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Disclosure of personal reactions that occur during therapy to supervisors and supervisory alliance among marriage and family therapy trainees and interns

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DISCLOSURE OF PERSONAL REACTIONS THAT OCCUR DURING THERAPY TO SUPERVISORS AND SUPERVISORY ALLIANCE AMONG MARRIAGE AND FAMILY THERAPY TRAINEES AND INTERNS

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by

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DEDICATION

This dissertation is dedicated to “the girls” Jeanne Billings, Marge Lollick and Miriam Busse. The wisdom, inspiration and love you gave me remains a cornerstone in my life. I miss you and wish I had more time with you, but you all have inspired me to keep growing, keep learning, keep working, and to never, never, give up.

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ABSTRACT

The purpose of this study was to investigate the likelihood of disclosure and comfort in disclosure of personal reactions occurring in the conduct of psychotherapy in the clinical supervision of marriage and family therapy trainees and interns/associates. This study replicated and expanded on Pakdaman, Shafranske and Falender 's (2014) and Daniel's (2008) analog studies of the effects of supervisory alliance on self-reported comfort and likelihood of disclosure of personal reactions in therapy with psychology interns and trainees. This study also investigated the relationship between working alliance and experiences of isomorphism and parallel process. There were a total of 161 participants; 56 trainees and 105 interns. The majority of the participants identified as female, Caucasian and heterosexual. Results indicated if trainees have a strong working alliance with their supervisor, they would feel safe and supported when sharing they are having personal reactions in therapy and if they feel isomorphism or parallel process is occurring. The results of this study have implications for supervision of marriage and family therapy therapists and possibly the field of mental health in general, as results were replicated from previous studies. The implications of the results are further explored.

Introduction

Clinical training provides opportunities to graduate students and interns to learn how to apply knowledge and skills acquired in graduate education in professional practice. Clinical supervision, which serves as the centerpiece of training, ensures the welfare of the client while simultaneously assisting the supervisee to develop clinical competence (Falender and Shafranske, 2004, Falender, Shafranske, and Falicov, 2014). The ability to recognize and manage personal reactions when conducting psychotherapy is one of the competencies that are developed in clinical supervision. A first step in developing this skill is the willingness of the supervisee to disclose and discuss in supervision instances when conducting psychotherapy that involved his or her personal reactions. Studies (Daniel, 2008; Pakdaman, Shafranske and Falender, 2014) have found that supervisory alliance influences the likelihood of psychology graduate students and supervisees to disclose and to feel comfortable in disclosing personal reactions. While previous studies have focused on psychology trainees, it is of interest to examine the role of alliance in countertransference disclosure in clinical supervision of other mental health professionals given the differences in profession and training. This study, employing an analog methodology, investigates the likelihood of disclosure and comfort in disclosure of personal reactions occurring in the conduct of psychotherapy in the clinical supervision of marriage and family therapy trainees and interns/associates.

Background

Marriage and Family Therapy

The American Association for Marriage and Family Therapy (AAMFT) has defined marriage and family therapists as "mental health professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems" (AAMFT, 2007). Marriage and Family Therapists (MFT's) are one of the biggest treatment providers in the United States, treating 1.8 million people at any given time (AAMFT, n.d.). Harper-Jacques and Limacher (2009) asserted that other mental health disciplines, such as clinical psychology, social work, and psychiatry, tend to focus on the individual in treatment. MFT's focus on how family and ecological systems affect client challenges and form their treatment based on systemic theory. MFT coursework is focused on human development, family studies, and clinical practice, whereas psychologists receive more training in psychological assessment and research. MFT's have specialized training in treating families. They can treat severe mental illness but are less likely to than psychologists.

Clinical Supervision

Clinical supervision is widely recognized as playing the central role in the training of a psychologist (Falender and Shafranske, 2010) and other mental health professionals. As defined by Bernard and Goodyear (2014), supervision is "an intervention provided by a more senior member of a profession to more junior member or members of that same profession" (p. 9). Ungar (2006) defines supervision as "the sharing of wisdom… while also intervening and building relationships that further the goals of good clinical practice (p. 62).

In addition to monitoring the client welfare, supervision aims to develop competence and professionalism (Falender and Shafranske, 2007). Competency is defined as skills, values and

knowledge (Falender, et. al., 2004, p. 773). Competency "involves the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein et. al. 2000, as cited in Falender and Shafranske, 2007).

Clinical supervision in marriage and family therapy. AAMFT formalized standards for training clinical supervisors in 1971 (Bernard, 2006, p.11). The AAMFT Supervision Responsibilities and Guidelines for AAMFT Approved Supervisors states that a supervisor is responsible to "evaluate the MFT's/MFT trainee's knowledge of systems theory, family development, particular family issues, gender and cultural issues, systemic approaches and interventions, human development, human sexuality, and ethical responsibilities" (AAMFT, 2007, p.12).

The AAMFT has identified 128 competencies in the practice of marriage and family therapy (AAMFT, 2004). Six of those competencies refer to supervision. AAMFT Approved Supervisors are expected to meet learning objectives that reflect the core competencies. One of these learning objectives is the facilitation and evaluation of "co-evolving therapist-client and supervisor-therapist-client relationships" (AAMFT, 2007, p.5). While building a supervisor-supervisee relationship, the supervisor must also attend to other responsibilities, which include ensuring proper and ethical client care.

AAMFT approved supervisors. The AAMFT has created a program, the Approved Supervisor program, in which supervisors are trained, certified, and approved to provide supervision to MFT trainees and interns. They are "mentors who support and nurture their supervisees' strengths and resources, and provide a learning environment that ensures thorough marriage and family therapy (MFT) training and education" (AAMFT, 2007, p. 3). To become

an Approved Supervisor, one must have a degree in marriage and family therapy or a related field, or complete two years of a marriage and family therapy doctoral program. Candidates to become Approved Supervisors complete courses on supervision and gain experience in supervision while being mentored by another Approved Supervisor for a minimum of 18 months (AAMFT, 2007). Candidates also must obtain two years of clinical experience after MFT licensure or after two receiving AAMFT Clinical Membership (AAMFT, 2007).

Approved supervisors are expected to meet learning objectives that reflect the core competencies. These learning objectives include knowledge of MFT models and the ability to create a model of supervision that uses pre-existing models and theory. The learning objectives also include facilitation and evaluation of "co-evolving therapist-client and supervisor-therapist-client relationships" (AAMFT, 2007, p. 5). The AAMFT Supervision Responsibilities and Guidelines for AAMFT Approved Supervisors states that a supervisor is responsible for evaluating the "MFT trainee's knowledge of systems theory, family development, particular family issues, gender and cultural issues, systemic approaches and interventions, human development, human sexuality, and ethical responsibilities" (AAMFT, 2007, p.12). While the profession aims for training to be conducted by certified supervisors, not all supervisors or marriage and family therapy trainees are supervised by AAMFT Approved Supervisors or even marriage and family therapists. Although laws are different in each state, licensed mental health professionals such as licensed clinical social workers, psychologists, and psychiatrists can supervise MFT trainees in many states. Therefore, not all MFT supervisors are held to the same standards of training for supervision, which may lead to differing training experiences for trainees.

Systemic supervision. One distinction between supervision of MFTs and psychologists is that the majority of MFT training programs use systemic theories to guide supervision (Carlson and Lambie, 2012, p.29). Developmental approaches are often employed in the training of psychologists whereas, Carlson and Lambie (2012) reported that they did not find any research on "the use of developmental supervisory approaches within family systems models" (p. 29). In contract to developmental models, which focus on the individual, systemic approaches consider systems, including supervision as a form of system. Lee and Nelson (2014) describe that system models are relational models. With relational models there is a belief that problems are not within the individual, but "different social settings and relationships increase the probability of desire and undesirable ideas, feelings, behaviors and interactional dynamics" (p. 41). In short, the client's challenges are not caused necessarily by a pathological or characterological issue within the client, but a symptom of how the client is responding to the systems around them. This is different than clinical models, which ascribe to a belief that a person's challenges can be due to a disorder or their personality. Systems models focus on "context and reciprocity" (Lee and Nelson, p. 41), rather than internal and individualistic issues.

Montgomery, Hendricks, and Bradley (2001) assert that there are three themes to all systemic theories. The first is that the family and social system should be the primary focus of change, rather than the individual. Focusing on the individual's diagnosis limits conceptualization of the individual's challenges and makes change difficult to create and maintain. In other words, if the systems that possibly contribute to the client's challenges aren't involved in the treatment, even through conceptualization, then change will be difficult to achieve. Second, the problem at hand should be considered within the familial and social context. When viewing the problem in its context, the supervisor and supervisee avoid "labeling

individuals (or families) as pathological or problematic" (Montgomery, et. al., 2001, p. 308). People don't exist outside of the context of their lives, and these circumstances can cause challenges (Nichols, 2008). Therefore, the third theme is that in order to create change, the whole system should be of focus in treatment. Because the therapist is involved in the family's lives in treatment, they become part of the family system (Ali and Bachicha, 2012, p. 306).

