adequate scale reliability. • Convergent and divergent validity were established through relationship to scales on the SSI (Both versions of the Client Focus scale have moderate correlations with the Task-Oriented scale on the Supervisor's (.50) and Trainee's (.52) versions of the SSI, but low correlations with the Attractive and Interpersonally Sensitive scales of the SSI for the Supervisor's (.20 and .30) and Trainee's (.04 and .21) versions.

			trainee endorses behaviors characteristic of each of 3 dimensions of supervision style: Attractive, Interpersonally Sensitive, and Task-Oriented; psychometrically adequate • Self-Efficacy Inventory (SEI; Friedlander & Snyder, 1983) – measures trainee's confidence/self-efficacy attributions in performing 21 activities (only trainees completed this outcome measure)	behavioral, or eclectic orientations; majority supervising in clinical psychology programs • 178 trainees – (73 m, 103 w, 2 gender unidentified); mean age of 29.95 years; interns in psychology internship programs and advanced practicum students in clinical and counseling psychology programs; indicated psychodynamic, cognitive behavioral, and eclectic orientation	• Trainee scores on Client Focus and Rapport scales of SWAI significantly predicted scores on SEI.
Friedlander & Ward (1984)	• Identifies important dimensions of supervisory style and develops an instrument – the Supervisory Styles Inventory (SSI) • Identifies dimensions of supervisory style influencing	• Instrument development • Item development • Study 1 and 2: Scale construction and initial validation (see p. 545-548 for data analyses) • Study 3 and 4: Cross validation (see p. 549 – 552)	• Item development: structured interview • Study 1: Likert scale to rate degree to which SSI items demonstrated their "general style of supervision" (p. 545) and demographic form • Study 2: same Likert scale to rate "current	• Item development: 20 professional counselors and supervisors in academic and clinical settings (11 m, 9 w), 13 psychologists, 3 psychiatrists, 4 social workers. • Study 1: 202 training directors of	• Analyses revealed 3 factors, used to construct 3 scales: Attractive (e.g., friendly, flexible, trusting, warm), Interpersonally Sensitive (e.g., intuitive, invested, committed, perceptive), and Task Oriented (e.g., structured, focused, goal oriented). • Styles are related to trainee level of experience – supervisors are more attractive and interpersonally sensitive with interns and more task oriented with practicum students.

	experienced supervisors' self-perceptions (Study 1) and supervisees' perceptions of their supervisors (Study 2) • Replicates factor structure and reliability of SSI on new samples of supervisors (Study 3) and trainees (Study 4) and assesses relationship between supervisory styles and (a) level of trainee experience and (b) supervisor theoretical orientation • Assesses relationships between SSI scales and (a) training context (b) supervisors' theoretical orientation, (c) trainees' experience level and (d) trainees' reported satisfaction with supervision	• Study 5: Cross validation (discriminant)	or most recent primary supervisor's general style of supervision" (p. 545) and information sheet with questions about participants' characteristics, sex of supervisor, and satisfaction with supervision; survey of supervisor behaviors for doctoral practicum students; Social Desirability Scale for master's students • Study 3: supervisor version of inventory (SSI-S) and information sheet about demographics and training characteristics • Study 4: trainee version of inventory (SSI-T) and information sheet about demographics and training characteristics • Study 5: SSI-T and 2 items about willingness to receive supervision from the supervisor	Association of Psychology Internship Centers internship programs; doctoral-level psychologists in hospitals or medical schools (69%), outpatient clinics (18%), university counseling or health centers (12%); average of 11.5 years of supervisory experience; 98% supervised interns, 60% practicum students; 42% psychodynamic orientation, 27% cognitive-behavioral; >50% process-oriented individual supervision • Study 2: 36 master's level students in counselor education and 147 doctoral trainees in counseling or clinical psychology, primarily in	• Supervisory style is related to theoretical orientation: task orientation endorsed by cognitive-behavioral oriented supervisors and interpersonally sensitive by psychodynamic and humanistic supervisors; attractive dimension crossed theoretical orientation. • Supervisory style is multidimensional, with variable levels of attractiveness, interpersonal sensitivity, and task orientation. • Other area of interest: Developed a conceptual model of determinants of supervisor behavior; each of the concentric circles signifies a different level of specificity, in descending order of abstraction. Model assumes each level influences the next: assumptive world → theoretical orientation→ style-role→strategy-focus→ format→ technique. ○ Styles correspond to Bernard's (1979) roles (task oriented = teacher; interpersonally sensitive = counselor; attractive = consultant).

	(Studies 1 – 4) • Discriminates within and between supervisors of different theoretical orientations working with the same supervisee and evaluates relationship between perceived supervisory style and supervisees' willingness to work with different model supervisors (Study 5) • *Supervisory style* – refers to supervisor's manner of approaching and interacting with trainees and of conducting supervision (Boyd, 1978; Holloway & Wolleat, 1981)			American Psychological Association accredited programs or internship sites; 39% worked at university health or counseling centers, 24% at hospitals or medical schools, 20% at community agencies, and 10% at psychology department training centers • Study 3: 135 professional staff supervisors at college or university counseling centers in 1982-83 Association of Psychology Internship Centers directory; average of 8.75 years of supervisory experience; process-oriented individual was main supervision format (47%), predominant theoretical orientation	

				psychodynamic (28%) or humanistic (25%) • Study 4: 105 trainees – master's level students in counselor education (27%) or social work (23%), doctoral-level students in counseling or clinical psychology (46%), and psychiatry residents (4%); 67% in practicum with an average of 5 semesters of counseling experience; 26% reported their supervisor's orientation was cognitive-behavioral, 27% psychodynamic, and 27% did not know. • Study 5: 28 predoctoral clinical and counseling psychology students at a northeastern state university with at least one	

				supervised experience	
Gatmon et al. (2001)	• Explores discussions of cultural factors in the supervisory relationship and the influence on satisfaction with supervision and working alliance	• Exploratory study	• The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) • The Supervision Questionnaire-Revised (Worthington & Roehlke, 1979) – 3 questions to assess supervisee satisfaction, perception of supervisor competence, and whether encounters improved supervisee counseling skills • Questions on discussion of cultural variables – whether discussions on gender, ethnicity, and sexual orientation took place and who initiated; questions on 7-point Likert scale on supervisee perceived levels of frequency, safety, depth, and satisfaction with discussions • Demographic questionnaire	• 289 predoctoral psychology interns at APA-accredited internship sites (86 m, 203 w); Racial/ethnic composition: 6.6% African American, 0.3% Arab American, 5.9% Asian American, 5.2% Chicano/Latino, 73.4% European American, 5.2% Jewish/Caucasian, 3.1% Multiracial; Sexual Orientation: 5.2% Bisexual, 87.9% Heterosexual, 6.2% Homosexual; • Supervisors (140 m, 147 w); Racial/ethnic composition: 5.2% African American, 0.7% Arab American, 3.5% Asian American, 2.4% Chicano/Latino, 79.2% European American, 8.0% Jewish/Caucasian,	• Cultural variables were discussed infrequently (in 12.5% to 37.9% of supervisory dyads) • When there was not a cultural match, the frequency of discussion of variables was ethnicity, gender, and then sexual orientation. • Supervisees who discussed ethnic similarities and differences with their supervisors reported stronger supervisory working alliance; no significant differences for gender and sexual orientation were found. • Supervisees who discussed gender similarities and differences reported higher satisfaction with supervision. • Those who discussed sexual orientation similarities and differences reported higher satisfaction and perceived their supervisors to be more competent. • Supervisory working alliance was correlated with the quality of discussions for the three cultural variables in terms of: frequency of discussion, depth of discussion, feeling of safety, satisfaction with discussion, and incorporation of variables in training. • Matching on cultural variables did not have a significant difference on supervisory alliance and satisfaction with supervision. • Supervisors should provide a safe place for frequent and deep discussions of cultural variables.

				0.3% Multiracial; Sexual Orientation: 1.7% Bisexual, 82.4% Heterosexual, 5.9% Homosexual, 8.7% Do not know	• Quality of the discussion of differences/similarities is more important than a match in cultural variables between supervisor and supervisee for establishing a strong supervisory alliance. • Limitations: exploratory study, several questions on cultural variables were not validated previously, response rate of 36% may reduce generalizability • *Authors do not indicate whether they modified the WAI for supervision.*
Gray, Ladany, Walker, & Ancis (2001)	• Explores nature and extent of supervisees' experience of counterproductive events in supervision • Explores how these events impact supervisory alliance and outcome • Explores how these events influence therapeutic process and outcome	• Qualitative study	• Semistructured interview – open ended interview divided into categories (e.g., description of counterproductive event, thoughts, feelings, and behaviors in response to event, supervision content before and after event, impact on supervisee's thoughts and feelings as a counselor) • Supervisory Satisfaction Questionnaire (SSQ; Ladany, Hill, Corbett, & Nutt, 1996; Larsen,Attkisson, Hargreaves, & Nguyen, 1979)	• 13 counseling psychology graduate student trainees (3 m, 10w) who reported having counterproductive event in supervision; Age range: 23-29; 12 White, 1 person of color; 4 master's level, 4 1st doctoral practicum, 3 advanced doctoral practicum, 2 predoctoral internship; Average of 14.38 weeks with supervisor when counterproductive event occurred • 13 supervisors (5 m, 8 w); Age	• Supervisees typically experienced counterproductive events when supervisor dismissed supervisee's thoughts and feelings and conceptualizations in support of own, engaged in inappropriate self-disclosure, was unprepared, misunderstood, emphasized weaknesses instead of improvement, rejected concerns about an ethical issue. • During event, all supervisees had negative thoughts about supervisor or supervisory relationship, and some had negative thoughts about self. • Supervisees had negative feelings during event. Typical feelings were: uncomfortable, upset or unsafe. • Supervisees typically experienced a counterproductive interaction after the counterproductive event (e.g., attempting not to be defensive). • Supervisees typically wished they had addressed event when it occurred and also wanted supervisor to acknowledge the event. • All supervisees perceived event to have

			• *counterproductive supervision events* – defined as "any experience that trainees identified as hindering, unhelpful, or harmful in relation to their growth as therapists" (p. 371)	range: 28-65; 5 White, 8 persons of color; 10 counseling psychologists, 3 clinical psychologists	weakened the supervisory relationship. Some were permanently weakened, but some were able to have a gradual recovery. • Supervisees altered their approach to supervisors following the event – most commonly by disclosing less and also by being more guarded and hypervigilant. o Reduced openness and vulnerability; therefore, events may have impeded process of growth. • Typically, supervisees' self-efficacy was negatively affected. • Most supervisees did not disclose their experience of the event with supervisor. o Of those who discussed in supervision, supervisees who processed how they and the supervisory relationship were affected indicated a positive resolution. o Processing event may have assisted with building and repairing of ruptured alliances. • Most supervisees believed that the event negatively impacted their clients. • Implication: processing of relationship may bring about opportunity for supervisor modeling of a clinical skill. • Limitations: lack of generalizability due to qualitative research; participant self-selection; researcher bias may have impacted research question development.
Ladany, Ellis, & Friedlander	• Assesses Bordin's (1983) proposal	• Correlational study	• The Working Alliance Inventory –Trainee	• 107 beginning practicum to intern-	• Changes in alliance were not predictive of changes in supervisees' self-efficacy but

(1999)	that changes in counselor trainees' perceptions of alliance during the course of supervision predict supervision outcomes	• Preliminary analyses: chi-square and t-test analyses • Major analyses: multivariate multiple regression analysis, post hoc analyses	version (WAI-T; Bahrick, 1990) measures trainees' perceptions of three factors of supervisory working alliance (agreement on goals, agreement on tasks, and emotional bond) • The Self-Efficacy Inventory (SEI; Friedlander & Snyder, 1983) – assesses trainees' perceptions of self-efficacy expectations as a counselor • Trainee Personal Reaction Scale-Revised (TPRS-R; Holloway & Wampold, 1984) – 12-item self-report instrument that measures trainees' satisfaction with supervision (satisfaction defined as perception of supervisor's personal qualities and performance, trainee's perception of own behavior in supervision, and trainee's comfort	level trainees (35 m, 72 w); average age 29.91 years; Racial/ethnic composition: 86% White, 7% African American, 3% Latino, 2% Asian American; majority in counselor education or counseling psychology (59%) or clinical psychology (36%) training programs	were predictive of satisfaction with supervision. o Specifically, a working alliance growing stronger in terms of emotional bond was related to greater satisfaction. • Reported self-efficacy significantly increased over time; cannot rule out unknown moderating variables in overall training context. • Results suggest the importance of evaluating the working alliance over time so that the bond aspect has adequate time to develop. • Results contradict those of Efstation et al. (1990) who showed a significant relationship between supervisory working alliance and self-efficacy when assessed at one time (difference may be due to using different alliance measures or Efstation et al.'s more advanced trainees). • Effective supervision may not necessarily be the most satisfying. • Limitations: threat to internal validity due to inability to randomly assign or manipulate predictor variables – unknown whether positive changes in emotional bond produced increased satisfaction with supervision or whether increased satisfaction with supervision produced positive changes in emotional bond.

			level in supervision) • Demographic questionnaire		
Ladany & Friedlander (1995)	• Examines relationship between trainee's perception of supervisory alliance and self-reported role ambiguity and conflict • Contributes to supervision practice and theory on importance of supervisory alliance	• Correlational study o Predictor variables: trainees' ratings on 3 subscales of WAI-T o Criterion variables: trainees' ratings on Role Conflict and Role Ambiguity scales of RCRAI • Data analyses: multivariate multiple regression analysis	• Working Alliance Inventory-Trainee version (WAI; Bahrick, 1990) – 3 subscales of agreement on goals, agreement on tasks, and emotional bond • Role Conflict and Role Ambiguity Inventory (RCRAI; Olk & Friedlander, 1992) – 29 items, 5-point Likert scale, self-report of trainees' perceptions of their role difficulties in supervision; 2 scales: Role Conflict and Role Ambiguity • demographic questionnaire	• 123 master's (26.80%) and doctoral (67.5%) level trainees in counseling or clinical psychology (42 m, 81 w); Mean age 30.07 years; 10 states and District of Columbia; Racial/ethnic composition: 85.4% White, 8.1% Black, 2.4% Latino, 1.6% Asian American, 2.4% no information; Training level: 26.8% beginning practicum, 19.5% advanced practicum, 47.9% internship or postdoctorate, 5.7% no information; Supervision: 40.7% college counseling centers, 22.8% community mental health centers, 20.3% VA hospitals;	• Supervisory alliance has significant relationship to supervisee's view of role conflict and ambiguity. o Stronger alliance is associated with less role conflict and ambiguity. o Strong emotional bond may lead supervisory dyad to be more likely to work through conflicts, which would reduce amount of role conflict. • Despite bond strength, role conflict was considered to occur in the absence of mutual agreement on both goals and tasks. • Goal-task component was significant and unique predictor of role ambiguity. o Trainees experienced less role ambiguity when supervisor clearly conveyed expectations. • Weekly time in supervision predicted greater role conflict; maybe an optimal amount of supervision that permits autonomous trainee growth and skill development. • Implications: supervisors should define explicitly goals and tasks because supervisee conflict and role ambiguity might be the outcome; may impact the therapeutic alliance. • Limitations: correlational study; relationship may be stronger due to less ambiguity or role conflict (Bernard & Goodyear, 2009); restricted generalizability due to demographics of sample (advanced, almost 50% intern level).

				Individual supervision with mainly male supervisors	
Ladany, Lehrman-Waterman, Molinaro & Wolgast (1999)	• Investigates degree to which supervisors adhered to ethical supervision practices, as perceived by supervisees • Examines supervisees' reactions: (a) whether supervisees discussed ethical violations with supervisors; (b) if supervisees disclosed ethical violation to someone else; (c) degree to which supervisees perceived violation to have affected their ability to give quality services to clients • Clarifies relation between supervisor ethical behaviors and supervision process and outcome (working	• Descriptive study – RQ 1, 2 • Correlational study – RQ 3	• Supervisor Ethical Practices Questionnaire (SEPQ; developed for study and validated through pilot studies) –16 sections with open ended format; provides definitions of supervisor ethical practices and prompts to describe experiences of supervisor's unethical behavior; also measures supervisee reactions to incidents: (a) whether had discussed matter with supervisor, (b) if discussed with someone else, (c) whether anyone in authority position at site was aware of incident and did not do anything about incident; 7-point scale to rate degree to which believed quality of client care was impacted by incident	• 151 psychotherapist trainees (36 m, 114 w, 1 unspecified) in counseling (68%) or clinical psychology (26%) training programs; Average age: 31.51 years; Racial/ethnic composition: 121 White, 12 African American, 9 Asian American, 4 Latino, 1 Native American, 4 not specified; doctoral-level (58%) or master's level (36%) or unspecified (6%) students in beginning practicum (28%), advanced practicum (29%), and internship (42%), unspecified (1%); 85% had at least one ethics in counseling course; Supervisors: mainly female	• Majority of supervisors adhered to most of the guidelines, but 51% of supervisees reported at least one supervisor ethical violation. o Most frequently violated guideline was adequate evaluation of performance (e.g., supervisor provides limited feedback), followed by confidentiality matters in supervision and capacity to work with different perspectives. ▪ Supervisors may have discomfort with evaluator role. Inadequate evaluation may compromise supervisee's learning capacity. o Most frequently adhered to guidelines were about sexual issues, keeping supervision separate from psychotherapy, and termination and follow-up matters. • Supervisee reactions: o 35% discussed violation with supervisor o 54% discussed with someone else; of these: ▪ 84% discussed with peer or friend in field ▪ 33% significant other ▪ 21% other supervisor ▪ 18% therapist ▪ 7% professor ▪ 7% relative ▪ 2% director of site

	alliance and supervisee satisfaction with supervision)		• Supervisor Ethical Behavior Scale (SEBS; rationally developed for study) – 45 items in closed-ended format measuring whether supervisees perceived supervisors to participate in ethical and unethical practices • [Predictor variable: frequency of violation measured by SEBS] • Working Alliance Inventory –Trainee Version (WAIT; Bahrick, 1990) • Supervisee Satisfaction Questionnaire (SSQ; Ladany et al., 1996; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) • [Criterion variables: agreement on supervision goals, agreement on supervision tasks, emotional bond, and supervisee satisfaction] • demographic questionnaire	(60%), doctoral degree (66%), master's degree (32%), unspecified (2%); Racial/ethnic composition: White (89%), African American (7%), Asian American (1%), unspecified (3%)	○ 14% reported someone in position of authority/power was aware of violation but did nothing. ○ Mild to moderately negative effect on client care quality. • Greater amount of ethical violations was significantly correlated with weaker supervisory alliance and less supervisee satisfaction. • Hours/week of individual supervision was positively correlated with WAI-T goal and bond scales. • Supervisees in community mental health centers and university counseling centers reported significantly fewer ethical violations than supervisees at school settings. • Implications: ○ Supervisees may have feared potential consequences of reporting. ○ Supervisees appeared to confide in peers who may have provided support, although were not in position to affect supervisors' behavior. ○ Dissatisfaction with supervision may be a positive reaction to supervisor's unethical behavior? • Limitations: cannot make causal inferences due to ex post facto design; potential 3rd variable confounds; only assessed supervisees' perceptions; order of questionnaire presentation may have influenced responses; generalizability only to supervisees with comparable demographic characteristics.

			• *Supervisee satisfaction* – defined as "supervisee's perception of the overall quality of supervision and the extent to which supervision met the needs and facilitated the growth of the counselor" (p. 448).		
Ladany, Walker, & Melincoff (2001)	• Examine relation between supervisor perceptions of supervisory style and supervision process – the supervisory working alliance and supervisor self-disclosure	• Correlational study	• Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) – ratings on Attractive, Interpersonally Sensitive and Task-oriented subscales as predictor variables • Working Alliance Inventory-Supervisor version (WAIS-S; Baker, 1991) – 36 item, 7-point Likert scale self-report measure of supervisor's perception of 3 parts of supervisory working alliance; 3 subscales of 12 items (a) agreement on goals (b) agreement on tasks, (c)	• 137 supervisors (55 m, 80 w, 2 gender not specified); Average age 45 years; Racial/ethnic composition: 119 White, 6 African American, 4 Asian American, 3 Latina, 1 Other, 4 did not specify; doctoral degrees (80%), master's degrees (20%); Graduate study: counselor education and counseling psychology (68%), clinical psychology (18%); Current work setting: college counseling center (33%),	• Supervisors' perceived style is related to their perceptions of the supervisory relationship. • Attractive style predicted all working alliance components; the more attractive (friendly, warm, supportive) the supervisor perceived him/herself to be, the more h/she perceived agreement on goals and tasks and a stronger emotional bond (trust). • Interpersonally Sensitive style (empathic, understanding, exploratory) or Task-oriented style predicted agreement on task component. • Attractive and Interpersonally Sensitive styles associated with perception of being more likely to self-disclose. Self-disclosure may be a method of conveying warm and invested styles. • A flexible supervisor who utilizes all 3 styles may be optimal for building strong supervisory alliance. • Limitations: cannot make causal inferences due to ex post facto design;

			emotional bond; as criterion variables; validity shown by empirical relationship with supervisor and supervisee characteristics (e.g., theoretical orientation and narcissism) • Supervisor Self-Disclosure Inventory (SSDI: Ladany & Lehrman-Waterman, 1999) as criterion variable • demographic questionnaire	community mental health center (15%), academic (15%), school (9%), hospital (6%), private practice (5%), and prison (2%); Median of 144 months of counseling experience, lifetime median of 25 supervisees, median of 64 months of supervision experience; • Trainees -identified as 35m, 99 w, 3 gender not specified; Racial/ethnic composition: 123 White, 5 African American, 3 Latina, 1 Asian American, 1 Native American, 2 did not specify; counselor education and counseling psychology (63%) or clinical psychology (14%); master's and	style scales are highly correlated – components may not be assessing completely separate dimensions; smaller effect size for task-oriented style and agreement on tasks; self-report of supervisors

				doctoral; beginning level/1st practicum (30%), advanced/beyond 1st practicum (27%), intern/predoctoral internship (31%), and postmaster's trainees (4%)	
Olk & Friedlander (1992)	• Examines nature and scope of trainees' experiences of role ambiguity and conflict in supervision • Investigates relationship between role difficulties and counseling experience, satisfaction with supervision, and satisfaction and anxiety with clinical experience • Develops and validates Role Conflict and Role Ambiguity Inventory (RCRAI) with RC and RA scales	• Study 1 – RCRAI instrument development o Content Analysis • Study 2 – Instrument validation o Factor analyses of 29 items o Construct validity of RC and RA scales	• Study 1 o Semistructured interview – provided descriptions of roles relevant for trainees (student, trainee, counselor, client, colleague) and Biddle's (1979) definition of role ambiguity and conflict and asked to describe situations where had experienced these difficulties as trainees; Supervisors asked to describe situation where observed supervisee having these role difficulties o Rating 75 items – degree to which	• Study 1 o 6 supervisors (4 m, 2 w) – counseling and clinical psychologists; Age range 30-50 years; Supervision experience: mean of 6.33 years; Average of 6.92 hours per week of supervision; 80% had supervisees at various training levels o 9 graduate level trainees (4 m, 5 w) in counseling or clinical psychology at practicum (*n*=3),	• RCRAI is reliable and valid measure of trainees' role conflict and ambiguity in supervision. • Items on RCRAI suggest: o Role ambiguity: (a) unsure about expectations of supervisor or how to function to meet the expectations and (b) unsure about criteria for evaluation. o Role conflict refers to experiences where expectations about student role contradict those related to counselor and colleague roles. ▪ Student role: trainee expected to follow supervisor's directions ▪ Counselor & colleague role: expected to make self-directed decisions • Role ambiguity is more common than role conflict across level of training. • Role ambiguity decreases with more experience. • Experienced trainees seem to have more role conflict and little role ambiguity. • Role conflict appears to be most challenging for advanced trainees who are not struggling with role ambiguity;

			describes present supervision on 5-point scale; higher scores indicate higher levels of role ambiguity or conflict • Study 2 RC and RA scores predictor variables; Criterion variables: ○ Trainee Personal Reaction Scale – Revised (TPRS-R; Holloway & Wampold, 1984) – 12 item self report that measures trainee's reactions to supervision, his/her performance in supervision, and supervisor's behavior ○ Job Descriptive Index (JDI; Smith, Kendall, & Hulin, 1969), most used measure of work satisfaction in organizational literature – estimate of general work satisfaction; used 3 subscales of	internship (*n* =3) or postdoctorate (*n* =3) levels; Age range: 25-40; Experience range: 1-11 years; Average amount of counseling-related supervision: 59 months ○ 2nd sample for initial validation – ○ 5 PhD level supervisors – Supervisory experience: 7-15 years ○ 5 counseling psychology doctoral trainees – at 3 levels of experience with average of 8 supervisors during training • Study 2 240 doctoral trainees (97 m, 137 w, 6 gender not indicated) in counseling and clinical psychology in practicum or	beginning trainees may have high levels of anxiety (e.g., about evaluation) that they may not experience or perceive conflicting aspects of roles; supervisors may want to allow ambiguity to decrease before informing trainees of possible conflicts. • Role difficulties predicted greater work-related anxiety and dissatisfaction and dissatisfaction with supervision. • Supervisors should provide role induction for beginning trainees (e.g., teaching about roles and expectations and informing about issues that might arise from trying to perform several roles at once (Bahrick, 1991). • Supervisors may have role conflict if believe that trainee is emotionally impaired, which may adversely impact client welfare. • Majority of trainees did not indicate high level of role difficulties, but these may negatively affect supervisory relationship. Do role difficulties affect supervision process/outcome? • Limitations: modest return rate but similar to those in other surveys on supervision (e.g., Efstation, Patton, & Kardash, 1990); cannot make causal inferences due to ex post facto design

			work, coworkers, and supervision ○ State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) – State form – 20 items that measure work-related anxiety ○ Demographic questionnaire – experience was defined as "number of months of counseling experience" (p. 392) rather than training level b/c students enter programs with varying amounts of experience	advanced practicum, internship, or postdoctoral fellowship programs, APA accredited; Age range: 21-59; 61% training at hospital or medical school, 10% psychology department sites, 7% community mental health centers, 7% university counseling centers, 15% other settings; Average counseling experience: 40.72 months (SD = 30.06, range 1 month – 15 years); Average of 6 supervisors	
Patton & Kivlighan (1997)	• Examines relationship between trainee's perception of supervisory working alliance and 2 assumed outcomes of supervision: (a) client's perception of working alliance	• Complex correlational study; Hierarchical linear modeling (HLM) nested design • Data analyses: hierarchical linear modeling	• Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) – based on Bordin's 3-part alliance of bond, agreement on goals, and agreement on tasks; 3 scales of 12 7-point Likert items; highly correlated	• 75 undergraduate students who volunteered to be "clients" (16 m, 59 w), Age range 19-23 years (*M*=20.12), Racial/ethnic composition: 8 African American, 69 European	• Established a link between supervisory and therapeutic alliance. • Trainee's perception of supervisory working alliance was significantly related to client's perception of working alliance. Weekly variations in quality of supervisory working alliance predicted weekly variations in therapeutic working alliance. • Supervisory working alliance was significantly related to trainee's general