Systems-focused supervision differs from individually orientated supervision in several ways. First, the supervisor provides instruction on systemic concepts. Second, the supervisor helps the supervisee understand how they have joined the family system. "All of these systems (the family system, the family-in-therapy system, and the supervision system) interact and influence one another" (Montgomery, et. al., 2001, p. 309). Due to his or her joining, the therapist will experience personal reactions, and those reactions will influence the family system (as well as the supervision system). Third, and possibly most importantly, systemic supervisors acknowledge, "supervision is embedded in and continually affected by a complex web of intersecting therapeutic, professional, and personal relationships" (Todd and Storm, 2014, p. 4). Systemic supervisors consider how the supervisee-supervisor and client-therapist, along with other relational systems, are related and affect each other (Todd and Storm, 2014, p. 4). Systemic supervisors focus on "incorporating systemic concepts such as context, isomorphism, relationship/interaction, multiple views, co-construction, complexity, self-reflexivity, and interconnection promotes a systemic/relational change process" (Todd and Storm, 2014, p. 6). This integration impacts the process of learning and the relationships involved in the therapeutic process.

Psychotherapist Personal Reactions

The therapist's personal reactions or countertransference to his or her client has been of clinical and training interest among the mental health professions. Virginia Satir (1987) succinctly observed, “it is easy to respond to a patient as though he or she is someone else in one’s past or present, and if one is not aware that this going on it will needlessly complicate the situation” (1987, p. 21). Kiesler (2001), writing from a clinical psychology perspective, defined countertransference as the “therapists' unconscious, preconscious, and conscious experiences and feelings registered in reaction to their clients, as well as to therapists' verbal and nonverbal actions observed with clients during their sessions” (p. 1062). While the term countertransference was created and used by psychoanalysts, terms such as *use of self* and *person of the therapist* were created by and are used by family therapists in reference to personal reactions that the majority of family systems theorists acknowledge the factor of the therapist’s preconscious and unconscious in the interaction with family systems (Feld, 1982). For example, many theorists, including Minuchin and Satir, use the phrase *use of self* or *person of the therapist*, rather than the *countertransference* to described personal reactions of therapists. According to Rober (1999) the use of self “refers to the experiencing process of the therapist and reflects the therapist as a human being and a participant in the conversation” (p. 4). Rober noted that the use of self includes their observations as well as “his imagination (the emotions, images, associations, and so on, that are evoked by his observations)” (1999, p. 4). The self includes not only the psychological events that influence the person’s life (Aponte, et. al. 2009), but is also culturally created due to the inevitable impact culture has on the formation of worldview (Simon, 2006). Cheon and Murphy (2007) also voiced that the self is culturally constructed, so therapists must investigate and understand their values, assumptions, and biases. Jackson and Weakland

(1971) asserted that countertransference and transference should only be considered in analysis and don't apply to family therapy. The purpose of describing both countertransference and use of self/person of the therapist is not to make distinctions between the two concepts, but to shed light on how both of these concepts describe personal reactions of therapists. To further illustrate the importance of understanding personal reactions in therapists, both concepts are reviewed.

Countertransference. Countertransference was first mentioned by Freud in 1910. He viewed countertransference as a result of the patient's influence on the therapist's unconscious, which the therapist must "recognize and overcome" (Freud, 1910, p. 144). Freud's initial beliefs resulted in the position that countertransference is a negative occurrence in treatment and must be rid of (or at least managed) in order for treatment to be successful. However, over time, understanding of the construct has evolved and today countertransference is viewed as an important informer of the therapeutic process (Gabbard, 2001). A review of the literature [see Appendix C] found that the definition of countertransference has changed from Freud's original view to include not only the therapist's personal reactions to the client, but the inter-relational factors involved in the therapeutic relationship. The different views of countertransference include, but are not limited to, the totalistic perspective, the relational/constructivist perspective, the complementary view, and the transtheoretical view. Winnicott (1949), also argued countertransference is useful and contended that therapist will react to the patient in the same manner that others will in the patient's life. Those who follow the totalistic view of countertransference agree that countertransference is a component of the transference and can be an indication of the patient's psychological structure. Therefore, it can be a valuable tool for the therapist to understand the patient. The relational/constructivist view of countertransference asserts countertransference is a jointly created experience by the patient and clinician (Gabbard,

2001, p. 984). Those who ascribe to this theory believe that viewing transference and countertransference in the classic/narrow view takes away the analysts responsibility in the interaction. Relational/Constructivist therapists freely examine both the transference and countertransference with their clients. Another understanding of countertransference, discussed by Levenson (2010) and Racker (1988), is the complementary view of countertransference. The complementary view of countertransference is that the therapist's reactions are associated with the client's relational patterns (Hayes, Gelso, and Hummel, 2011). Kiesler (2001) stated countertransference is the "therapists' unconscious, preconscious, and conscious experiences and feelings registered in reaction to their clients, as well as to therapists' verbal and nonverbal actions observed with clients during their sessions" (p. 1062). Kiesler (2001) summarizes that there are two types of countertransference; subjective and objective countertransference. Subjective countertransference is reactions to the client that reflect the unmet needs of the therapist, which can be harmful to the client if, not understood by the therapist. Objective countertransference is the reaction of the therapist to the unmet needs of the client, which can provide information about the client's interpersonal world and be used in therapy to create change (p. 1057). The key to differentiating between subjective and objective countertransference is found in the therapist discerning whether or not his or her reactions are different reactions to other clients as well as if the reactions are similar to reactions of others towards the client.

Use of self. Murray Bowen (1978) was the first theorist to discuss the person as the therapist by sharing his experiences of his use of self in therapy (Aponte, 1987). Bowen advocated for therapists to understand their family dynamics in order to understand how those dynamics affect their participation and experience of other family systems. Although Bowen was

the first publically to describe his use of self in therapy, he has certainly not been the last to describe the usefulness of the use of self in treatment. Notably, Virginia Satir, Carl Whitaker, Salvador Minuchin and Jay Haley all discussed the importance of use of self in therapy (Aponte, 1987). Although these theorists and therapists agree that therapists should engage in use of self in therapy, they do not all agree on how the self should be used in treatment. Additionally they do not agree how therapists should be trained to use the self in treatment.

Two of the theorists who most discussed use of self in therapy were Bowen and Satir. Bowen believed that family problems are due to the family being an *undifferentiated ego mass* in which family members have not differentiated themselves from the family as a whole. This leads to confusion, emotional reactivity, and triangulation, which is the tendency for family members to seek resolve of conflicts from a third party (Feld, 1982; Nichols, 2008). The therapist must keep himself/herself differentiated while working with the family and, therefore, must be either neutral or distant from the family's process to avoid becoming part of the undifferentiated ego mass. Virginia Satir stated "use of the self by the therapist is an integral component of the therapeutic process, and it should be used consciously for treatment purposes" (1987, p. 22). Therefore, Satir only self-disclosed when trying to create a connection with a client or to strengthen her empathy with a client (Lum, 2002). Satir believed that therapists should strive to be congruent with themselves (Lum, 2002, p. 182). When therapists are congruent they can be fully engaged and present with the client, as well as feel "a state of peaceful harmony" within themselves (Lum, 2002, p. 182). To remain congruent, the therapist needs to engage in consistent self-assessment and development of self-awareness of their internal processes (Lum, 2002). Congruence is shown when a therapist can accept their feelings as they are and can set aside judgments and reactions but still be fully present with the client.

Countertransference in family therapy. Although systems therapists may not use the term countertransference to describe personal reactions in therapy, there still exists some research on countertransference in family therapy. Family therapists use countertransference "to understand unspoken family rules or systems of object relations" (Kiesler, 2001, p.1058). Feld (1982) defines countertransference in family therapy as "the family therapist's preconscious perception of the family he or she is treating as if it were his/her family of origin". Halperin (1991) asserted that family therapists can be reminded of their family dynamics while working with families, or the family unconsciously elicits certain reactions from the therapist.

Management of Personal Reactions

Management of countertransference. Countertransference management has been correlated with therapy outcome (Friedman and Gelso, 2000). Hayes, et. al. (2011) noted thought that there is a lack of research connecting countertransference to distal outcomes of psychotherapy. Nearly all the research focuses on immediate outcomes (Hayes, et. al., 2011). Nevertheless, research on the outcomes of countertransference is useful in understanding the possible impact countertransference can have on client care.

Hayes and Gelso (2001) stated countertransference can help therapists gain insight about the client. They also reported that discussing countertransference "can offset the power imbalance inherent in the therapy relationship, deepen the therapeutic alliance, and provide the client with a sense of universality" (p. 1048). But, when countertransference is poorly managed and becomes a countertransference behavior, the client and therapist will have difficulties agreeing on the goals and tasks of therapy "and have difficulties forming a close emotional bond", leading to a weaker alliance (Hayes and Gelso, 2001, p.1049). Therapist countertransference can result in "errors of perception; wrong decisions about treatment; an

inability to reflect thoughtfully and objectively; emotional distancing from the client; avoidance of or under involvement with a client's areas of concern; over-involvement with clients", as well as lack of empathy for the client (Kiesler, 2001, p. 105). As Kiesler (2001) notes, rejecting the presence of countertransference can lead the therapist to not detect or attend to a client's interpersonal issues as influencing the therapeutic as well as other relationships, which would be a significant omission in therapy.