	and (b) trainee's adherence to time-limited dynamic psychotherapy (TLDP; Strupp & Binder, 1984), the counseling model taught in supervision		scales that measure generalized nonspecific alliance factor; only WAI composite score used for study • Supervisor Working Alliance Inventory – Supervisee form (SWAI; Efstation et al., 1990) assesses aspects of supervisory relationship; 2 scales of Rapport and Client Focus were combined in the analyses • Vanderbilt Therapeutic Strategies Scale (VTSS; Butler, Henry, & Strupp, 1992) measures counselor's observed adherence to TLDP; 2 scales of Psychodynamic Interviewing Style and Time-Limited Dynamic Psychotherapy Specific Strategies	American; prescreened for appropriateness for brief psychotherapy • Graduate level counselor trainees (22 m, 53 w) in prepracticum course at public Midwestern university; Age range 22-51 years (*M*=27.71); Racial/ethnic composition: 11 African Americans, 64 European Americans • Supervisors – doctoral students in counseling psychology (7 m, 18 w); Age range 27-41 years (*M*=32.30), Racial/ethnic composition: all European American; Average of 412 hours of counseling experience and 103 hours of supervisory experience • Judges – 3 senior undergraduate	psychodynamic interviewing skills but not to adherence to specific strategies of TLDP. • Can infer that trainees gain knowledge about developing and maintaining relationships in supervision and apply it to counseling relationship. • Study strength: Ratings obtained from 3 perspectives; most of working alliance research done from only client self-report. Limitation: no casual relationship identified; clients were volunteers. • Other info of interest: • WA and TA most likely provide indication of strength of relationship

				psychology students (1 m, 2 w), all European American	
Stanard & Hughes (2008)	• Assesses development of a supervisory working alliance and satisfaction with supervision in a peer group supervision model	• Causal-comparative study • Data analysis: t-tests and analyses of variance	• Peer model: advanced counseling students gave feedback on specific skills to beginner counseling students in lab of beginning counseling skills class • Supervision Satisfaction Questionnaire (SSQ; Ladany, Hill, Corbett, & Nutt, 1996) – 8 item Likert scale, assesses supervisee's satisfaction with supervision. Items address quality/kind of supervision, degree to which met supervisee needs, supervision efficacy, and total satisfaction. • Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990), Trainee form and Supervisor form. • Trainees completed SSQ and SWAI-Trainee • Supervisors	• Master's level students in school or community counseling program and counseling students in educational specialist degree school or community counseling program • Divided into 2 groups (trainees or supervisors) according to enrollment in classes • Trainees: 31 master's level graduate students (5 m, 26 w) in beginning counseling skills classes. 84% under 35 years old. 26 Caucasians, 4 African Americans, and 1 unspecified race. • Supervisors: 13 master's level students (1 m, 12	• Trainees were satisfied with supervision and the two groups had similar, positive perceptions of the alliance. • Trainees indicated peer supervision was beneficial for developing their skills and enhancing their understanding of counseling concepts. Feedback on counseling approach and technique, and peer support and encouragement were found to be especially helpful. • Limitations: inexperience of the peer supervisors; supervision was restricted to providing feedback on a specific skill set taught in class; small sample size of mainly White females from one university.

			completed SWAI-Supervisor	w). 8 in advanced counseling methods class, 2 in internship placement and 3 educational specialist graduate students in independent supervision practicum. 62% over 30 years old. 12 Caucasians and 1 African-American. None had supervision experience	

Disclosure – Theoretical Contributions

This table provides theoretical contributions to disclosure in supervision, specifically in regards to group supervision. Model descriptions with case illustrations suggest that this process-centered approach provides a structured, safe environment for sharing perspectives and working through countertransference.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Bransford (2009)	• Describes experiential, process-centered approach for group supervision for	• Model discussion with case illustrations	• N/A	• N/A	• Approach is inclusive, strength-based, and has a structured format. • Nearly all MSW student trainees participated in this type of supervision process; may be empowering for students.

	clinical social workers in practice, fieldwork, and classroom exercises				○ Approach may be an effective and empowering way to explore parallel process in group supervision. • Approach is designed to decrease competition between supervisees. • Students and clinicians view structured approach as less competitive and as providing a safe and respectful arena for multiple perspectives.
Counselman & Gumpert (1993)	• Describes benefits of small group supervision with designated leader for supervision of individual and couples therapy • Presents a group model and illustrates the significance of group process and learning opportunities in this format	• Model discussion with case illustrations	• N/A	• N/A	• Small group format (3-5 members) can provide supportive environment for identifying parallel process while providing a more potent interpretation; an observation/interpretation made by several may be more fully understood and integrated. • Support and acceptance may allow group members to work through countertransference. • A peer supervision group with a leader provides the collegial atmosphere but also the structure needed to create a safe holding environment. ○ Leader should function primarily as a group facilitator, not a supervisor ○ Maintaining a clear group contract is essential

Disclosure – Empirical Studies and Compilations

The following table presents findings from empirical studies and compilations on disclosure in supervision. Three studies found that most supervisees engage in nondisclosure of information to their supervisors. Of these three studies, two found that the material most often not disclosed concerned the supervisory relationship and events, and findings from the third indicated that negative feelings and concerns regarding evaluation were common reasons for nondisclosure for interns in both perceived good and

problematic supervisory relationships. Supervisee nondisclosure was inversely related to satisfaction with supervision in each of the studies that also assessed satisfaction. Most nondisclosures (related to supervision or concerns about peers who demonstrated problematic behavior) were discussed with a peer or friend in the field.

Author/ Year	Research Questions/ Objectives	Research Approach/Design	Instrumentation	Sample	Major Findings
Duan & Roehlke (2001)	• Describes racially different supervision dyads' perception and evaluation of the supervisory relationship	• Descriptive study	• Cross-Racial Supervision Survey – 24 item questionnaire developed for the study assessing participants' perception of (a) supervisors' prior experience with and knowledge of supervising counseling trainees of same race as supervisee, supervisors' behaviors to attend to issues related to race, whether conflicts or agreements took place, (b) supervisors' positive attitudes	• 60 psychology predoctoral interns (40 m, 20 w) from APA-accredited internships at university counseling centers; training program (77% counseling psychology, 16% clinical psychology, 7% professional schools) • 58 supervisors (30 m, 28 w) • all dyads had 1 Caucasian participant	• There were substantially more supervisory dyads with a Caucasian supervisor and an ethnic minority supervisee than vice versa. • Supervisors reported addressing more cultural issues than supervisees perceived they did. • Both supervisees and supervisors had high satisfaction with the supervision experience. • Supervisee comfort with self-disclosing and perception of supervisors' positive views toward them predicted supervisee satisfaction. • Supervisors' positive views toward supervisees, perception of supervisees' comfort with self-disclosure, and extent to which they thought their supervisees considered them to be trustworthy, helpful, and expert predicted supervisors' satisfaction. • Supervisors should take the primary initiative for addressing cross-racial issues. • Limitations: findings are more representative of dyads with Caucasian supervisor and ethnic minority supervisee; no construct validity for survey established

			toward supervisees (liking, respect, and interest/value supervisee culture), (c) supervisors' characteristics (expertise, trustworthiness, and helpfulness), (d) supervisors' expectations of supervisee self-disclosure, supervisees' degree of comfort with self-disclosure, and general satisfaction with relationship; 2 open ended questions on factors contributing to satisfaction or dissatisfaction and critical incidents • Demographic questionnaire		
Hess et al. (2008)	• Explores predoctoral interns' nondisclosure in supervision	• Qualitative study with illustrative examples • Consensual qualitative research	• Semistructured interview: describe particular incident of	• 14 predoctoral interns (3 m, 11 w) at university counseling centers in East	• All interns withheld information from supervisors. • In good supervisory relationships, interns felt safe (e.g., open, respectful, nonjudgmental) and comfortable sharing issues of professional and

	• Explores: -Why intentional disclosures occurred -Content of these nondisclosures -Factors that would have supported disclosure -Perceived effect of nondisclosure on therapist development and supervisor and therapeutic relationships • Assesses satisfaction with supervisory relationship and supervisor style, which have been associated with disclosure and nondisclosure	(CQR)	nondisclosure (one that intern perceived as having significantly affected intern professionally or personally, or supervisory and/or therapeutic relationship) that happened during predoctoral internship; what contributed to nondisclosure, what might have facilitated disclosure, and effect of the nondisclosure • Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) • Supervisory Satisfaction Questionnaire (SSQ; Ladany et al., 1996) – shortened version 6 of 8 questions because 2 were not pertinent for interns	Coast states – Racial/ethnic composition: 10 European American/White, 2 African American, 2 Asian American; Age range 27-38 years (M=31.21); Sexual orientation: 10 heterosexual, 2 lesbian, 1 gay, 1 bisexual; primarily counseling psychology PhD programs; Theoretical orientation (not mutually exclusive): psychodynamic (*n*=6), relational/interpersonal /humanistic (*n*=6), eclectic/integrative (*n*=4), cognitive-behavioral (*n*=2), developmental (*n*=1), existential (*n*=1), feminist (*n*=1)	personal nature. • In problematic supervisory relationships, interns did not feel safe or comfortable disclosing; relationships viewed as critical and evaluative. • Personal reactions to clients (and other clinical issues) were nondisclosures for interns in good supervisory relationships. • Nondisclosures related to overall dissatisfaction with the supervisory relationship for interns in problematical supervisory relationships. • Negative feelings and concerns regarding evaluation were common reasons for nondisclosure for both groups. • Power dynamics, supervisor theoretical orientation, and demographic/cultural variables were other reasons. • Power imbalances (e.g., impeding theoretical expression and using cultural dominance) as reasons for nondisclosure were not found in good supervisory relationships. • Interns reported that nondisclosures had adverse effects on themselves and their client relationships. • Interns in problematical relationships reported that nondisclosures had negatively affected the supervisory relationship. • Nondisclosure should be considered an expected aspect of supervision. • Supervisors should be alert for covert and overt signs. • Limitations: supervisees who did not participate may have given different responses; even though the small sample size is in line with CQR guidelines, conclusions should be viewed as provisional; purposeful selection process prevents results from being generalized;

				• 14 supervisors (5 m, 9 w) – Racial/ethnic composition: 11 European American/White, 1 African American, 2 Asian American; Sexual orientation: 11 heterosexual, 3 unknown sexual orientation; Theoretical orientation (not mutually exclusive) as reported by intern: psychodynamic (*n*=7), interpersonal/developmental (*n*=5), cognitive behavioral (*n*=2), eclectic/other (*n*=3); Supervisors were rated moderately competent (M= 5.57) by interns using a 7 point scale (1 = not very competent; 7 = very	limitations of recall; participants may have chosen nondisclosures that portrayed them in a certain way.

				competent) • Judges (6 European American women) – 4 doctoral students in psychology or education, 2 PhD therapists; Age range: 28-48 years (M=38.66, SD =5.96); Theoretical orientation (not mutually exclusive): psychodynamic (*n*=2), dynamic-humanistic (*n*=2), interpersonal (*n*=1), interpersonal-feminist (*n*=1), social constructionist (*n*=1), and integrationist (*n*=1)	
Ladany, Hill, Corbett & Nut (1996)	• Investigates nature and degree of supervisee nondisclosure o Investigates reasons for various types of nondisclosure	• Correlational study	• Supervisee Nondisclosure Survey (developed for this study) – use thought-listing technique to identify thoughts, feelings, and	• 108 supervisees (21 m, 86 w, 1 unspecified) – Average age 30.47 years; Racial/ethnic composition: 87 European Americans, 5	• Nondisclosure influences supervision process. • Most supervisees withhold information from supervisors; material varies in perceived importance but averages at moderate level. • Negative reactions toward supervisor were material that 90% of supervisees did not disclose. Personal issues, clinical errors, concerns about evaluation, overall client observations were contents of nondisclosure.

	○ Describes how supervisee avoids disclosure • Examines whether supervisor approach/style is related to number and content of and reasons for supervisees not disclosing • Establishes whether content of and reasons for nondisclosure are related to supervisees' satisfaction with supervision		reactions not shared with supervisor; definitions and examples of five areas of nondisclosure are provided: (a) personal issues (b) information related to supervisee's clients (e.g., observing unusual client mannerism) (c) supervisee-client interactions (e.g., therapeutic mistake), (d) features of the supervisor, (e) supervisor-supervisee interactions. For each nondisclosure, asked to write reasons and the manner of the nondisclosure: (a) active (e.g., stating that did not want to discuss when supervisor inquired), (b)	Hispanic Americans, 4 African Americans, 4 Asian Americans, 1 Native American, 1 unspecified); majority in counseling (63%) or clinical (21%) psychology training programs; Training level: doctoral (65%) or master's (33%)students in beginning practicum (39%), advanced practicum (32%), internship (26%), unspecified (4%); median of 12 months prior counseling experiences; currently receiving individual supervision for median of 1 hr per week at college counseling centers (62%),	Negative reactions to clients, countertransference, client-counselor attraction, positive reactions to supervisor, supervision setting issues, supervisor appearance, supervisee-supervisor attraction, and positive reactions to clients were also material of nondisclosures. • Most frequent reasons for nondisclosures were the material was perceived as unimportant, too personal, negative feelings (e.g., shame), poor supervisory alliance (e.g., mistrust), deference, impression management, and to a lesser degree, supervisor agenda, political suicide, pointlessness, and opinion that supervisor was not competent. • Deference to supervisor was a reason for not disclosing negative reactions to supervisor; dispersing power differential in relationship may result in fewer nondisclosures and facilitate discussion important for developing therapeutic competence. • Nondisclosure mostly was done in passive manner. • Most nondisclosures (53%) discussed with a peer or friend in the field. ○ Nondisclosures discussed with someone else were perceived as significantly more important to counselor functioning than those that were not shared. ○ Much supervision may be conducted by peers, who have less supervision and counseling experience than the supervisor. ○ Supervisees may receive more support, encouragement and require less impression management and fear of professional harm than with supervisor. • Supervisor style was not associated with frequency but was associated with content of and

			passive (neither supervisee nor supervisor brought up topic) (c) diversionary (supervisee avoided by bringing up another topic). Also asked to rate on 10-point scale importance of material not disclosed to their functioning as a therapist. Asked whether had shared the material with someone else besides supervisor and to indicate with whom they shared: peer or friend in the field, friend not in field, therapist, relative, significant other, another supervisor, and other. • Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984)	community mental health centers (18%), schools (8%), and hospitals (7%) with predominantly male (58%) supervisors, Racial/ethnic composition: 89 European Americans, 4 African Americans, 2 Hispanic Americans, 2 Native Americans, 1 Asian American, 11 unspecified	reasons for nondisclosure; supervisees more likely to withhold negative reactions from supervisors perceived as less interpersonally sensitive, attractive, and task oriented. o Information rated as especially important was not shared with supervisors rated as unattractive (i.e., not supportive); reveals that good alliance is necessary if supervisee is to have comfort in sharing important information, specifically negative reactions to supervisor. • Supervisees reported less satisfaction when they reported more negative reactions to supervisors, which they failed to disclose due to poor alliance, supervisor lack of competence, and fear of professional politics. Nondisclosures appear to be directly related to supervisees' view of supervision quality and degree to which supervision meets their needs and assists their development. • Supervisees whose needs are not met are likely to have more difficulty with challenging clinical issues; nondisclosures may compromise client welfare and supervisee training. • Limitations: correlational, not causal results; generalizability only to participants with comparable demographics; self-selection, etc. • Suggestion for future research: examination of efficacy of peer supervision may provide insight into process of supervision and how this format meets supervisee needs.

			• Supervisory Satisfaction Questionnaire (SSQ) – modified version of Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) – 8 items with 4-point scale rating satisfaction with several aspects of supervision • Demographic questionnaire		
Ladany & Lehrman-Waterman (1999)	• Determines nature and frequency of supervisor self-disclosures as perceived by trainees • Determines how supervisor style is related to frequency of supervisor self-disclosure • Investigates how supervisor self-disclosures affect the supervisory working alliance	• Correlational study • Data analyses: univariate multiple regression analysis, multivariate multiple regression analysis	• Supervisor Self Disclosure Questionnaire (SSDQ; rationally and theoretically developed and validated in pilot study) – use thought listing technique to describe self-disclosures by current supervisor; provided general definition and definition of each type of	• 105 counselor trainees (82 w, 23 m) in counselor education and counseling psychology (67%) or clinical psychology (30%) programs; Average age: 30.39 years; Racial/ethnic composition: 84 White, 12 African American, 3 Asian American, 5 Hispanic, 1 unspecified);	• 91% of trainees reported at least 1 supervisor self-disclosure. o Most frequent types were personal issues (73%), neutral counseling experiences (55%), and counseling struggles (51%). • Frequency of self-disclosures was associated with supervisory working alliance. Greater self-disclosure by supervisor predicted stronger supervisory alliance. o Trainee perception of emotional bond and agreement with supervisor on goals and tasks was positively correlated with number of supervisor self-disclosures. o Trainees perceived stronger emotional bond when supervisors shared counseling struggles more often. ▪ Revealing struggles suggests supervisor vulnerability, which may be powerful intervention to develop

			supervisor self-disclosure rationally derived from literature: (a) favorable or unfavorable info, (b) past or present experiences, (c) intimate or nonintimate info (d) similar or different experiences than those of trainee (e) process comments about supervision, (f) self-disclosures with minimal or no relevance to supervision • Supervisor Self-Disclosure Index (SSDI; Watkins, 1990) – 9 item self-report inventory, theoretically and rationally developed from self-disclosure types described in literature; 5-point scale where rate degree to which supervisor	Supervised counseling experience: median of 24 months, median of 16 supervision sessions • 105 supervisors (51% m), doctoral degrees (67%) master's degrees (33%); Racial/ethnic composition: White (81%), Latino (8%), African American (6%), Asian American (3%), biracial (2%) • 3 judges – 2 coauthors (male professor and female doctoral student) and female doctoral student	relationship; stronger alliance may promote more trainee self-disclosure that may provide more learning opportunities. o Self-disclosure could be used to build initial relationship or to repair strained supervisory relationship. • Supervisor style was associated with frequency of self-disclosure. o Supervisors perceived to have an Attractive (supportive and warm) supervisory style were likely to more frequently self-disclose. May do so to diffuse hierarchical nature of supervisory relationship. • Supervisor style was associated with content of self-disclosure. o Attractive supervisory style was most often associated with sharing neutral counseling experiences. o Interpersonally sensitive style was associated with being less likely to share neutral counseling experiences. o Task-oriented style was less likely to disclose personal issues or successful counseling experiences. • Limitations: self-report (may have only reported disclosures most important to them); no causal link between self-disclosure, alliance, style; lack of generalizability of the sample.

			made the types of self-disclosures • Supervisory Styles Inventory (SSI) • Working Alliance Inventory-Trainee version (WAI-T) • Demographic questionnaire		
Rosenberg, Getzelman, Arcinue, & Oren (2005)	• Describes students' experiences of peers who demonstrate problematic behavior in professional psychology programs • Objectives: (1) determine if students are aware of problematic peers, (2) gain students' views on who has responsibility, (3) discover the types of problems observed, (4) learn students' actions or responses (5) determine how problematic peer influences	• Descriptive pilot study	• Survey – 6 sections that match the research objectives; includes checklists and open-ended questions for recommendations • Impairment defined as "a serious deficit in the areas of personal functioning (awareness of self/impact on others, the use of supervision, and management of personal stress); knowledge and application of professional standards (ethics,	• 129 students (27 m, 102 w) – 87 master's (MFT) level, 42 doctoral-level gradate students in clinical or counseling psychology doctoral programs at 4 Southern California graduate schools; Mean age: 28.5 yrs, range 22-52 yrs; Racial/ethnic background: Caucasian (64%), Asian (15%), African American (8%), Latino/a (6%), Middle Eastern (2%) (Convenience	• The majority (85%) of students reported at least 1 problematic peer. o Mean number reported per respondent was 3.32; which is higher than reported in studies of training directors. o Students may have more opportunity to interact with peers and may have access to more information. • Students believe faculty members are mostly responsible for handling problematic peers but students have some responsibility. • Majority of problems reported were associated with emotional issues and interpersonal functioning. o Problems most often identified: lack of awareness of impact on others (60%), emotional difficulties (58%), clinical deficiency (54%), poor interpersonal skills (52%). • Most often, students gossiped to each other (57%), consulted with one another (49%), or withdrew from the peer (45%). o Less often, students brought concerns to faculty (23%). • Problematic peer significantly affects students

	respondent's functioning, relationships with other peers and faculty, and views of the learning environment and training program, (6) request best practice recommendations for managing issue of problematic trainee behavior		relevant mental health law, and professional behavior); and competency (skill) in areas such as conceptualization, diagnosis, and assessment, and appropriate clinical interventions" (p. 667)	sample)	and the learning environment. • Students identified the impact of the problematic peer to include: avoiding the peer, feeling fearful that the peer will hurt or damage clients, feeling frustrated at faculty for failing to identify and for not screening out problematic peer. • Students did not believe there was an adequate means to voice concerns about problematic peers in their programs. • Talking with the problem peer was reported by students to be an action that they could reasonably carry out. • Limitations: reliability and validity of self-report instrument was not assessed; possible bias because high percentage of respondents from 2 programs.
Yourman & Farber (1996)	• Investigates extent to which supervisee nondisclosure occurs in supervision • Investigates extent to which certain clinical, demographic, and supervisory factors predict nondisclosure	• Correlational study • Data analyses: multiple regression model	• The Supervisory Questionnaire (SQ) – 66 item self-report measure developed for the study; 43 items use 7-point Likert-type scale to assess how often an event or feeling occurs in supervision; 23 items use 7-point Likert-type scale to assess how well certain adjective describes their supervisor in supervision;	• 93 doctoral students (26 m, 67 w) mainly in clinical psychology from NY metropolitan area; Age range 22-49 years (*M*=31.2); Racial/ethnic composition: Caucasian 74.2%, Hispanic American 11.8%, African American 5.4%, Asian American 4.3%, foreign 2.2%, and Native American 1.1%; Average of 11.2	• Most supervisees generally provide honest account of interactions with clients but also consciously distort and/or conceal some information part of the time. • 30-40% of supervisees withhold material (e.g., admitting to clinical errors) at moderate to high frequency; these interactions may have high possibility of shame. • Almost 50% of supervisees tell supervisor what he/she appears to want to hear at moderate to high level of frequency. • Supervisees are more likely to withhold rather than distort information. • None of the demographic variables (supervisee age, supervisee gender, supervisor gender, gender interactions, ethnicity, theoretical orientation match or mismatch, and supervisee's years in the program) were significantly related to nondisclosure. • More frequent supervisee satisfaction and

			open-ended section to describe interaction with supervisor where omitted material, disregarded instructions, or concealed a comment or feeling; Total score calculated based on scores of 11 items selected beforehand for relevance to supervisee nondisclosure	months in this supervision; Primary theoretical orientation: psychodynamic 64.2%, cognitive behavioral 22.6%, eclectic 5.4%, other/undecided 5.4%, and behavioral 3.2%; Supervisors: 46 m, 47 w	supervisor discussion of countertransference were associated with less frequent nondisclosure. • 3 categories of supervisee nondisclosure: information about events in therapy session, supervisee's feelings about client, and supervisee's feelings about supervisor. • Similar to Ladany, Hill, Corbett, and Nutt (1996), material most often not disclosed concerned supervisory relationship and events. o Nondisclosure may not be distorting process of therapy; however, may reflect comparable process in therapy. • Ladany et al. (1996) and these findings suggest that countertransference discussion may be challenging but productive activity. • Nondisclosure, concealment, and distortion may be unavoidable in supervision. • Programs should stress training instead of evaluation component of supervision; emphasize that optimal learning occurs through examining mistakes, which are inevitable.

References

Agnew, T., Vaught, C. C., Getz, H. G., & Fortune, J. (2000). Peer group clinical supervision program fosters confidence and professionalism. *Professional School Counseling, 4*(1), 6-12. Retrieved from Academic Search Elite database.

Akhurst, J., & Kelly, K. (2006). Peer group supervision as an adjunct to individual supervision: Optimising learning processes during psychologists' training. *Psychology Teaching Review, 12*(1), 3-15. Retrieved from http://www.bps.org.uk/dtrp/what-is-the-psychology-teaching-review.cfm

Bahrick, A. S. (1990). *Role induction for counselor trainees: Effects on the supervisory working alliance* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 9014392)

Barry, P. (2006). Forming and belonging to a peer consultation group for your own mental health and creating a psychotherapy practice that addresses specific topics. *Perspectives in Psychiatric Care, 42*(1)*,* 63-66. doi: 10.1111/j.1744-6163.2006.00051.x

Benshoff, J. M. (1993). Peer supervision in counselor training. *Clinical Supervisor, 11*(2), 89-102. doi: 10.1300/J001v11n02_08

Benshoff, J. M. (1994, April). Peer consultation as a form of supervision. *ERIC Digest,* 1-6. Retrieved from http://www.eric.ed.gov/PDFS/ED372352.pdf

Benshoff, J. M., & Paisley, P. O. (1996). The structured peer consultation model for school counselors. *Journal of Counseling & Development, 74*(3), 314-318. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Upper Saddle River, NJ: Pearson.

Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry, 162*(5), 890-898. doi: 10.1176/appi.ajp.162.5.890

Borders, L. D. (1991). A systematic approach to peer group supervision. *Journal of Counseling & Development, 69*(3), 248-252.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-260.

Bordin, E. S. (1983). Supervision in counseling: II. Contemporary models of supervision: A working alliance based model of supervision. *Counseling Psychologist, 11*(1), 35-42.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice.* (pp. 13-37). Oxford England: John Wiley & Sons.

Bos, S. (1998). Perceived benefits of peer leadership as described by junior baccalaureate nursing students. *Journal of Nursing Education, 37*(4)*,* 189-191.

Bransford, C. (2009). Process-centered group supervision. *Clinical Social Work Journal, 37*(2), 119-127. doi: 10.1007/s10615-009-0200-x

Brown, J. B., Hogg, W., Delva, D., Nanchoff-Glatt, M., & Moore, L. (1999). Peer consultation reflection exercise: Innovative strategy for personal and professional development. *Canadian Family Physician, 45,* 1509-1515. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2328478/pdf/canfamphys00040-0123.pdf

Butler, S. K., & Constantine, M. G. (2006). Web-based peer supervision, collective self-esteem and case conceptualization ability in school counselor trainees. *Professional School Counseling, 10*(2), 146-152. Retrieved from http://www.schoolcounselor.org/content.asp?contentid=235

Caplan, G. (1970). *The theory and practice of mental health consultation*. New York, NY: Basic Books.