Five qualities essential to managing countertransference include "self-insight, self-integration, conceptualizing ability, empathy, and anxiety management" (Friedman and Gelso, 2000, p.1223). Countertransference management involves both self-insight and self-integration. Self-insight refers to the awareness about areas of unresolved conflict. Self-integration is the degree in which those conflicts are resolved. Clients with therapists who were better able to manage their countertransference made more improvements in therapy. Additionally, strong therapeutic alliances "mitigated the negative effects of the countertransference" (Hayes, et. al., 2011, p.92). Therapists who are healthier and more self-integrated have fewer countertransference reactions and better outcomes with their clients (Hayes and Gelso, 2001).

Management of use of self. Timm and Blow (1999) emphasized that the person as the therapist issues are seen as *red flags* in literature, ways in which therapists personal experiences can negatively impact the work with their clients. Cheon and Murphy summarized Satir in stating that "therapists should be in touch with, be aware of, and be monitoring the self in order to recognize the variety of reactions to clients' problems" (2007, p. 4). Timm and Blow summarized similar concerns, describing when therapists who do not understand their selves, they set themselves up for "superficial therapeutic relationships, ineffective interventions, burn-out, and simply poor service" (1999, p. 336). Roberto (1997) summarized that when therapists

are reminded of their own family impasses they experience “anxiety, less responsive in sessions, feeling shut down affectively and cognitively, distress" and tend to engage in "premature closure of topics", and have "difficulties setting or following up on therapeutic assignments” (p. 168).

Timm and Blow (1999) asserted that the therapist’s experiences, even those that are traumatic, can help the therapist identify and connect with the clients. Cheon and Murphy (2007) emphasized that in order to use the self in therapy, the therapist must be able and willing to allow him/herself to face their vulnerability and tolerate ambiguity. To gain knowledge and understanding of the self, therapists engage in their therapy, supervision, and consultation (Aponte, 1992; Cheon and Murphy, 2007; Timm and Blow, 1999).

Aponte (1987) summarized that the family systems theorists are divided into two camps in their opinions on how training for the use of self should be addressed. The first camp believes that training should focus on technical skills and that involving the personal life of the therapist can be inappropriate. Aponte (1987) stated that those in this camp, including Salvador Minuchin and Jay Haley, were concerned that looking carefully at the trainee’s personal life violates boundaries. The second camp, including Bowen and Satir, endorsed focusing on the trainee’s own reactions in training to allow trainees to assess those reactions, and teach them how to interpret these reactions and use these reactions during interventions with the client (Aponte, 1994). Aponte created the Person/Practice Model to mold a training program focused on helping trainees with the use of self. In this model, trainees engage in personal exploration through interventions such as genograms, interviewing their families and making timelines of their lives.

Ethics and management of personal reactions. Ethical care of clients includes awareness and management of personal reactions of therapists. In fact, a competence for MFT’s defined by the American Association for Marriage and Family Therapy (AAMFT) is the

"evaluation of (therapist) reactions to the treatment process and their impact on effective intervention and clinical outcomes" (AAMFT, 2007, p. 5). As stated by Kiesler (2001, p. 1059) "training requires sophisticated discovery and identification of the distinctive client and therapist behaviors involved". Supervision can be the arena in which clinicians can learn to manage countertransference and use these reactions to inform and positively impact treatment. It is clear that when personal reactions are not managed properly, they not only can be counterproductive in therapy, but also can impede a client's growth in therapy. Therefore, it is important for trainees to learn to manage personal reactions in supervision.

Disclosure of Personal Reactions in Supervision

Self disclosure in supervision is important in helping supervisors become aware of the goals of the trainee, as well as the developmental level of the trainee and growth areas of the trainee (Inman, et. al., 2011). Ladany, Hill, Corbett, and Nutt (1996) discovered that 97.2% of supervisees withheld information from their supervisors, including both positive and negative reactions to clients. Content of nondisclosure included personal issues, clinical mistakes, both positive negative reactions to the supervisor, sexual transference, opinions about the attraction of the supervisor, and concerns about evaluation (Ladany, et. al.,1996). Reasons for nondisclosure included impression management, belief that the supervisor would not be helpful, concern the alliance with the supervisor was not strong enough, or that the "the issue to be unimportant, too personal, or involving feelings that were too negative," (Ladany, et. al., 1996, p.14). There also may be a cultural factor within therapists. Hayes and Gelso (2001) noted that there exists a taboo about countertransference; Good therapists don't have countertransference. Therefore, trainees may not report countertransference in fear that they will not be perceived to be a good therapist.

Nondisclosure is related to the supervisory relationship. Research has shown that supervisees are concerned about the power differential in the supervisor-supervisee relationship, concerned about evaluation, and question if their supervisor will respect confidentiality in supervision (Inman, et. al., 2011). These concerns can lead to nondisclosure. Additionally, the trainees' satisfaction with their relationship with their supervisor and "ability to choose their supervisor is related to disclosure" (Inman, et. al., 2011, p.150). Ninety percent of the participants in Ladany et. al.'s study (1996) reported that they didn't disclose because of possible negative reactions their supervisors may experience. When trainees didn't talk about the client issues with their supervisor, the tended to talk about the issue with a friend or peer (Ladany et. al., 1996), which is concerning due to possible violations of client confidentiality.

Working Alliance

The supervisory alliance refers to "the collaborative partnership between supervisor and supervisee" (Todd and Storm, 2014, p. 170) and is necessary to ensure client welfare (Falender, Shafranske, and Falicov, 2014; Shafranske and Falender, in press). AAMFT core competencies, including research and evaluation, sensitivity to culture and diversity, and therapeutic interventions involve supervisory working alliance. Holloway (1987) noted that the supervisory relationship might be the most critical aspect of allowing the supervisee to move towards independence. Supervisors need to have the ability to create and maintain a supervisory working alliance (Falender and Shafranske, 2010) for effective supervision to occur (Chen and Bernstein, 2000). The concept of the supervisory alliance is based on Bordin's (1979) theory of therapeutic alliance [Appendix B]. The supervisory working alliance consists of three components; a mutual agreement between the trainee and supervisor about the goals and tasks of supervision and "an emotional bond between the trainee and supervisor" (Ladany, p. 5, 2004). Ladany, Ellis and

Friedlander (1999) noted that most supervisors use more than one model of supervision, but the supervisory alliance is a common factor in supervision not matter what model is used.

Working alliance and personal reactions. Ligiero and Gelso (2002) asserted that working alliance is affected by both positive and negative countertransference. In Ligiero and Gelso's study (2002), when a trainee experienced more countertransference with a client, the supervisor and trainee were more likely to disagree about the strength of the bond between client and therapist, which can elicit even more countertransference with the client. Ladany, Ellis, and Friedlander (1999) noted that a stronger bond seems to be related with comfort in self-disclosure during supervision, but in supervisor supervisee dyads with a weak alliance, the trainee is more likely to not disclose events with clients to the supervisor (Ladany, 2004; Ladany, et. al., 1996). In an analog study of pre-doctoral psychology interns, Daniel (2008), found that supervisory alliance and supervisee comfort and likelihood in disclosing countertransference reactions were related. Daniel postulated that the ability of the supervisor to normalize countertransference would be a factor that would strengthen the supervisory alliance. Pakdaman, Shafranske and Falender (2014) replicated Daniel's research by examining the relationship between working alliance and countertransference disclosure with psychology trainees as well as doctoral interns and. She also found a relationship between supervisory alliance and likelihood and comfort in disclosing countertransference.

Parallel Process and Isomorphism

In supervision, the concepts of isomorphism and parallel process can be used to understand transference and countertransference. Parallel process and isomorphism are often used interchangeably, but they have different "historical roots" (Koltz, Odegard, Feit, Provose, and Smith, 2012, p. 233). The concept of parallel process was introduced by psychodynamic

theorists, but the concept of isomorphism was introduced by systems theorists (Koltz, et. al. 2012). Both concepts describe replications of interpersonal and interrelational patterns.

"Isomorphism… was proposed as a framework for doing systemic supervision" (Roberts, Winek, and Mulgrew, 1999, p. 293). Isomorphism refers to when a structural pattern between counseling and supervision is replicated "at the client/family level, therapist/trainee level, and supervisory level in both directions" (Weir, 2009, p. 61). When isomorphism is occurring, the client counselor relationship will be replicated in the supervisor trainee relationship or vise versa. Due to this symbiotic relationship, the supervisor can use isomorphism as an intervention to help the trainee change the system. There are 3 types of isomorphism: coercive, mimetic, normative (DiMaggio and Powell, 1991, as cited in Wier, 2009). Mimetic isomorphism, the type of isomorphism most focused on in literature on marriage and family therapy, is when patterns in relationships are mimicked in other relationships. Todd and Storm (2014) note that understanding isomorphism can lead to understanding of client problems and guide treatment, as isomorphism is a concept found in most systemic theories.