Carifio, M. S., & Hess, A. K. (1987). Who is the ideal supervisor? *Professional Psychology: Research and Practice, 18,* 244-250. doi: 10.1037/0735-7028.18.3.244

Chen, E. C., & Bernstein, B. L. (2000). Relations of complementarity and supervisory issues to supervisory working alliance: A comparative analysis of two cases. *Journal of Counseling Psychology, 47*(4), 485-497. doi: 10.1037/0022-0167.47.4.485

Clark, R. A., Harden, S. L., & Johnson, W. B. (2000). Mentor relationships in clinical psychology doctoral training: Results of a national survey. *Teaching of Psychology, 27*(4), 262-268. Retrieved from http://teachpsych.org/top/index.php

Claveirole, A., & Mathers, M. (2003). Peer supervision: An experimental scheme for nurse lecturers. *Nurse Education Today, 23*(1), 51-57. doi: 10.1016/S0260-6917%2802%2900162-4

Coban, A., E., & Demir, A. (2007). The effect of structured peer consultation program on school counselor burnout in Turkey. *Journal of Applied Sciences, 7*(23)*,* 3774-3779. doi: 10.3923/jas.2007.3774.3779

Counselman, E. F., & Gumpert, P. (1993). Psychotherapy supervision in small leader-led groups. *Group, 17*(1), 25-32. doi: 10.1007/BF01419603

Counselman, E. F., & Weber, R. L. (2004). Organizing and maintaining peer supervision groups. *International Journal of Group Psychotherapy, 54*(2)*,* 125-143. doi: 10.1521/ijgp.54.2.125.40391

Crutchfield, L. B., & Borders, L. D. (1997). Impact of two clinical peer supervision models on practicing school counselors. *Journal of Counseling & Development, 75*(3), 219-230. Retrieved from http://www.counseling.org/publications

Cutler, R. L. (1958). Countertransference effects in psychotherapy. *Journal of Consulting Psychology, 22*(5), 349-356. doi: 10.1037/h0044815

Dalenberg, C. J. (2004). Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 438-447. doi: 10.1037/0033-3204.41.4.438

Daniel, C. H. (2008). *The relationship between the supervisory alliance and countertransference disclosure among psychology interns* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3324654)

Duan, C., & Roehlke, H. (2001). A descriptive "snapshot" of cross-racial supervision in university counseling center internships. *Journal of Multicultural Counseling and Development, 29*(2)*,* 131-146. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology, 37*(3), 322-329. doi: 10.1037/0022-0167.37.3.322

Ellis, A. (2001). Rational and irrational aspects of countertransference. *Journal of Clinical Psychology, 57*(8), 999-1004. doi: 10.1002/jclp.1067

Ellis, M. V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 447-507). New York: John Wiley & Sons, Inc.

Ellis, M. V., Ladany, N., Krengel, M., & Schult, D. (1996). Clinical supervision research from 1981 to 1993: A methodological critique. *Journal of Counseling Psychology, 43*(1), 35-50. doi: 10.1037/0022-0167.43.1.35

Falender, C. A., & Shafranske, E. P. (2004*). Clinical supervision: A competency-based approach.* Washington, DC: American Psychological Association.

Freud, S. (1910). The future prospects of psycho-analytic therapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 11, pp. 139-152). Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Friedlander, M. L., & Ward, L. G. (1984). Development and validation of the supervisory styles inventory. *Journal of Counseling Psychology, 31*(4), 541-57. doi: 10.1037/0022-0167.31.4.541

Friedman, S. M., & Gelso, C. J. (2000). The development of the inventory of countertransference behavior. *Journal of Clinical Psychology, 56*(9), 1221-1235. doi:10.1002/1097-4679(200009)56:9<1221::AID-JCLP8>3.0.CO;2-W

Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice, 57*(8), 983-991. doi: 10.1002/jclp.1065

Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., & Rodolfa, E. (2001). Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter? *Journal of Multicultural Counseling & Development, 29*(2)*,* 102-113. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Gelso, C. J., & Hayes, J. A. (2001). Countertransference management. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 418-422. doi: 10.1037/0033-3204.38.4.418

Granello, D. H., Kindsvatter, A., Granello, P. F., Underfer-Babalis, J., & Moorhead, H. J. H. (2008). Multiple perspectives in supervision: Using a peer consultation model to enhance supervisor development. *Counselor Education & Supervision, 48*(1), 32-47. Retrieved from http://www.unco.edu/ces/

Grant, J. (2006). Training counselors to work with complex clients: Enhancing emotional responsiveness through experiential methods. *Counselor Education & Supervision, 45*(3), 218-230. Retrieved from http://www.unco.edu/ces/

Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. *Journal of Counseling Psychology, 48*(4), 371-383. doi: 10.1037/0022-0167.48.4.371

Greenburg, S. L., Lewis, G. J., & Johnson, M. (1985). Peer consultation groups for private practitioners. *Professional Psychology: Research and Practice, 16*(3), 437-447. doi: 10.1037/0735-7028.16.3.437

Hart, G. (1990). Peer consultation and review. *The Australian Journal of Advanced Nursing, 7*(2)*,* 40-46. Retrieved from http://www.ajan.com.au/

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology, 64*(6), 1326-1336. doi: 10.1037/0022-006X.64.6.1326

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 292-299. doi: 10.1037/0033-3204.43.3.292

Hayes, J. A. (1995). Countertransference in group psychotherapy: Waking a sleeping dog. *International Journal of Group Psychotherapy, 45*(4), 521-535.

Hayes, J. A., & Gelso, C. J. (2001). Clinical implications of research on countertransference: Science informing practice. *Journal of Clinical Psychology, 57*(8), 1041-1051. doi: 10.1002/jclp.1072

Heimann, P. (1950). On counter-transference. *International Journal of Psycho-Analysis, 31,* 81-84. Retrieved from http://www.wiley.com/bw/journal.asp?ref=0020-7578

Hess, S. A., Knox, S., Schultz, J. M., Hill, C. E., Sloan, L., Brandt, S., . . . Hoffman, M. A. (2008). Predoctoral interns' nondisclosure in supervision. *Psychotherapy Research,18*(4)*,* 400-411. doi: 10.1080/10503300701697505

Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 365-372. doi: 10.1037/0033-3204.38.4.365

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36*(2), 223-233. doi: 10.1037/0022-0167.36.2.223

Horvath, A. O., & Greenberg, L. S. (Eds.). (1994). *The working alliance: Theory, research, and practice*. Oxford England: John Wiley & Sons.

Kiesler, D. (2001). Therapist countertransference: In search of common themes and empirical referents. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice*, *57*(8)*,* 1053-1063. doi: 10.1002/jclp.1073

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development, 77*(4)*,* 447-455. Retrieved from http://www.counseling.org/publications

Ladany, N., & Friedlander, M. L. (1995). The relationship between the supervisory working alliance and trainees' experience of role conflict and role ambiguity. *Counselor Education & Supervision, 34*(3), 220-231. Retrieved from http://www.unco.edu/ces/

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*(1)*,* 10-24. doi: 10.1037/0022-0167.43.1.10

Ladany, N., & Lehrman-Waterman, D. (1999). The content and frequency of supervisor self-disclosures and their relationship to supervisor style and the supervisory working alliance. *Counselor Education & Supervision, 38*(3), 143-160. Retrieved from http://www.unco.edu/ces/

Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist, 27*(3)*,* 443-475. doi: 10.1177/0011000099273008

Ladany, N., Walker, J. A., & Melincoff, D. S. (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure. *Counselor Education & Supervision, 40*(4), 263-275. Retrieved from http://www.unco.edu/ces/

Lang, E. V., Sood, A., Anderson, B., Kettenmann, E., & Armstrong, E. (2005). Interpersonal and communication skills training for radiology trainees using a rotating peer supervision model (microteaching). *Academic Radiology, 12,* 901-908. doi: 10.1016/j.acra.2005.03.064

Lewis, G. J., Greenburg, S. L., & Hatch, D. B. (1988). Peer consultation groups for psychologists in private practice: A national survey. *Professional Psychology: Research and Practice, 19*(1)*,* 81-86. doi: 10.1037/0735-7028.19.1.81

Ligiéro, D. P., & Gelso, C. J. (2002). Countertransference, attachment, and the working alliance: The therapist's contribution. *Psychotherapy: Theory, Research, Practice, Training, 39*(1), 3-11. doi: 10.1037/0033-3204.39.1.3

Logan, W. L. (1997). Peer consultation group: Doing what works for counselors. *Professional School Counseling, 1*(2)*,* 4-6. Retrieved from http://www.schoolcounselor.org/content.asp?contentid=235

Markus, H. E., Cross, W. F., Halewski, P. G., Quallo, H., Smith, S., Sullivan, M., . . . Tantillo, M. (2003). Primary process and peer consultation: An experiential model to work through countertransference. *International Journal of Group Psychotherapy, 53*(1), 19-37. doi: 10.1521/ijgp.53.1.19.42807

Minkle, B., Bashir, A. S., & Sutulov, C. (2008). Peer consultation for mediators: The use of a holding environment to support mediator reflection, inquiry, and self-knowing. *Negotiation Journal, 24*(3), 303-323. doi: 10.1111/j.1571-9979.2008.00186.x

Morgan, B. D. (2006). Peer consultation: A unique experiential model for P/MHNP students. *Perspectives in Psychiatric Care, 42*(4), 238-244. doi: 10.1111/j.1744-6163.2006.00095.x

Olk, M. E., & Friedlander, M. L. (1992). Trainees' experiences of role conflict and role ambiguity in supervisory relationships. *Journal of Counseling Psychology, 39*(3), 389-397. doi: 10.1037/0022-0167.39.3.389

Page, B. J., Pietrzak, D. R., & Sutton, J. M. J. (2001). National survey of school counselor supervision. *Counselor Education and Supervision, 41*(2), 142-150. Retrieved from http://www.unco.edu/ces/

Patton, M. J., & Kivlighan Jr., D. M. (1997). Relevance of the supervisory alliance to the counseling alliance and to treatment adherence in counselor training. *Journal of Counseling Psychology, 44*(1), 108-115. doi: 10.1037/0022-0167.44.1.108

Racker, H. (1953). A contribution to the problem of counter-transference. *The International Journal of Psychoanalysis, 34*, 313-324. Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Racker, H. (1957). The meanings and uses of countertransference. *The Psychoanalytic Quarterly, 26*, 303-357. Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Reich, A. (1951). On counter-transference. *The International Journal of Psychoanalysis, 32*, 25-31. Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Remley, T. P., Benshoff, J. M., & Mowbray, C. A. (1987). A proposed model for peer supervision. *Counselor Education and Supervision, 27*(1), 53-60. Retrieved from http://www.unco.edu/ces/

Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly, 62*, 553-571. Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Renko, M., Uhari, M., Soini, H., & Tensing, M. (2002). Peer consultation as a method for promoting problem-based learning during a paediatrics course. *Medical Teacher, 24*(4), 408-411. doi: 10.1080/01421590220145789

Rosenberg, J. I., Getzelman, M. A., Arcinue, F., & Oren, C. Z. (2005). An exploratory look at students' experiences of problematic peers in academic professional

psychology programs. *Professional Psychology: Research and Practice, 36,* 665-673. doi: 10.1037/0735-7028.36.6.665

Rosenberger, E. W., & Hayes, J. A. (2002a). Origins, consequences, and management of countertransference: A case study. *Journal of Counseling Psychology, 49*(2), 221-232. doi: 10.1037/0022-0167.49.2.221

Rosenberger, E. W., & Hayes, J. A. (2002b). Therapist as subject: A review of the empirical countertransference literature. *Journal of Counseling & Development, 80*(3)*,* 264-270. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psychoanalysis*, *3*, 43-47. Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Schreiber, P., & Frank, E. (1983). The use of a peer supervision group by social work clinicians. *Clinical Supervisor, 1*(1)*,* 29-36. doi: 10.1300/J001v01n01_04

Shafranske, E. P., & Falender, C. A. (2008). Supervision addressing personal factors and countertransference. In C. A. Falender & E. P. Shafranske (Eds.)*, Casebook for clinical supervision: A competency-based approach* (pp. 97-120). Washington, DC: American Psychological Association.

Spice, C. G., & Spice, W. H. (1976). A triadic method of supervision in the training of counselors and counseling supervisors. *Counselor Education and Supervision, 15*(4)*,* 251-258.

Stanard, R. P., & Hughes, J. T. (2008). Using peer supervisors in counselor education training: Research findings. *Perspectives in Peer Programs, 21*(1)*,* 1-11.

Todd, W. E., & Pine, I. (1968). Peer supervision of individual psychotherapy. *The American Journal of Psychiatry, 125*(6), 780-784.

Tummala-Narra, P. (2004). Dynamics of race and culture in the supervisory encounter. *Psychoanalytic Psychology, 21*(2)*,* 300-311. doi: 10.1037/0736-9735.21.2.300

Wagner, C. A., & Smith, J. P., Jr. (1979). Peer supervision: Toward more effective training. *Counselor Education and Supervision, 18*(4)*,* 288-293.

Wilkerson, K. (2006). Peer supervision for the professional development of school counselors: Toward an understanding of terms and findings. *Counselor Education & Supervision, 46*(1), 59-67. Retrieved from http://www.unco.edu/ces/

Winnicott, D. W. (1949). Hate in the counter-transference. *The International Journal of Psychoanalysis, 30*, 69-74. Retrieved from http://www.pep-web.org.lib.pepperdine.edu

Yeh, C. J., Chang, T., Chiang, L., Drost, C. M., Spelliscy, D., Carter, R. T., & Chang, Y. (2008). Development, content, process and outcome of an online peer supervision group for counselor trainees. *Computers in Human Behavior, 24*(6), 2889-2903. doi: 10.1016/j.chb.2008.04.010

Yourman, D. B., & Farber, B. A. (1996). Nondisclosure and distortion in psychotherapy supervision. *Psychotherapy: Theory, Research, Practice, Training, 33,* 567-575. doi: 10.1037/0033-3204.33.4.567

Zins, J. E., & Murphy, J. J. (1996). Consultation with professional peers: A national survey of the practices of school psychologists. *Journal of Educational & Psychological Consultation, 7*(1), 61-70. doi: 10.1207/s1532768xjepc0701_5

Zins, J. E., Ponti, C. R., & Murphy, J. J. (1992). Peer-mediated professional development groups for special services practitioners. *Special Services in the Schools, 6*(3)*,* 179-193. doi: 10.1300/J008v06n03_10

APPENDIX B

Working Alliance Inventory

Working Alliance Inventory: Peer 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 peer supervisor. As you read the sentences, mentally insert the name of your current (or most recent) peer supervisor in place of _____ in the text. If you have more than one peer supervisor, select the one with whom you spend the most time.

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), circle 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 impressions are what is wanted.

1. I feel uncomfortable with _____.
2. _____ and I agree about the things I will need to do in peer supervision.
3. I am worried about the outcome of our peer supervision sessions.
4. What I am doing in peer supervision gives me a new way of looking at myself as a counselor.
5. _____ and I understand each other.
6. _____ perceives accurately what my goals are.
7. I find what I am doing in peer supervision confusing.
8. I believe _____ likes me.
9. I wish _____ and I could clarify the purpose of our sessions.
10. I disagree with _____ about what I ought to get out of peer supervision.
11. I believe the time _____ and I are spending together is not spent efficiently.
12. _____ does not understand what I want to accomplish in peer supervision.
13. I am clear on what my responsibilities are in peer supervision.
14. The goals of these sessions are important to me.
15. I find what _____ and I are doing in peer supervision is unrelated to my concerns.
16. I feel that what _____ and I are doing in peer supervision will help me to accomplish the changes that I want in order to be a more effective counselor.
17. I believe _____ is genuinely concerned for my welfare.
18. I am clear as to what _____ wants me to do in our peer supervision sessions.
19. _____ and I respect each other.
20. I feel that _____ is not totally honest about his or her feelings towards me.
21. I am confident in _____'s ability to supervise me.

22. _____ and I are working towards mutually agreed-on goals.
23. I feel that _____ appreciates me.
24. We agree on what is important for me to work on.
25. As a result of our peer supervision sessions, I am clearer as to how I might improve my
    counseling skills.
26. _____ and I trust one another.
27. _____ and I have different ideas on what I need to work on.
28. My relationship with _____ is very important to me.
29. I have the feeling that it is important that I say or do the "right" things in peer supervision with _____.
30. _____ and I collaborate on setting goals for my peer supervision.
31. I am frustrated by the things we are doing in peer supervision.
32. We have established a good understanding of the kinds of things I need to work on.
33. The things that _____ is asking me to do don't make sense.
34. I don't know what to expect as a result of my peer supervision.
35. I believe the way we are working with my issues is correct.
36. I believe _____ cares about me even when I do things that he or she doesn't approve of.

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 current (or most recent) primary supervisor in place of _____ in the text. If you have more than one primary supervisor, select the one with whom you spend the most time.

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), circle 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 impressions are what is wanted.

1. I feel uncomfortable with _____.
2. _____ and I agree about the things I will need to do in supervision.
3. I am worried about the outcome of our supervision sessions.
4. What I am doing in supervision gives me a new way of looking at myself as a counselor.
5. _____ and I understand each other.
6. _____ perceives accurately what my goals are.
7. I find what I am doing in supervision confusing.
8. I believe _____ likes me.
9. I wish _____ and I could clarify the purpose of our sessions.
10. I disagree with _____ about what I ought to get out of supervision.
11. I believe the time _____ and I are spending together is not spent efficiently.
12. _____ does not understand what I want to accomplish in supervision.
13. I am clear on what my responsibilities are in supervision.
14. The goals of these sessions are important to me.
15. I find what _____ and I are doing in supervision is unrelated to my concerns.
16. I feel that 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.
17. I believe _____ is genuinely concerned for my welfare.
18. I am clear as to what _____ wants me to do in our supervision sessions.
19. _____ and I respect each other.
20. I feel that _____ is not totally honest about his or her feelings towards me.
21. I am confident in _____'s ability to supervise me.
22. _____ and I are working towards mutually agreed-on goals.

23. I feel that _____ appreciates me.
24. We agree on what is important for me to work on.
25. As a result of our supervision sessions, I am clearer as to how I might improve my counseling skills.
26. _____ and I trust one another.
27. _____ and I have different ideas on what I need to work on.
28. My relationship with _____ is very important to me.
29. I have the feeling that it is important that I say or do the "right" things in supervision with _____.
30. _____ and I collaborate on setting goals for my supervision.
31. I am frustrated by the things we are doing in supervision.
32. We have established a good understanding of the kinds of things I need to work on.
33. The things that _____ is asking me to do don't make sense.
34. I don't know what to expect as a result of my supervision.
35. I believe the way we are working with my issues is correct.
36. I believe _____ cares about me even when I do things that he or she doesn't approve of.

Scoring Key for the Working Alliance Inventory

TASK Scale	2	4	7	11	13	15	16	18	24	31	33	35
Polarity	+	+	-	-	+	-	+	+	+	-	-	+
BOND Scale	1	5	8	17	19	20	21	23	26	28	29	36
Polarity	-	+	+	+	+	-	+	+	+	+	-	+
GOAL Scale	3	6	9	10	12	14	22	25	27	30	32	34
Polarity	-	+	-	-	-	+	+	+	-	+	+	-

Permission to use Working Alliance Inventory-Supervisee Version

Sent: Tue 3/16/2010 8:18 AM

Dear Sara,
Yes, you may have my permission to use the WAI-S, and to modify it. Your study sounds interesting and will certainly make a needed contribution to the literature.
The instrument was published and discussed in Carol Falender and Edward Shafranske's 2004 book Clinical Supervision: A Competency-Based Approach.

Best Regards,
Audrey

Audrey S. Bahrick, Ph.D.
Senior Staff Psychologist
University Counseling Service
The University of Iowa

APPENDIX C

Reaction Disclosure Questionnaire

Reaction Disclosure Questionnaire – Peer Supervisee

Instructions: Consider your relationship with your current (or most recent) peer supervisor. How comfortable do you feel disclosing your personal reactions to your clients to him or her? While keeping your peer supervisor in mind, read the following scenarios carefully. Rate your comfort in and likelihood of discussing these scenarios with your current (or most recent) peer supervisor in a one-on-one interaction in peer supervision. If you have more than one peer supervisor, select the one with whom you spend the most time.

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 peer supervision with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer supervisor?

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

2. After reviewing several audiotapes of your sessions with a particular client, you notice that you have been avoiding further discussions of certain topics with the client. 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 discuss this with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	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 peer supervision with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer 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 the client's problems. 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 peer supervision with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer supervisor?

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

5. You have a client that 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 peer supervision with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer 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 peer supervision with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer 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 the client discusses this. How comfortable would you be with discussing this reaction in peer supervision with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer 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 him or her, 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 peer supervision with your current (or most recent) peer supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) peer supervisor?

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

Reaction Disclosure Questionnaire – Supervisee

Instructions: Consider your relationship with your current (or most recent) 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 and likelihood of discussing these scenarios with your current (or most recent) primary supervisor in a one-on-one interaction in supervision. If you have more than one primary supervisor, select the one with whom you spend the most time.

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 (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) supervisor?

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

2. After reviewing several audiotapes of your sessions with a particular client, you notice that you have been avoiding further discussions of certain topics with the client. 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 discuss this with your current (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) supervisor?

1	2	3	4	5	6	7
Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very likely	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 (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) 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 the client's problems. 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 (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) supervisor?

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

5. You have a client that 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 (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) 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 (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) 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 the client discusses this. How comfortable would you be with discussing this reaction in supervision with your current (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) 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 him or her, 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 (or most recent) supervisor?

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

How likely would you be to disclose these feelings with your current (or most recent) supervisor?

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

Permission to use Reaction Disclosure Questionnaire

Sent: Tue 3/9/2010 7:21 AM

Hi Sara,
This email shall serve as my written permission to use my countertransference disclosure measure for your dissertation study.

Colleen H. Daniel, Psy.D.

APPENDIX D

Demographic Questionnaire

Demographic Questionnaire

Instructions: For each item, please select the answer choice that is most appropriate for you. If there is not an answer that is appropriate, select "other" and type your response in the box provided.

1. Type of doctoral program:
A. Clinical
B. Counseling
C. Other _____

2. Degree sought:
A. Ph.D.
B. Psy.D.
C. Other _____

3. Year in doctoral program:
A. First
B. Second
C. Third
D. Fourth
E. Other _____

4. How many months did you receive peer supervision during the period of August 2010 to April 2011?
A. Less than 3 months
B. 3 to 6 months
C. 6 to 9 months

5. How often did you receive peer supervision during the period of August 2010 to April 2011?
A. Less than 1 hour per week
B. 1 to 2 hours per week
C. More than 2 hours per week

6. How many months did you receive supervision from your primary supervisor during the period of August 2010 to April 2011?
A. Less than 3 months
B. 3 to 6 months
C. 6 to 9 months

7. How often did you receive supervision from your primary supervisor during the period of August 2010 to April 2011?
A. Less than 1 hour per week
B. 1 to 2 hours per week
C. More than 2 hours per week

8. You expect that information you disclose in peer supervision, such as clinical errors,
A. Will be discussed with your primary supervisor
B. May be discussed with your primary supervisor
C. Will be discussed with your primary supervisor only if client safety is involved
D. Will only be discussed with your primary supervisor with your permission

9. Has your disclosure in peer supervision ever resulted in negative consequences (e.g., a poor evaluation) from your primary supervisor?
A. Yes
B. No
C. Unknown

10. In the space below, list two factors that have influenced your disclosure of personal reactions to clients in peer supervision with your peer supervisor.

11. Which best describes your primary theoretical orientation?
A. Cognitive-behavioral (includes cognitive and behavioral)
B. Family systems
C. Humanistic/existential
D. Psychodynamic
E. Other _____

12. Which gender do you identify with?
A. Female
B. Male
C. Other (trans, intersex) _____

13. Which best describes your racial/ethnic identification?
A. African American/Black
B. Asian/Pacific Islander
C. Hispanic/Latino
D. Native American/Alaskan Native
E. White (non-Hispanic)
F. Bi-racial/Multi-racial
G. Other _____

14. Which best describes your peer supervisor's primary theoretical orientation?
A. Cognitive-behavioral (includes cognitive and behavioral)
B. Family systems
C. Humanistic/existential
D. Psychodynamic
E. Other _____

15. Which gender does your peer supervisor identify with?
A. Female
B. Male
C. Other (trans, intersex) _____
D. Unknown

16. Which best describes your peer supervisor's racial/ethnic identification?
A. African American/Black
B. Asian/Pacific Islander
C. Hispanic/Latino
D. Native American/Alaskan Native
E. White (non-Hispanic)
F. Bi-racial/Multi-racial
G. Other _____
H. Unknown

17. Which best describes your primary supervisor's primary theoretical orientation?
A. Cognitive-behavioral (includes cognitive and behavioral)
B. Family systems
C. Humanistic/existential
D. Psychodynamic
E. Other _____

18. Which gender does your primary supervisor identify with?
A. Female
B. Male
C. Other (trans, intersex) _____
D. Unknown

19. Which best describes your primary supervisor's racial/ethnic identification?
A. African American/Black
B. Asian/Pacific Islander
C. Hispanic/Latino
D. Native American/Alaskan Native
E. White (non-Hispanic)
F. Bi-racial/Multi-racial
G. Other _____
H. Unknown

APPENDIX E

Recruitment Letter to Program Directors

Recruitment Letter to Program Directors

Dear Program Director,

I am a doctoral student in the Psy.D Program at Pepperdine University. For my dissertation, I am examining supervisee countertransference or personal reaction disclosure within peer supervision and the role alliance plays in such disclosure. Peer supervision can be described as supervision-in-training and occurs in a one-on-one interaction. To my knowledge, this is the first empirical study on peer supervision in clinical and counseling psychology doctoral programs. I am contacting all directors of APA accredited clinical and counseling psychology doctoral programs and requesting their assistance with my study. This study has been approved by the Graduate and Professional Schools Institutional Review Board at Pepperdine University.

If your program has peer supervision for psychotherapy or counseling cases, I would very much appreciate if you would forward this email to your students. Participation from your students would involve completing an online survey about their experience with their current peer and primary supervisors, their comfort with sharing their reactions to hypothetical client situations with both supervisors, and their demographic information. Survey completion time is approximately 15 minutes; no identifying information will be requested regarding themselves or their academic and training programs.

The study poses no greater than minimal risk to participants, such as possible discomfort in reflecting on the supervision alliances or hypothetical client situations. In the unlikely event a participant were to experience discomfort in responding to the research questionnaires, I will recommend that participants discuss their reactions with their peer supervisor, primary supervisor, program director, director of clinical training, faculty member, or clinician whom they trust.

If you have questions or comments please do not hesitate to contact me at my email address XXXXX or my dissertation Chairperson, Dr. Edward Shafranske at XXXXX or Dr. Yuying Tsong, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600.

Thank you for your support with this study.

Sincerely,

Sara Mack, M. S.
Doctoral student, Clinical Psychology
Pepperdine University

APPENDIX F

Recruitment Letter to Participants

Recruitment Letter to Participants

Dear Psychology Doctoral Student:

I am a doctoral student in the Psy.D Program at Pepperdine University. For my dissertation, I am examining supervisee countertransference or personal reaction disclosure within peer supervision and the role alliance plays in such disclosure. Peer supervision can be described as supervision-in-training and occurs in a one-on-one interaction. It is a form of consultation in which more experienced peers provide (under supervision) many functions similar to those provided by the supervisor of record. I am requesting assistance with my study from doctoral students in all APA accredited clinical and counseling psychology doctoral programs. **However, if you have not had a peer supervisor for psychotherapy or counseling cases in the 2010-2011 academic year, then this study is not intended for you and you can delete this email at this point.**

I would very much appreciate your help in completing an online survey about your experience with your current peer and primary supervisors, your comfort with sharing your reactions to hypothetical client situations with both supervisors, and your demographic information. No identifying information will be requested on you or your academic and training programs. Survey completion time is approximately 15 minutes. Through your participation, you will have the opportunity to be entered in a drawing to win a $50 gift certificate to Amazon.com. It is not necessary to complete the survey in order to participate in the drawing. The study poses no greater than minimal risk to participants, such as possible discomfort in reflecting on the supervision alliances or hypothetical client situations. Please note that participation is voluntary. By completing the surveys you are acknowledging that you have been informed about the study and are giving your consent to participate. The surveys are on the website SurveyMonkey. A link to the web address of the surveys can be found at the end of this letter.