Parallel process is an occurrence in which the therapeutic relationship between client-therapist relationship is replayed in the supervisory relationship. Ladany et. al. (2000) state that parallel process can aid the supervisor and therapist in understanding the client-therapist relationship. "Parallel process is an intrapsychic phenomenon that unconsciously occurs on the part of the supervisee and originates in a relationship in one setting and is reflected in a relationship in a different setting" (Koltz, et. al., 2012, p. 233). When parallel process is occurring, a supervisee will unconsciously play out a client's characteristic with the supervisor. Wheeler and Richards (2007) note that parallel process can help supervisees therapist understand

negative transference and countertransference issues when managed effectively by supervisors and explored in supervision.

Koltz et. al. (2012) asserted that parallel process and isomorphism are different concepts Parallel process focuses on intrapsychic dynamic in which the supervisee will adopt a particular characteristic of the client as his/her own or identifies with the client, while isomorphism is defined as a repeated relational pattern between client and therapist with the supervisor and supervisee. He provided an example. A client is angry with the therapist because the therapist confronts the client. If parallel process is occurring the therapist would be angry with their supervisor if the supervisor confronts the therapist or makes suggestions. If isomorphism is occurring, the structural elements of the relationship between therapist and client would be replayed. For example, if the therapist usually ignore the client's anger and doesn't provide feedback, then the supervisor would ignore the supervisee while talking about this client. Bernard and Goodyear (2014) describe that the concepts "are two sides of the same coin" (p. 137) and research is needed to determine if they are actually different.

Purpose and Importance of Study

The current study is based on the research of Daniel (2008), Pakdaman, Shafranske and Falender (2014), which examined the role of supervisory alliance on countertransference disclosure among psychology trainees (Pakdaman, Shafranske and Falender; Shafranske & Falender, in press). Due to the major role that MFTs have in the field of mental health, as well as the importance of supervision in the training of MFTs, it is beneficial to understand the relationship between supervisory working alliance and disclosure of personal reactions in supervision in this population. This information not only aids MFT supervisors, trainees and interns/associates in creating working alliances, but also helps build understanding of possible

differences in supervisory working alliance and disclosure of personal reactions in supervision between MFT trainees, MFT interns/associates, psychology trainees and psychology interns.

Method

Research Approach and Design

This study replicated and expanded on Pakdaman, Shafranske and Falender 's (2014) and Daniel's (2008) analog studies of the effects of supervisory alliance on self-reported comfort and likelihood of disclosure of countertransference. Unlike the investigations of Pakdaman, Shafranske and Falender (2014) and Daniel (2008), this study had a different sample by focusing on marriage and family therapy trainees rather than psychology trainees and interns. Replication of research is an important aspect of scientific research, as a sound study will be able to be replicated with similar results (Chow, 2010). Replication is an important step in the experimental method because it helps determine if results are reliable, if they can be applied, and are generalizable (Chow, 2010). If the results of this study were similar to the results of Pakdaman, Shafranske and Falender and Daniel, then it can be understood that supervisory alliance is related to the self-reported comfort and likelihood of disclosure of personal reactions in therapy in supervision, not only with psychology trainees and interns, but in marriage and family trainees and interns/associates as well. Any differences would lead to consideration of the role theoretical orientation might have on disclosure of countertransference (such as the MFT emphasis on systems theory). Given that MFT's treat a large number of patients in mental health, it is important to understand how personal reactions in therapy and supervisory alliance are related in order to build competence in management of personal reactions and improve training of MFTs.

This study is an analog study. There are benefits and limitations of analog studies, studies that simulate real life situations without actually subjecting participants to the situations themselves (Glossary/Lexicon, 2015). In this study, participants are asked to respond to

hypothetical situations involving countertransference without observing their reactions in real time or subjecting them to the situations themselves According to Weiner and Craighead (2010), analog studies are useful because they allow for researchers to simulate a real world situation while controlling external variables. In this study, each participant answers questions about the same hypothetical situations. The limitations of analog studies though, include that the phenomenon studies is not actually occurring. Therefore, we cannot fully claim that the hypothetical situations would elicit the same reactions as if the participants were experiencing countertransference in real life. Despite this limitation, the analog study allows research to be conducted when replicating a real world phenomenon or situation may cause discomfort to participants and also may be difficult to replicate with every participant.

Pakdaman, Shafranske and Falender (2014) added the variable of developmental level of the psychology trainees in her study. She operationalized developmental level as the years of clinical psychotherapy experience a trainee has accrued. Additionally, Pakdaman, Shafranske and Falender (2014) took supervisory developmental level in account in her study. This study will not be investigating developmental level because the participants will be only marriage and family trainees. Marriage and family therapy supervisors are less likely to use the developmental model for supervision (Carlson and Lambie, 2012). Therefore, this study will not measure developmental level. This study addressed the concepts of isomorphism and parallel process though, as these concepts have driven supervision and isomorphism is an important aspect of systemic theory. As Weir (2009) said, the literature on isomorphism is limited, despite how isomorphism can affect treatment and supervision. It is the hope that this study added to the understanding of isomorphism in training.

Research Hypotheses

The following research hypotheses were tested:

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

Instrumentation

To remain true to the purpose of a replication study, this study used the same instruments as Pakdaman, Shafranske and Falender (2014), who built upon Daniel's original study (2008). The survey was comprised of a participant demographic questionnaire, the Working Alliance Inventory-Supervisee Form (WAI-S), and the Countertransference Reaction Disclosure Questionnaire. To expand Pakdaman, Shafranske and Falender 's and Daniel's studies questions focusing on isomorphism and family therapy were added to the Countertransference Reaction Disclosure Questionnaire.

Working Alliance Inventory Supervisee form. Bahrick (1990) created the Working Alliance Inventory-Supervisee form (WAI-S) and adapted it from Horvath and Greenberg's Working Alliance Inventory (WAI). The WAI measured the working alliance between client and therapist. The WAI has adequate reliability (Horvath and Greenberg, 1989). Items on the WAI were designed to "capture a feeling, sensation, or attitude in the client's field of awareness that may be present or absent depending on the strength of one of the components of Bordin's concept of the working alliance" (Horvath and Greenberg, 1989, p. 225). An important aspect to the WAI is that it was designed to be void of theoretical orientation, as Bordin's theory is said to be void of orientation as well. The WAI has two forms, one for the client and one for the

therapist.

Bahrick (1990) formed the WAI-S to measure the working alliance between the supervisor and supervisee. The WAI-S includes two forms, one for the supervisee and one for the supervisor, but only the supervisee form will be used in this study. Like the WAI, the WAI-S was formulated to be void of theoretical orientation. Bahrick (1990) changed the WAI to make it applicable for supervision by changing the words "therapist" and "client" to "supervisor" and "supervisee". "Client problems" was changed to "supervisee issues" and "supervisee concerns" (Bahrick, 1990). The WAI-S is comprised of 36 statements, with each aspect of the working alliance, the bond, task and goals, assigned 12 questions. Like the WAI, the WAI-S is also measured through a likert scale. Bahrick (1990) found a 97.6% interrater reliability for the bonds aspect, 64% for the tasks aspect and 60% for the goal aspect. There have not been additional tests on the reliability of the WAI-S. Audrey Bahrick granted permission to use the WAI-S in this study (See Appendix H).

Countertransference Reaction Disclosure Questionnaire. The Countertransference Reaction Disclosure Questionnaire was created by Daniel (2008) to assess supervisee's comfort in disclosing countertransference reactions, which include behaviors and feelings, to their supervisor. The comfort in disclosure is measured through 8 hypothetical situations that were created based on literature about countertransference. Specifically, Daniel used Betan, Heim, Conklin, and Westen's Countertransference Questionnaire (2005) as a model for the Countertransference Reaction Disclosure Questionnaire. A factor analysis of Betan et. al.'s (2005) study revealed 8 common situations, including "1) overwhelmed/disorganized, 2) helpless/inadequate, 3) positive, 4) special/overinvolved, 5) sexualized, 6) disengaged, 7) parental/protective, and 8) mistreated/criticized" (Pakdaman, Shafranske and Falender , 2014).

Hypothetical situations were created from these factors in order to avoid asking trainees about their specific experiences of countertransference feelings and behaviors, which would possibly create discomfort for the participants, as well as "negative affect states" (Daniel, 2008). The Countertransference Reaction Disclosure Questionnaire was created to be independent from any specific theoretical orientation. After reading each scenario, the participant rates how comfortable and likely they are to disclose countertransference reactions on a 7 point Likert-scale. One question was added regarding countertransference in family therapy. This question was formed to reflect Kielser's (2001) definition of countertransference in family therapy.

Three questions were added to the Countertransference Reaction Disclosure Questionnaire. Questions were formed based on the definitions of isomorphism and parallel process. The questioned were aimed to reflect the replication of relational patterns in supervision and treatment. These questions are also on a 7 point Likert-scale and scored the same manner as the Countertransference Reaction Disclosure Questionnaire.