If you have questions or comments please do not hesitate to contact me at my email address XXXXX or my dissertation Chairperson, Dr. Edward Shafranske at XXXXX or Dr. Yuying Tsong, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600.

Thank you for your support with this study.

Sincerely,

Sara Mack, M. S.
Doctoral student, Clinical Psychology
Pepperdine University

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

APPENDIX G

Follow-up Letter to Program Directors

Follow-up Letter to Program Directors

Dear Program Director,

A few weeks ago, I had contacted you to request your assistance in forwarding this email to your students as I am recruiting participants for a study on peer supervision. I would like to take this opportunity to remind you of my study.

I am a doctoral student in the Psy.D Program at Pepperdine University. For my dissertation, I am examining supervisee countertransference or personal reaction disclosure within peer supervision and the role alliance plays in such disclosure. Peer supervision can be described as supervision-in-training and occurs in a one-on-one interaction. To my knowledge, this is the first empirical study on peer supervision in clinical and counseling psychology doctoral programs. I am contacting all directors of APA accredited clinical and counseling psychology doctoral programs and requesting their assistance with my study. This study has been approved by the Graduate and Professional Schools Institutional Review Board at Pepperdine University.

If your program has peer supervision for psychotherapy or counseling cases, I would very much appreciate if you would forward this email to your students. Participation from your students would involve completing an online survey about their experience with their current peer and primary supervisors, their comfort with sharing their reactions to hypothetical client situations with both supervisors, and their demographic information. Survey completion time is approximately 15 minutes; no identifying information will be requested regarding themselves or their academic and training programs.

The study poses no greater than minimal risk to participants, such as possible discomfort in reflecting on the supervision alliances or hypothetical client situations. In the unlikely event a participant were to experience discomfort in responding to the research questionnaires, I will recommend that participants discuss their reactions with their peer supervisor, primary supervisor, program director, director of clinical training, faculty member, or clinician whom they trust.

If you have questions or comments please do not hesitate to contact me at my email address XXXXX or my dissertation Chairperson, Dr. Edward Shafranske at XXXXX or Dr. Yuying Tsong, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600. Thank you for your support with this study.

Sincerely,

Sara Mack, M. S.
Doctoral student, Clinical Psychology
Pepperdine University

APPENDIX H

Introduction to the Survey and Consent to Participate

Introduction to the Survey and Consent to Participate

This survey examines supervisee countertransference or personal reaction disclosure within peer supervision and the role supervisory alliance plays in disclosure. The survey includes questions about my experience with my current peer supervisor and primary supervisor, my comfort with and likelihood of sharing my reactions to hypothetical client situations with both supervisors, and my demographic information. Survey completion time is approximately 15 minutes.

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. Although there are no direct benefits to all participants in this study, I understand that possible benefits may include reflecting on and gaining greater understanding of my supervisory relationships and my reactions to clients, which may improve my ability to manage these reactions. Furthermore, increased knowledge about peer supervision and trainees' disclosure of reactions to clients may contribute to a greater understanding of countertransference management for clinical training and the field of professional psychology.

Additionally, I understand that I may choose to enter a drawing to win a $50 gift certificate to Amazon.com. I also understand that it is not necessary to complete the survey in order to participate in the drawing. If I would like to be entered in the drawing, I must email XXXXX and type *Amazon* in the subject line. I understand that the researcher will randomly select one email address and will contact the individual by email to inform him or her that he or she has won the drawing. The winner will also receive an email from Amazon.com with a claim code for the gift certificate. I understand that my email address will not be linked to my survey responses. However, my anonymity as a participant will be compromised as the researcher may learn my identity if my entry is the winning entry.

I understand that participation in this study poses no greater than minimal risk and that I may decline to participate and/or discontinue participation at any time. Potential risks include emotional discomfort due to reflecting on my supervision alliances, my experience in supervision, or hypothetical client situations as well as slight fatigue or inconvenience. Should I experience any emotional discomfort or negative reactions to the survey, I understand that it is recommended that I discuss them with my peer supervisor, primary supervisor, program director, director of clinical training, faculty member, or clinician whom I trust.

If I have questions or comments I may contact the researcher at XXXXX or her dissertation Chairperson, Dr. Edward Shafranske at XXXXX or Dr. Yuying Tsong, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600.

Do you give your consent to participate?

☐ Yes, I understand that by checking the button to the left, I have voluntarily consented to participate in the research.

☐ No, I do not give my consent to participate.

APPENDIX I

Pepperdine IRB Application

PEPPERDINE IRB

APPLICATION FOR APPROVAL OF RESEARCH PROJECT

Date: 03/21/2011 IRB Application/Protocol #:

Principal Investigator: Sara Mack

☐ Faculty ☐ Staff ☒ Student ☐ Other

School/Unit: ☐ GSBM ☒ GSEP ☐ Seaver ☐ SOL ☐ SPP

☐ Administration ☐ Other:

Street Address:

City: State: Zip Code:

Telephone (work): Telephone (home):

Email Address:

Faculty Supervisor: Edward Shafranske, Ph.D., ABPP *(if applicable)*

School/Unit: ☐ GSBM ☒ GSEP ☐ Seaver ☐ SOL ☐ SPP

☐ Administration ☐ Other:

Telephone (work):

Email Address:

Project Title: Supervisory Alliance and Countertransference Disclosure in Peer Supervision

Type of Project (Check all that apply):

☒ Dissertation ☐ Thesis

☐ Undergraduate Research Study ☐ Independent

☐ Classroom Project Research ☐ Faculty

☐ Other:

Is the Faculty Supervisor Review Form attached? ☒ Yes ☐ No ☐ N/A

Has the investigator(s) completed education on research with human subjects? ☒ Yes ☐ No

Please attach certification form(s) to this application. See Attached

Is this an application for expedited review? ☒ Yes ☐ No

If so, please explain briefly, with reference to Appendix C of the Investigator's Manual.

This application is submitted for expedited review because the research presents no more than minimal risk to human subjects and employs a survey methodology. No identifying information will be collected and thus anonymity will be ensured. A request for a waiver of documentation of informed consent has been submitted. Implicit consent will be obtained when the participant completes the survey. Participation requires that the

participant verify that he or she understands the nature of the study as well as the potential risks and benefits of participation and that he or she voluntarily consents to participate.

1. Briefly summarize your proposed research project, and describe your research goals and objectives:

Supervision provides the essential foundation for the training of professionals in the mental health field (Bernard & Goodyear, 2009) and has the critical functions of assuring the integrity of clinical services and building competence in the supervisee (Falender & Shafranske, 2004). Among the competencies that are developed during clinical training is the ability to recognize and to appropriately respond to the impact of personal factors and therapist reactions on the therapeutic process. In addition to formal supervision, clinical training may include peer supervision, which is a developing trend in professional psychology (Bernard & Goodyear, 2009). Peer supervision serves as a form of consultation in which more experienced peers provide (under supervision) many (but not all) of the functions found in the supervision of record. One area in which peer supervision may play a particularly important role is in providing consultation specific to the management of personal reactions, heretofore referred to as countertransference. It is hypothesized that countertransference may be more readily disclosed and addressed by supervisees with their peer supervisors, as peers may provide additional support, validation, and connection (Butler & Constantine, 2006) without the threat of evaluation (Benshoff, 1994).

Substantial gaps exist in the literature on peer supervision. Little is known about the format of peer supervision in clinical and counseling psychology doctoral programs that lies between traditional supervision and consultation among classmates. Given the limited literature on peer supervision and the emphasis on clinical competence in the field, the purpose of this study is to provide the first empirical investigation of the impact of peer supervision with respect to the competency of countertransference management. Moreover, given the high rate of nondisclosure reported (Ladany et al., 1996; Yourman & Farber, 1996; Hess et al., 2008), this study aims to contribute as well to the empirical research on the relationship between supervisory alliance in general and countertransference disclosure (Daniel, 2008). In this study, peer supervision will be defined as an ongoing relationship in which a more senior trainee serves as a consultant to a less senior trainee. The primary supervisor will refer to the supervisor at the training site who is responsible for the supervisee's work and under whose license the supervisee practices.

Based on Daniel's (2008) finding that the supervisory alliance is related to the likelihood of and comfort with countertransference disclosure, it is hypothesized that this association exists in peer supervision. The following research hypotheses will be tested: (a) comfort level with countertransference disclosure in peer supervision is positively related to supervisory alliance; and (b) likelihood of countertransference disclosure in

peer supervision is positively related to supervisory alliance. The independent variable is the supervisory working alliance, and the dependent variables are the degree of comfort with and likelihood of countertransference disclosure. In a sample of doctoral-level clinical and counseling psychology peer supervisees, research questions will address the relationships between (a) the peer supervisee's perceived working alliance with the peer supervisor and his or her degree of comfort with and likelihood of countertransference disclosure, (b) the peer supervisee's perceived working alliance with the primary supervisor and his or her degree of comfort with and likelihood of countertransference disclosure, and (c) the peer supervisee's degree of comfort with and likelihood of countertransference disclosure to peer supervisor compared to primary supervisor. This study will involve a quantitative research design. A correlational approach will be used to study the relationship between supervisory alliance and countertransference disclosure. In addition to quantitative methods, this study includes a qualitative aspect. Participants will be invited to list factors that influence their disclosure in peer supervision and primary supervision.

2. Estimated Dates of Project:

From: 05/01/2011 To: 04/30/2012

3. Cooperating Institutions and Funded Research. Circle and explain below; provide address, telephone, supervisor as applicable.

3.1 ☐Yes ☒No This project is part of a research project involving investigators from other institutions.

3.2 ☐Yes ☒No Has this application been submitted to any other Institutional Review Board? If yes, provide name of committee, date, and decision. Attach a copy of the approval letter.

3.3 ☐Yes ☒No This project is funded by or cosponsored by an organization or institution other than Pepperdine University.

Internal Funding (indicate source):

External funding (indicate source):

Funding Status: ☐ Funded ☐ Pending Explain, if needed:

4. Subjects

4.1 Number of Subjects: minimum of 380 Ages: 23-72; based on demographic information provided by the Association of Psychology Postdoctoral and Internship Centers (APPIC) Match Survey (2009)

Discuss rationale for subject selection.

Participants will be students enrolled in clinical and counseling psychology doctoral programs accredited by the American Psychological Association (APA). Participants must have a peer supervisor and be currently engaged in supervised clinical experience. At present, there are 235 APA accredited clinical psychology doctoral programs and 69 APA accredited counseling psychology doctoral programs (APA, 2011). There is no available data, however, to determine the actual number of students enrolled in APA accredited clinical and counseling psychology doctoral programs or how many of these students have peer supervisors, as there is great variability in the number of students enrolled in each program and there have been no studies on peer supervision in APA accredited programs. For instance, APA accredited clinical psychology programs have an average of 15 incoming students (Norcross, Ellis, & Sayette, 2010), while APA accredited counseling psychology programs have, on average, 7 incoming students (Norcross, Evans, & Ellis, 2010). Nonetheless, programs that are more likely to have peer supervision are ones designed to focus on clinical training, such as member institutions of the National Council of Schools and Programs of Professional Psychology (NCSPP). A full member of NCSPP is defined as an "institution organized as a doctoral level professional school or program of psychology accredited by the American Psychological Association (APA)" (NCSPP, 2008). The total number of students in the NCSPP member programs was estimated to be $N = 7560$. This number was obtained by taking the average of five programs' first year cohort size for 2010 (listed on each program's website) and multiplying this number (30) by the total number of programs (63) to get 1890 first-year students. This number (1890) was multiplied by the estimated number of years in these programs prior to internship (4) to arrive at 7560. To have adequate power of 0.5 at 95% confidence level, a minimum of 380 participants is needed. This sample size was calculated using the formula $n= N/(1+N(e)^2)$, with p=.5 and +/- 5% variability (Israel, 2009).

During recruitment, program directors at all APA accredited clinical and counseling psychology doctoral programs will be emailed with the recruitment letter. It is unknown, however, whether directors will forward the study information to students. Therefore, this study may result in a smaller rate of return than the average response rate of 39.6% for Internet-based surveys (Cook, Heath, & Thompson, 2000).

4.2 Settings from which subjects will be recruited. Attach copies of all materials used to recruit subjects (e.g., flyers, advertisements, scripts, email messages):

Participants will be recruited from all APA accredited clinical and counseling psychology doctoral programs. According to The Commission on Accreditation's (CoA) *Guidelines and Principles for Accreditation of Programs in Professional*

Psychology, these programs provide training and preparation for practice that "should be based on the existing and evolving body of knowledge, skills, and competencies that define the declared substantive practice area(s) and should be well integrated with the broad theoretical and scientific foundations of the discipline and field of psychology in general" (APA, 2007, p. 3). Recruitment will be conducted via email contact with program directors (*see Appendix A*). Directors will be asked to forward a recruitment letter (*see Appendix B*) to students in their program via email. Three weeks after the recruitment letter is emailed to program directors, a follow-up email will be sent to directors as a reminder to forward the recruitment letter to their students *(see Appendix C)*.