Demographic questionnaire. A demographics questionnaire was developed (based on Pakdaman, Shafranske and Falender , 2014), but expanded to reflect possible differences in demographic information of marriage and family therapists from the American Association of Marriage and Family Therapists webpage and Approved Supervisor Handbook (2007). Questions were added such as type of supervision received (group or individual), type of degree and license their supervisor has obtained, and time spent engaging in family and couples therapy. There were 21 demographic questions that were in multiple-choice format for the survey to the CAMFTE students (Appendix F). Additional questions were added to the survey for interns and trainees not in CAMFTE programs (Appendix G and Appendix H). These questions included questions about their status as trainee or intern, as well as a question about graduating from a

CAMFTE accredited program for interns.

Research Procedures

The following sections describe the procedures used in participant recruitment, protection of the participants, and the administration of the survey.

Participant recruitment. Participants were recruited through 4 different approaches: (1) Contacting COMAFTE directors of training by email twice and asking them to disseminate the survey through email to their students; (2) Posts on online AAMFT Community forums; (3) Facebook posts in groups for MFTs, MFT trainees and MFT interns/associates; and (4) Direct mail to MFT interns in California to participate either by mail and online. The initial recruitment did not yield sufficient responses; therefore additional, avenues of recruitment were implemented.

Addresses for registered interns were purchased through the BBS. The interns were provided a stamped and addressed envelope to send the completed survey back to the investigator. Interns also had the option of completing the survey online. Interns were not asked to write any personal identifying information on the questionnaire or on the envelope so they remained anonymous. Four hundred of the 15,844 interns from California were sent letters due to limited funding. Participants were randomly selected. Twenty-two interns sent back paper surveys to the investigator. Information was not available regarding the number of interns, who received the survey by mail but completed the survey online.

Participants. Eligible participants included MFT trainees and interns/associates. Only MFT Trainees who advanced to trainee status by completing the necessary coursework to begin to practice psychotherapy while under supervision by a licensed clinician were eligible for the study. All MFT interns or associates were also invited to participate. Interns and associates were

defined as those who have graduated from MFT programs and are currently accruing hours to be eligible for licensure through providing therapy under supervision. Participants were required to currently be working at a training site. There were a total of 161 participants; 56 trainees and 105 interns. Fourteen participants consented to the study but did not begin the study. They were not included in the analyses. The majority of the trainees and interns identified as female, Caucasian and heterosexual. Please see tables 1 and 2 for participant data.

Training experiences and theoretical orientation. A majority of trainees either worked in a university counseling center or community counseling center. The remaining participants worked in school districts, private outpatient clinics and hospitals. Half of participants worked with a combination of adults, children and spent more than half of their time conducting individual therapy. About half of the participants reported they spent less than 25% of their time conducting family therapy. Participants varied in their theoretical orientations but most ascribed to one branch of family systems therapy. The trainees varied in their clinical experience, but the majority had less than a year of experience. They also varied in the time they spent with their supervisor, but the majority had spent less than 9 months at their current site. Over half of them had spent less than 6 months with their current supervisor. About half of the participants received 1-2 hours of individual supervision per week and over half of the participants (56.8%) received 1-2 hours of group supervision per week.

Over a quarter of the interns worked at training at a community counseling center. Approximately one third of the interns reported they worked with adults, while another quarter worked with children/adolescents and another quarter worked with a combination of adults, children, adolescents and families. A majority of interns spent at the most 75% - Over half of the interns reported they spend less than 25% of their time conducting family therapy. Over 75%

percent of the interns reported that they spend less than 25% of their time conducting couples therapy. In regards to theoretical orientation, 31.5% of the interns reported that their primary theoretical orientation was cognitive behavioral, with the next two highest rated orientations as existential/humanistic and psychodynamic. In regards to clinical experience, over half of the interns had over 24 months of clinical experience and had spent 12 or more months at their current site with their current supervisor. About half of the CA interns received 1-2 hours of individual supervision each week and 1-2 hours of group supervision per week.

Supervisor characteristics. Over half of the trainee's supervisors were female and Caucasian. A majority of the participants believed that their supervisor identified as the same sexual orientation. Twenty-three supervisors had a PhD degree and a large majority were licensed marriage and family therapists.

The interns reported that the majority of their supervisors were female and Caucasian. Over half of the interns believed that they were of the same sexual orientation as their supervisors and about half of the interns reported that their supervisor had an MFT degree and were licensed as marriage and family therapists. In regards to the supervisor's theoretical orientation, the three orientations that were most reported were cognitive behavioral psychodynamic and existential/humanistic. Less than half of the intern's supervisors were AAMFT approved supervisors.

Human subjects protection. Prior to recruitment of participants and data collection, the Pepperdine Institutional Review Board reviewed the study to ensure the safety of the participants and ensure the study follows the Ethical Principles and Guidelines for the Protection of Human Subjects of Research as stated by the Belmont Report, U.S. Supervisory Alliance 22 Code of Regulations, DHHS (CFR) Title 45, Part 46: Entitled Protection of Human Subjects, and Parts

160 and 164: Standards for Privacy if Individually Identifiable Health Information and the California Protection of Human Subjects in Medical Experimentation Act (United States Department of Health and Human Services, 1979). An expedited review was sought because there only existed a minimal possibility that participants would experience discomfort in response to answering questions about the hypothetical scenarios.

Consent for participation. On the website that contains the instruments for this study, the first page explained the study's purpose, the intent of the study, and potential risks and benefits of participation. The participants were notified in the informed consent that they could withdraw participation in the study at any point and could refuse to participate (See Appendix D and Appendix E). Participants were also notified of the steps the researcher is taking to protect their confidentiality. The participants consented by checking a box that said they agreed to participate in the study and understood the risks, benefits and nature of the study. No personally identified information of the participants was collected on any of the research measures. Participants who filled out the paper survey were sent a copy of the consent form and consented by writing a check on a line that said they agree to participate in the study (Appendix E).

Potential benefits and risks. There were no direct benefits to participating in this study, but participants may have felt satisfied knowing that their participation in this study may have added to the clinical literature about supervision, working alliance and countertransference. By completing this study, participants may have also reflected on their own experiences in supervision and with countertransference, which may have aided them in understanding their own experiences. A possible benefit of participation is that participants had the option of entering a drawing from which they may have won one of four $30 gift cards to Amazon.com upon completion of the study. When participants completed the survey, they had the option of

sending an email to an address that was created solely to obtain participant emails for the drawing. Survey data was not connected to the participant's emails in any way. After the study was complete and the gift cards were sent to the drawing winners, the emails from participants were deleted and the email account was discontinued. No records of email addresses were kept.

There existed no more than minimal risk to participants in this study. To protect the participants, the researcher made every attempt to reduce possible risk in participating in this study. The supervisee was not asked for any information about their supervisor. It is likely that supervisees will be discussing the alliance in their evaluations of their supervisors and therefore, filling out the WAI-S was not be a novel experience. Although it is unlikely a participant would feel discomfort while filling out the WAI-S, filling out the WAI-S may have reminded the participant of negative experiences with supervisors, which could have caused some discomfort. Discussion of countertransference is common in supervision and often is uncomfortable to process with supervisors. Therefore, filling out the Reactions Questionnaire may cause some discomfort. The Reactions Questionnaire was based on common reactions of therapists (Betan, et. al. 2005) and presented through hypothetical scenarios in order to allow participants to report on common countertransference reactions without providing personal information or examples. Despite these attempts to reduce risk, there was a possibility that participants may have reacted to the measures. If such a reaction occurred, participants were encouraged to discuss these reactions with clinicians at their training site, with their director of training, or with a faculty member. They were also given the contact information for the chair of this dissertation, Edward Shafranske, Ph.D., ABPP, who could have provided the participant with a referral for a psychotherapist or consultant, if needed.

Data collection and recording. The investigator contacted by email the clinical training directors of all COAMFTE accredited programs and asked them to forward to their students the recruitment email that contained the link to the study. The clinical training directors did not receive information regarding if their students participated in the study or results their student's surveys. Participants in the survey remained anonymous and therefore, the data was anonymous. All files regarding study results will be stored on the researcher's computer and protected by a password.

The participants who participated by completing paper surveys and mailing the survey to the investigator were asked in the recruitment letter to not put any personally identifying information on the survey or envelope when they sent the survey back to the investigator (See Appendix J). The participants who were recruited through Facebook and the AAMFT Forums were also not asked for any personal information and their Facebook profiles or AAMFT membership were note connected to the survey in any way. All data will be destroyed 5 years after completion of the research analysis.

Results

The data was compiled by the Internet-based survey company and transferred into a statistical software package (SPSS 22). The surveys that were obtained via mail were coded and inputted into the data file by the researcher. Prior to computing frequencies and descriptive analyses, data was reviewed for missing item patterns, outliers, and whether the sample approximated a normal distribution and was appropriate for the proposed analyses. Data was organized by type of trainee. Two types of groups provided information regarding the survey items; trainees and interns/associates. A total of 161 participants started the Internet-based survey and 147 completed the survey.

Descriptive Analyses

Each component of the WAI-S, i.e., bond, task and goal, were measured. The data for the WAI-S components was normally distributed (See Table 3). Comfort in disclosing personal reactions and likelihood of disclosing personal reactions were each examined in three ways. First, descriptive statistics were run using the 8 question original scale. Second, the isomorphism/parallel process questions were examined. Third, the original questionnaire and the isomorphism/parallel process questions were examined. (See Table 5). Through a visual inspection of the data for the factor of sexualized countertransference in the Countertransference Reaction Disclosure Questionnaire it appears that there is a significant difference between sexualized countertransference and the other types of countertransference.

Correlations

Pearson product moment correlations were conducted to determine examine the relationships between the WAI-S components of task, goal and bond. Results indicated a significant positive relationship between each of the WAI-S components in all three groups (see

Table 5). Pearson product moment correlations were also conducted to determine whether there was a relationship between the level of comfort and likelihood of disclosing countertransference. Results indicated that there was a strong positive relationship between likelihood and comfort of disclosure for all three groups (see Table 5, Table 6 and Table 7).

Research Hypotheses

This section presents the results of statistical analyses designed to test the following hypotheses:

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

Pearson product moment correlations (Pearson R) were conducted to test the hypotheses (see Table 5, Table 6, Table 7, Table 8 and Table 9). For the whole sample, as well as trainees and interns separately, trainees and interns, results showed positive associations between each component of supervisory alliance and reported comfort and likelihood of disclosure. In regards to the whole sample, relationships were found between the WAIS task component and level of comfort, $r(127) = .436$, $p = .01$, WAIS task and level of likelihood of disclosing $r(127) = .472$, $p = .01$. Relationships were found between the WAIS goal component and the level of likelihood of disclosing countertransference $r(127) = .430$, $p = .01$ and the WAI-S goal component and the comfort of disclosing countertransference, $r(127) = .420$, $p = .01$. Finally, relationships were found between the WAIS bond component and the level of likelihood of disclosing countertransference $r(127) = .621$, $p = .01$ and the WAI-S bond component and the comfort of disclosing countertransference, $r(127) = .570$, $p = .01$. These results may have been affected by

the small sample size and therefore may not represent an accurate depiction of these relationships.

Isomorphism and Parallel Process

Given that the isomorphism/parallel process questions were created for this study and added to the Countertransference Reaction Disclosure Questionnaire, Pearson product moment correlations were calculated with the original 8 question questionnaire, the original questionnaire with the isomorphism/parallel process questions, and only the 3 isomorphism/parallel process questions to see if the addition of the isomorphism/parallel process questionnaire affected results. With the trainees and interns, significant results were found between each WAI-S component and likelihood and comfort in disclosure with the original 8 item Countertransference Reaction Disclosure Questionnaire, the Countertransference Reaction Disclosure Questionnaire and isomorphism/parallel process questions together, and the isomorphism/parallel process questions (see Table 9).

Demographics, Working Alliance and Personal Reactions

Additional analyses were performed to examine the effects of individual differences in the supervisory relationship, such as similarity in gender, on comfort and likelihood of disclosure and supervisory alliance. No significant differences were found in respect to similarity of sexual orientation, ethnicity, or gender. A one-way ANOVA was used to investigate if the months of total clinical experience affected comfort and likelihood of disclosure and no significant differences were found. A one-way ANOVA was calculated to investigate if theoretical orientation impacted countertransference disclosure and no significant differences were found. Finally, an independent samples t-test was used to examine if the match of theoretical orientation

between supervisor and supervisee was related to comfort and likelihood of countertransference disclosure. No significant results were found.

A one-way ANOVA was calculated to examine if the type of site the intern/trainee worked at affected the intern/trainees comfort and likelihood of countertransference disclosure. A one way analysis of variance showed that the effect of training site was significant for disclosure (11 item scale), $F(8,114) = 2.096$, $p = .042$. Post hoc analyses using the Scheffé post hoc criterion for significance indicated that those individuals who were less likely to disclose countertransference ($M = 40.5$, $SD = 26.16$) worked at correctional facilities. It should be noted though that only 2 participants reported that they worked in correctional facilities.

Each type of countertransference was examined in relation to demographic variables of gender, sexual orientation and ethnicity. A relationship between every type of countertransference and these variables was not found, except between gender of supervisor and sexualized countertransference. Results indicated that if the supervisor was male, the supervisees were less likely to disclose sexualized countertransference $r(127) = .643$, $p = .05$.

Discussion

This study investigated the relationship between the supervisory working alliance and the likelihood and comfort in disclosure of countertransference reactions of MFT Interns/Associates and MFT trainees using an analog research design. The stronger the reported supervisory working alliance was, the more likely the interns and trainees were to disclose countertransference reactions and the more comfort they felt in disclosing those reactions.

Relationships were also found between WAI-S components and isomorphism/parallel process for the trainees and interns. This may suggest that likelihood of disclosing personal reactions related to isomorphism and parallel process, as well as comfort in disclosing these reactions are positively related to working alliance. Based on these results, if trainees have a strong working alliance with their supervisor, they would feel safe and supported when sharing if they feel isomorphism or parallel process is occurring. Results also may suggest that the questions of isomorphism/parallel process were similar to the questions about countertransference. These findings are important because it illustrates that there is not only a relationship between supervisory working alliance and comfort and likelihood in disclosing countertransference but there are also relationships between the supervisory working relationship and comfort and likelihood of disclosure with parallel process and isomorphism. These results also suggest that supervisory experiences in regards to supervisory working alliance and disclosure of countertransference may not be very different between psychology interns, psychology trainees, MFT interns, and MFT trainees.

This study was a replication study of Daniels (2008) and Pakdaman, Shafranske and Falender (2014). This study replicated the results of both Pakdaman, Shafranske and Falender (see Table 6 for comparison chart), but also built upon their studies by focusing on marriage and

family therapist trainees and interns/associates and investigating the relationship between supervisory working alliance and isomorphism/parallel process. These results are congruent with other studies focused on supervisory working alliance and personal reactions in therapy. Daniels' (2008) and Pakdaman, Shafranske and Falender ’s (2014) studies were replicated, but with a different population. As Chow (2010) notes, replication of research studies tests in part whether results can be generalized. Daniel’s study was replicated twice with consistent results.

Additionally, a significant relationship was found between likelihood of disclosing sexualized countertransference in therapy and supervisor gender. When the supervisor was male, the supervisee was less likely to disclose sexualized countertransference. Pakdaman, Shafranske and Falender (2014) found that male trainees were more likely to report sexualized countertransference; however, this difference was not found in this study. The majority of participants in Pakdaman, Shafranske and Falender ’s (2014) study and this study were female, perhaps given the relatively small number of male participants.

Ladany et. al. (1996) found that sexual countertransference is one of the most common topics not disclosed in supervision. Ladany et. al. (1996) summarized that a reason why sexual countertransference was not disclosed was because trainees did not feel it was important to discuss their attraction to their clients. Harris (2001) conducted a study with trainees from COAMFTE accredited programs. In his study, he found that one third of the trainees would not tell a colleague about their sexual attraction towards clients in fear that the colleague would report them for making an ethical violation (Harris, 2001). These studies, as well as other studies focused on sexual countertransference, though, did not examine how gender of the supervisor influenced disclosure. Carneiro, Russon, Moncrief and Wilkins (2012) described that there exists a “taboo” about sexual attraction towards clients that “perpetuates a cycle of shame” so therapists

do not disclose their attraction towards clients. Carniero et. al. (2012) postulated that due to gender roles, female therapists feel less power in society and in relationships with males, which may lead to nondisclosure. Ponton and Sauerheber (2014) described that examining sexual attraction towards clients can be disturbing for both trainee and supervisor. Given that the majority of participants were female and given they may be affected by gender roles, it is possible that having a male supervisor would inhibit the supervisee from disclosing sexual attraction towards clients. It is important that supervisors are highly aware of the tendency for trainees to not disclose sexualized countertransference so they may not only work towards creating safety in the supervisory relationship so the trainee can share if they are experiencing sexualized countertransference, but also so the supervisor can have a heightened awareness if the trainee may be experiencing sexualized countertransference so the supervisor can address the subject in supervision. Heightened awareness of the presence of sexualized countertransference and of the tendency for trainees to not disclose sexualized countertransference may help the supervisor aid the supervisee in addressing the countertransference so it is not acted upon.

Implications

The replication of Daniels' (2008) and Pakdaman, Shafranske and Falender ’s (2014) studies with a different population of mental health professionals brings to light that there may be similarities in training of mental health professionals despite different models of supervision. This study illustrates that working alliance and countertransference disclosure are related in training of mental health professionals, both psychologists and MFTs.