4.3 Criteria for inclusion and exclusion of subjects:

These criteria must be met for inclusion in this study: (a) must be a student enrolled in an APA accredited clinical or counseling psychology doctoral program, (b) have a peer supervisor, and (c) be currently engaged in supervised clinical experience. The only criterion for exclusion is lack of Internet access.

4.4 ☒Yes ☐No Will access to subjects be gained through cooperating institutions? If so, discuss your procedures for gaining permission for cooperating individuals and/or institutions, and attach documentation of permission. **You must obtain and document permission to recruit subjects from each site**.

Program directors will give implicit permission to recruit participants by forwarding through email the invitation to participate to students in their program.

4.5 ☐Yes ☒No Will subjects receive compensation for participation? If so, discuss your procedures.

As an incentive to complete the questionnaires, participants will have the opportunity to be entered in a drawing for a $50 gift certificate to Amazon.com. This statement will be included on the final page of the survey: "If you would like to be entered in the drawing for a $50 gift certificate to Amazon.com, please email XXXXX and type *Amazon* in the subject line. The researcher will randomly select one email address and will contact the individual by email to inform him or her that he or she has won the drawing. The winner will also receive an email from Amazon.com with a claim code for the gift certificate. Your email address will not be linked to your survey responses. However, your anonymity as a participant will be compromised as the researcher may learn your identity."

After the study has been completed, the researcher will randomly select one email address to be the winner of the drawing. The researcher will email the individual to inform him or her that he or she has won the drawing. The individual will also

receive an email from Amazon.com with a claim code for the gift certificate. The winner will receive the following email:

"CONGRATULATIONS! You are the winner of a $50 gift certificate to Amazon.com. You provided your email adress to me after you completed the questionnaires for my study. You will receive an email from Amazon.com with a claim code for the gift certificate. I will delete your email address after I receive confirmation that you have received the gift certificate from Amazon.com. Thank you again for your participation in my dissertation research on peer supervision, supervisory alliance, and therapist personal reaction disclosure. If you have questions or concerns, please email me at XXXXX"

4.6 Describe the method by which subjects will be selected and for assuring that their participation is voluntary.

Recruitment will be conducted via email contact with program directors. Directors will be asked to forward a recruitment letter to students in their program via email. Three weeks after the recruitment letter is emailed to program directors, a follow-up email will be sent to directors as a reminder to forward the recruitment letter to their students. The recruitment letter to participants states, "Please note that participation is voluntary. By completing the surveys you are acknowledging that you have been informed about the study and are giving your consent to participate." The letter provides a link to the web address of the survey. Data collection is separate from the recruitment letter, which allows individuals time to review the letter prior to accessing the survey.

At the beginning of the survey, there will be a statement of introduction and consent to participate (*see Appendix D*), in which the individual must confirm that he or she understands that he or she is voluntarily consenting to participate in the research. Implicit consent will be obtained when the participant completes the survey. Participation will imply that the participant volunteers to complete the survey and comprehends the nature of the research as well as the risks and benefits of participation (Daniel, 2008). Additionally, participation in the drawing for the gift certificate is voluntary.

5. Interventions and Procedures to Which the Subject May Be Exposed

5.1 Describe specific procedures, instruments, tests, measures, and interventions to which the subjects may be exposed through participation in the research project. Attach copies of all surveys, questionnaires, or tests being administered.

A survey instrument will be developed to collect data via online administration. The survey will include the Working Alliance Inventory-Supervisee Form, the Reaction Disclosure Questionnaire, and a Demographic Questionnaire (*see Appendices E-G*). Recruitment will commence in May 2011; the investigator

anticipates emailing program directors within the first three weeks of May 2011. Program directors will be asked to forward a recruitment letter to students in their program via email. The recruitment letter will contain a link to the website SurveyMonkey.com, an online service that will hold the questionnaires. Potential participants will be informed of the purpose of the study, the procedures, possible risks and benefits of participation, right to confidentiality, steps taken to maintain confidentiality, and their right to decline to participate or leave the study at any time. In addition, as an incentive to complete the questionnaires, participants will be informed of the opportunity to be entered in a drawing for a $50 gift certificate to Amazon.com. At the beginning of the survey, there will be a statement of introduction and consent to participate. Implicit consent will be obtained when the participant completes the survey. The following measures will be included:

Working Alliance Inventory-Supervisee form (WAI-S). This self-report instrument, developed by Bahrick (1990), assesses the strength of the supervisory working alliance. Bahrick adapted the instrument from Horvath and Greenberg's (1989) Working Alliance Inventory (WAI), the most recognized measure of therapeutic alliance (Bernard & Goodyear, 2009). The WAI-S has 36 items with three subscales of 12 items that relate to the alliance components of goals, tasks, and bond. Participants rate how they think or feel about their supervisor for each item using a 7-point Likert-type scale from 1 ("Never") to 7 ("Always"). Inter-rater reliability of the Working Alliance Inventory/Supervision has been established: 97.6% agreement for items assessing the bond factor, 60% agreement for items assessing the goals factor, and 64% agreement for items assessing the tasks factor (Bahrick, 1990). Although face validity has been established, no other psychometric properties have been tested (Daniel, 2008). Yet, given the importance of the supervisory relationship, numerous studies have utilized this instrument (e.g., Daniel, 2008; Ladany, Ellis, & Friedlander, 1999; Ladany & Friedlander, 1995; Ladany, Lehrman-Waterman, Molinaro & Wolgast, 1999). Permission has been given by Bahrick to use and modify the instrument for this study *(see Appendix H)*. Therefore, items refer to "peer supervisor/peer supervision" rather than "supervisor/supervision" on the form completed for the peer supervisor. The directions have also been modified to request that participants select the peer supervisor and primary supervisor with whom they spend the most time if they have multiple peer and primary supervisors. The overall working alliance score will be the independent variable.

Reaction Disclosure Questionnaire. This self-report instrument was developed by Daniel (2008) to assess the supervisee's comfort with and likelihood of disclosing countertransference feelings and behaviors to his or her primary supervisor in eight hypothetical countertransference situations. Participants rate their comfort with disclosing their reactions to their clients to their primary supervisor and also how likely they would be to do so. The instrument uses a Likert scale from 1 ("extremely uncomfortable" or "extremely unlikely") to 7 ("extremely comfortable" or "extremely likely"). Hypothetical situations were used to control for variance in participants' prior experiences of

countertransference as well as to reduce the chance of a participant having a negative reaction while responding to the questionnaire. The items were developed based on existing measures of countertransference (i.e., Inventory of Countertransference Behavior, ICB, Friedman & Gelso, 2000; Countertransference Questionnaire, Betan, Heim, Conklin, & Westen, 2005) and represent frequent manifestations of countertransference across theoretical orientations. On the Reaction Disclosure Questionnaire, countertransference is referred to as "personal reactions" in order to obtain responses from individuals of various theoretical orientations. Face validity was established through a pilot study, but reliability has not been demonstrated (Daniel, 2008).

In this study, likelihood of disclosing reactions and comfort in disclosing will be the dependent variables. Permission has been given by Daniel to use and modify the instrument for this study *(see Appendix I)*. This investigator has changed "supervisor" to "peer supervisor" on the form completed in reference to the peer supervisor. Participants are instructed to select the peer supervisor and primary supervisor with whom they spend the most time if they have multiple supervisors. Also, they are asked to consider their likelihood of and comfort with disclosing in one-on-one interactions.

Demographics questionnaire. This questionnaire was developed by the investigator and consists of questions inquiring about participants' demographic information and experience in supervision. The following information is requested: the trainee's type of degree program, degree sought, year in program, duration and frequency of both peer supervision and primary supervision received from August 2010 through April 2011, expectations regarding confidentiality of disclosure in peer supervision, and whether negative consequences have occurred from disclosure in peer supervision. In addition, the trainee's theoretical orientation, gender, and race/ethnicity, as well as the peer and primary supervisors' theoretical orientation, gender, and race/ethnicity are requested. The questionnaire has forced-choice items with a blank section for participants to provide supplementary information if the response "other" is endorsed. Blank space also is provided for participants to write in factors that have influenced their disclosure in peer supervision. Demographic items are based on information available from the 2009 Association of Psychology Postdoctoral and Internship Centers (APPIC) Match Survey (APPIC, 2009) and the APA 2010 Graduate Study in Psychology (Hart, Wicherski, & Kohout, 2010).

5.2 ☐Yes ☒No Are any drugs, medical devices or procedures involved in this study? Explain below.

5.3 ☐Yes ☒No No Are the drugs, medical devices or procedures to be used approved by the FDA for the same purpose for which they will be used in this study? Explain below.

5.4 ☐Yes ☒No Does your study fall under HIPAA? Explain below. No individually identifiable health information will be requested in this investigation.

6. Describe all possible risks to the subject, whether or not you consider them to be risks of ordinary life, and describe the precautions that will be taken to minimize risks. The concept of risk goes beyond physical risk and includes risks to the subject's dignity and self-respect, as well as psychological, emotional, and behavioral risk. Discuss the procedures you plan to follow in the case of adverse or unexpected events.

This study has been designed to present no more than minimal risk to participants. However, a potential risk is that some participants may experience discomfort if their current alliance with their peer or primary supervisor is not optimal, or they may be reminded of previous supervisory relationships. Since discussions about alliance should take place in supervision, new negative feelings arising from study participation are not anticipated. Indeed, participants are expected to reflect on alliance and their personal reactions to clients in the context of clinical training (Daniel, 2008). Even though hypothetical situations will be provided to prevent emotionally distressing reactions from being triggered by past and present clinical experiences, there is the possibility that participants may have an uncomfortable reaction. Other risks may include slight fatigue or inconvenience due to the time needed to complete the survey. If participants do experience any negative reactions, they will be directed to discuss them with their peer supervisor, primary supervisor, program director, director of clinical training, faculty member, or clinician whom they trust. The above-mentioned risks and procedures to follow in the event of negative reactions are included in the Introduction to the Survey and Consent to Participate statement.

7. Describe the potential benefits to the subject and society.

Although there are no direct benefits to all participants in this study, participants may experience the benefit of reflecting on and gaining greater understanding of their alliance with their peer supervisor and primary supervisor. They may also benefit from reflecting on and gaining greater understanding of their reactions to clients (Daniel, 2008). This may improve their ability to manage these reactions, which is a clinical competence. Furthermore, increased knowledge about peer supervision and trainees' disclosure of reactions to clients may contribute to a greater understanding of countertransference management for clinical training and the field of professional psychology.

8. Informed Consent and Confidentiality and Security of the Data

8.1 ☒Yes ☐No Is a waiver of or alteration to the informed consent process being sought? If yes, please attach the **Application for Waiver or Alteration of Informed Consent Procedures form.** If not, describe the ability of the subject to give informed consent. Explain through what procedures will informed consent be assured.

See Attached.

8.2 Attach a copy of the consent form. Review the *Instructions for Documentation of Informed Consent* in Section VII.A of the Investigator Manual.

8.3 ☐Yes ☒No Is the subject a child? If yes, describe the procedures and attach the form for assent to participate.

8.4 ☐Yes ☒No Is the subject a member of another vulnerable population? (i.e., individuals with mental or cognitive disabilities, educationally or economically disadvantaged persons, pregnant women, and prisoners). If yes, describe the procedures involved with obtaining informed consent from individuals in this population.

8.5 If HIPAA applies to your study, attach a copy of the certification that the investigator(s) has completed the HIPAA educational component. Describe your procedures for obtaining Authorization from participants. Attach a copy of the Covered Entity's HIPAA Authorization and Revocation of Authorization forms to be used in your study (see Section XI. of the Investigator Manual for forms to use if the CE does not provide such forms). If you are seeking to use or disclose PHI without Authorization, please attach the **Application for Use or Disclosure of PHI Without Authorization** form (see Section XI). Review the HIPAA procedures in Section X. of the Investigator Manual.

Not applicable.

8.6 Describe the procedures through which anonymity or confidentiality of the subjects will be maintained during and after the data collection and in the reporting of the findings. Confidentiality or anonymity is required unless subjects give written permission that their data may be identified.

The investigator will utilize the online service SurveyMonkey (available at http://www.surveymonkey.com/) to conduct the survey. The website enables the investigator to create a survey in which the responses are anonymous, that is, the website will not request or track any personal information, and the survey will be configured so that no IP addresses are tracked.

If participants choose to enter the drawing to win the Amazon.com gift certificate, their anonymity will be compromised, as they will need to email the investigator from their email address. If during the drawing the participant's email address is randomly selected as the winner, the investigator will send an email informing the participant that he or she has won. In addition, an email from Amazon.com will

be sent to the participant's email address with the claim code for the gift certificate. Throughout the study, any email addresses will be kept confidential, and all participant email addresses will be deleted after the gift certificate has been awarded.

During data collection, data will be kept on the investigator's password protected computer and a USB flash drive. Following study completion, data will be stored on a USB flash drive and kept by the investigator in a locked file for 5 years; the data files will then be destroyed.

8.7 Describe the procedures through which the security of the data will be maintained.

During data collection, data will be kept on the investigator's password protected computer and a USB flash drive. Following study completion, data will be stored on a USB flash drive and kept by the investigator in a locked file for 5 years; the data files will then be destroyed.

I hereby certify that I am familiar with federal and professional standards for conducting research with human subjects and that I will comply with these standards. The above information is correct to the best of my knowledge, and I shall adhere to the procedure as described. If a change in procedures becomes necessary I shall submit an amended application to the IRB and await approval prior to implementing any new procedures. If any problems involving human subjects occur, I shall immediately notify the IRB Chairperson. I understand that research protocols can be approved for no longer than 1 year. I understand that my protocol will undergo continuing review by the IRB until the study is completed, and that it is my responsibility to submit for an extension of this protocol if my study extends beyond the initial authorization period.