This study also may bring to question if there are distinct differences in training or if there is a convergence between the different fields of mental health in regards to training. As mentioned in the literature review, MFT’s conduct therapy in multiple settings, just as other

mental health professionals do. Perhaps there may be an overlap in jobs between the different disciplines. It is interesting though that many of the supervisors theoretical orientations in this study were not systemic theories. It is unclear if the supervisors identified as systemic supervisors, even if they had MFT degrees. As Todd and Storm (2014) noted "most supervisors become more integrative as a result of their increased supervisory competency and by incorporating additional ideas, as the practice of supervision evolves and changes occur in the wider context" (p. 6). This integration may lead to more similarities in training. Lee, Nichols, Nichols, and Odom (2004) found in a survey of AAMFT Approved Supervisors that few of the supervisors "were informed by a singular model" and described themselves as eclectic or integrative" (p. 63). As the supervisor leads to supervisee in determining treatment, this integration and convergence of theories may impact the course of treatment. Will the supervisor encourage the supervisee to notice isomorphism and systemic influences? Or will they emphasize more so the use of evidence based practices? As noted by Todd and Storm (2014), supervisors make choices in supervision that affect what the trainee does with the client.

Another salient question is are MFTs informing their practice on systemic theory? With the rise of evidence based practice and the push for clinicians to use evidence based practices, can MFTs still use systemic theory to inform practice? These are questions to be considered and possibly an area of future research.

There are many implications of this study for supervision. First, it is important for supervisors to focus on creating a safe working environment to build working alliance with the trainee in order to allow supervisees a space to process the reactions they have in therapy. Secondly, as isomorphism and parallel process were related to working alliance, it highlights the importance of addressing these concepts in supervision so the trainee can use them to inform

practice.

As described by Todd and Storm (2014), a supervision contract can create guidelines for supervision. While creating that contract, whether verbal or written, asking a trainee about what would make them feel safe in supervision can build trust. Lee and Nelson (2014) found that there are four qualities of supervision that allow for safety in disclosure include "confidentiality, attentive and respectful listening, alertness for microaggression, and allowing trainees the right to pass on sharing" (p. 11-12). Todd and Storm (2014) assert that open communication between supervisor and supervisee about what the supervisee wants to share about their personal histories is crucial. They describe that supervisors are held to honoring whatever limits supervisees chose while being clear about the confidentiality of supervision. Lee and Nelson (2014) expand upon the importance of open communication by noting that both the supervisor and trainee must feel comfortable in sharing personal part of themselves.

Lee and Nelson (2014) suggest that supervisors begin supervision by discussing the ideas that the supervisor and supervisee have about the content and process of supervision to not only determine if the supervisor and supervisee are a good fit, but to set some goals and expectations for the supervisory experience. Topics to cover in this discussion can include the supervisor and supervisee's beliefs about the purpose of therapy, how change is made in therapy and what the job of a therapist is.

Limitations

There are several limitations to this study. The first is that the number of participants was small, considering that there are 23,586 interns in California alone (Board of Behavioral Sciences, 2015). Therefore, claims of representativeness of the data are compromised in light of the response rate.

The second limitation was related to recruitment; when the study was first conducted with CAMFT trainees, the trainees were not directly recruited, but the training directors of programs were asked to send the link of the study. It is unknown how many training directors actually forwarded the study to their students. It was also unclear how many trainees and interns read the advertisements on social media.

It was unclear if the training in California for MFT interns differed from training in other states. Therefore, it must be taken in consideration that the majority of the participants in this study were from a specific geographic location.

The majority of the participants and their supervisors identified as White and Heterosexual. Therefore, these results may not be generalizable for supervisees and supervisors who do not identify as heterosexual, female and white. The lack of diversity is a salient limitation in this study. Overall, there is a lack of research focused on race and ethnicity and working alliance and disclosure of personal reactions in supervision (Weiling and Mashall, 1999). Lawless, Gale and Bacigalupe (2001) reported that there is a lack of empirical research focused on race and ethnicity in MFT supervision. With a lack of diversity in the research, it is unclear how ethnic and racial differences can affect working alliance and likelihood and comfort in disclosing personal reactions, so the research may not be generalizable to all trainees. The lack of research focused on race and ethnicity is an issue in the field and may leave supervisors less prepared to help non-Caucasian supervisees. Weiling and Marshall (1999) found that 75% of the supervisees they surveyed had never had a supervisor that was from a different race or ethnic background, but wished they did because they believed having a supervisor from a different ethnic background would help them build cultural competency, which is a core competency for marriage and family therapists (American Association for Marriage and Family Therapy, 2004).

Another limitation is that this study is an analog study. As discussed in the methods section, although analog studies allow researchers to study theories and situations wherein exposing a participant to a real life situation may be discomforting for the participant, the analog study is a simulation of a situation or phenomenon. In other words, with analog studies there is most always a concern about external validity (Kazdin, 1978). It is possible that participants may respond differently to countertransference reactions if they experienced them in real life.

Recommendations for Future Studies

As the sample size of interns/associates from states other than California in this study was small, a replication of this study with trainees not from California would be interesting, especially in comparison to the interns from California. This may shed light on possible differences in training between geographic locations. Additionally, a study seeing if there are differences in supervisory alliance and disclosure of personal reactions in therapy with other mental health professionals such as social workers, licensed professional counselors would allow for comparisons between fields.

This study did not inquire if a match in gender between supervisor and supervisee influenced countertransference disclosure. In this study, it was found that supervisees are less likely to disclose sexual countertransference if their supervisor was male. As a relationship between gender of supervisor and disclosure of sexual attraction toward a client was found, and there appears to be a lack of research on this subject, it is recommended for additional research to be conducted to see how gender may influence the supervisory relationship and disclosure of personal reactions in therapy.

As stated in the limitations, analog studies do not allow for phenomenon and theories to be researched in real world situations. It would be interesting to see if participants would respond

differently in real situations when experiencing countertransference. It is recommended that a study be done investigating working alliance and disclosure of personal reactions in therapy without using an analog study. Perhaps a study using a qualitative method, interviewing both supervisor and supervisee may provide more information about the working alliance and disclosure of personal reactions. Another possible study could be taping supervision sessions and investigating how disclosure of personal reactions is handled and experienced in supervision.

Given the lack of research on how ethnic and racial differences may impact the supervisory experience, it is recommended that researchers focus on how race and ethnicity may impact the supervisory experience, especially in terms of working alliance and disclosure of personal reactions.

The empirical research on isomorphism and parallel process is scarce. This study added to the understanding of these concepts and suggests that these concepts may be similar to countertransference. Additional research should be conducted to better understand these concepts and how they are present in supervision.

Finally, this study did not investigate differences in working alliance and countertransference disclosure between trainees who are obtaining PhD degrees and master's degrees in marriage and family therapy, which may add to the literature on training of marriage and family therapists.

Conclusion

Personal reactions in therapy, whether termed *use of self* or countertransference, influence the therapeutic relationship, which is a key component to treatment of mental disorders and client challenges. Research supports that working alliance in supervision is related to the likelihood of supervisees to disclosure the personal reactions they experience in therapy to their

supervisors. Working alliance is also related to how comfortable supervisees feel when disclosing the reactions they have to their clients with their supervisors. When the working alliance is poor, supervisees may withhold these reactions, which impact their ability to help their clients. Unmanaged personal reactions can lead to over involvement with the client, burn out for the therapist, inability to connect with the client, and weak therapeutic alliances. Supervision is the space in which therapists learn how to manage their personal reactions in therapy. Without disclosure of personal reactions though, trainees may not learn how to manage their personal reactions. As Satir, (1987) noted, the use of self is an important part of therapy and should be used to create a connection with the client. Use of self involves identifying personal reactions and either setting them aside or using these reactions to empathize with the client. Through a strong working alliance, supervisors and supervisees may create a safe space to explore reactions trainees have in therapy so these reactions may be used to enhance client care.

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APPENDIX A

Tables

Table A1
Participant Demographics- Interns: (N= 105)

Characteristic	n	%
Current Training Site		
Other	18	19.6
Community Counseling	32	34.8
University Counseling Center	6	6.5
Consortium	1	1.1
State/County/Other Public Hospital	6	6.5
Correctional Facility	2	2.2
Private Outpatient Clinic	4	4.3
School District	9	9.8
Child/Adolescent Psychiatric or Pediatric Dept	1	1.1
Private Psychiatric Hospital	13	14.1
Population		
Adults	36	39.1
Children/Adolescents	29	31.5
Geriatrics	1	1.1
Families	1	1.1
Combined	25	27.2
Time spent individual therapy		
100%	9	9.9
75-99%	36	39.6
50-74%	28	30.8
25-49%	11	12.1
Less than 25%	7	7.7
Time spent family therapy		
100%	1	1.1
75-99%	6	6.6
50-74%	6	6.6
25-49%	20	22
Less than 25%	58	63.7

(continued)

Characteristic	n	%
Time spent couples therapy		
75-99%	4	4.4
50-74%	6	6.6
25-49%	10	11
Less than 25%	71	78
Primary Theoretical Orientation		
Other	8	8.7
Cognitive Behavioral	29	31.5
Existential/Humanistic	20	21.7
Psychodynamic	13	14.7
Family Systems: Bowenian	1	1.1
Family Systems: Strategic	1	1.1
Family Systems: Structural	1	1.1
Family Systems: Experiential	2	2.2
Family Systems: Narrative	4	4.3
Family Systems: Solutions Focused	8	8.7
Family Systems: Emotion-Focused	5	5.4
Secondary Theoretical Orientation		
Other	5	5.6
Cognitive Behavioral	14	15.6
Existential/Humanistic	16	17.8
Psychodynamic	17	18.9
Family Systems: Bowenian	8	8.9
Family Systems: Strategic	2	2.2
Family Systems: Structural	8	8.9
Family Systems: Experiential	3	3.3
Family Systems: Narrative	5	5.6
Family Systems: Solutions Focused	10	11.1
Family Systems: Emotion-Focused	2	2.2

(continued)

Characteristic	n	%
Months of Clinical Experience		
0-3	3	3.3
3-6	3	3.3
6.9	1	1.1
9-12	5	5.4
12-18	7	7.4
18-24	14	15.2
Over 24 months	56	60.9
Other	3	3.3
Time at Current Site		
0-3	8	8.8
3-6	7	7.7
6.9	6	6.6
9-12	8	8.8
12 or more	62	68.1
Time With Supervisor		
0-3	12	13
3-6	11	12
6.9	8	8.7
9-12	14	12.2
12 or more	47	51.1
Time in Individual Supervision		
.5- 1 hour	21	41.2
1-2 hours	24	47.1
More than 2 hours	6	11.8
Time in Group Supervision		
Other	4	7.8
1-2 hours	30	58.8
More than 2 hours	17	33.3

(continued)

Characteristic	n	%
Race		
Other	8	8.7
African American	4	4.3
Asian/Pacific Islander	7	7.6
Hispanic/Latino	14	15.2
White	59	64.1
Gender		
Other (Transgender, Intersex, Androgynous)	4	4.3
Female	76	82.6
Male	12	13
Sexual Orientation		
Other	6	6.5
Heterosexual	75	81.5
Gay	3	3.3
Lesbian	2	2.2
Bisexual	4	4.3
Questioning	2	2.2
Supervisor Theoretical Orientation		
Other	8	7.6
Cognitive Behavioral	31	29.5
Existential/Humanistic	15	14.3
Psychodynamic	24	22.9
Family Systems: Bowenian	2	1.9
Family Systems: Structural	1	1
Family Systems: Experiential	1	1
Family Systems: Solutions Focused	7	6.7
Family Systems: Emotion Focused	3	2.9
Supervisor Gender		
Female	64	69.6
Male	28	30.4

(continued)

Characteristic	n	%
Supervisor & Trainee sexual orientation match		
Yes	64	69.6
No	19	20.7
I don't know	9	9.8
Supervisor Race/Ethnicity		
Other	6	6.5
African American	8	8.7
Asian/Pacific Islander	4	4.3
Hispanic/Latino	4	4.3
White	69	75
I don't know	1	1.1
Supervisor Degree		
Other	4	4.7
Ph.D	11	12
Psy.D.	5	5.4
M.D.	1	1.1
M.F.T.	55	59.8
M.A	8	8.7
L.S.W.	8	8.7
Supervisor License		
Other	10	11
Psychologist	10	11
LMFT	70	76.9
MD	1	1.1
COAMFTE Accredited		
Yes	30	35.3
No	13	15.3
I don't know	42	49.4
AAMFT Approved Supervisor		
Yes	35	40.7
No	13	15.1
I don't know	38	44.2

Table A2

Participant Demographics: Trainees (N= 56)

Characteristic	n	%
Current Training Site		
Community Counseling	14	28
University Counseling Center	19	38
State/County/Other Public Hospital	1	2
Consortium	1	2
Private Outpatient Clinic	3	6
School District	3	6
Other	9	18
Population		
Adults	13	25.5
Children/Adolescents	6	11.8
Families	5	9.8
Combined	27	52.9
Time spent individual therapy		
75-99%	13	25.5
50-74%	20	39.2
25-49%	18	35.3
Time spent family therapy		
75-99%	1	2
50-74%	8	15.7
25-49%	17	33.3
Less than 25%	25	49
Time spent couples therapy		
50-74%	10	20.4
25-49%	19	38.8
Less than 25%	20	40.8

(continued)

Characteristic	n	%
Primary Theoretical Orientation		
Other	6	11.8
Cognitive Behavioral	2	3.9
Existential/Humanistic	1	2
Psychodynamic	2	3.9
Family Systems: Bowenian	5	9.8
Family Systems: Structural	3	5.9
Family Systems: Experiential	10	19.6
Family Systems: Narrative	5	9.8
Family Systems: Solutions Focused	10	19.6
Family Systems: Emotion-Focused	7	13.7
Secondary Theoretical Orientation		
Other	3	5.9
Cognitive Behavioral	6	11.8
Existential/Humanistic	3	5.9
Family Systems: Bowenian	7	13.7
Family Systems: Structural	6	11.8
Family Systems: Experiential	8	15.7
Family Systems: Narrative	5	9.8
Family Systems: Solutions Focused	7	13.7
Family Systems: Emotion-Focused	5	11.8
Months of Clinical Experience		
0-3	2	4.4
3-6	5	11.1
6.9	6	13.3
9-12	10	22.2
12-18	4	8.9
18-24	2	4.4
Over 24 months	16	35.6

(continued)

Characteristic	n	%
Time at Current Site		
0-3	5	9.8
3-6	12	23.5
6.9	9	17.6
9-12	11	21.6
12 or more	14	27.5
Time With Supervisor	19	37.3
0-3	16	31.4
3-6	7	13.7
6.9	3	5.9
9-12	6	11.8
12 or more		
Time in Individual Supervision		
.5- 1 hour	21	41.2
1-2 hours	24	47.1
More than 2 hours	6	11.8
Time in Group Supervision		
Other	4	7.8
1-2 hours	30	58.8
More than 2 hours	17	33.3
Race		
Other	1	2
African American	3	5.9
Asian/Pacific Islander	4	7.8
Hispanic/Latino	3	5.9
White	40	78.4
Gender		
Other (Transgender, Intersex, Androgynous)	2	3.9
Female	39	76.5
Male	10	19.6

(continued)

Characteristic	n	%
Sexual Orientation		
Heterosexual	43	84.3
Gay	1	2.2
Lesbian	1	2.2
Bisexual	6	11.8
Supervisor Theoretical Orientation		
Other	8	14.3
Cognitive Behavioral	1	1.8
Existential/Humanistic	3	5.4
Psychodynamic	3	5.4
Family Systems: Bowenian	9	16.1
Family Systems: Strategic	3	5.4
Family Systems: Structural	6	10.7
Family Systems: Experiential	3	5.4
Family Systems: Narrative	6	10.7
Family Systems: Solution-Focused	7	12.7
Family Systems: Emotion-Focused	2	3.6
Supervisor Gender		
Female	33	58.9
Male	18	32.1
Supervisor & Trainee sexual orientation match		
Yes	38	67.9
No	9	16.1
I don't know	4	7.1
Supervisor Race/Ethnicity		
African American	2	4
Asian/Pacific Islander	1	2
Hispanic/Latino	3	6
White	41	82
I don't know	3	6

(continued)

Characteristic	n	%
Supervisor Degree		
Other	12	26.7
Ph.D	23	51.1
Psy.D.	2	3.6
M.F.T.	6	13.3
M.A	11	8.7
L.S.W.	1	1.8
Supervisor License		
Other	5	8.9
Psychologist	4	7.1
LMFT	41	73.2

Table A3

Descriptive Table for WAI-S

	Trainees				Interns			
Variable	M	SD	Skewness	Kurtosis	M	SD	Skewness	Kurtosis
WAI-S Task	5.142	.626	-.559	-.158	4.975	.725	-.691	-.158
WAI-S Bond	5.577	.827	-.235	-.235	5.441	1.12	-.949	.514
WAI-S Goal	5.678	.998	-.687	-.687	5.301	1.21	-.789	-.467

Table A4

Descriptive Table for CRDQ

	Trainees				Interns			
Variable	M	SD	Skewness	Kurtosis	M	SD	Skewness	Kurtosis
				The 11 item CRDQ				
CD	60.11	8.85	.019	-.735	58.71	10.99	-.525	.413
LD	61.89	8.03	.089	-.816	60.89	11.50	-.889	.724
				The 8 item CRDQ				
CD	44.33	6.24	-.200	-.483	43.14	8.10	-.618	.532
LD	15.68	5.66	.041	-.913	44.62	8.46	-.907	.704
				Isomorphism and Parallel Process Questions Only				
CD	15.70	3.08	.042	-.808	15.58	3.33	-.217	-.071
LD	16.26	2.85	-.138	-.692	16.18	3.42	-.636	.378

Note. CD= Comfort in disclosing countertransference reactions. LD= Likelihood to disclose countertransference reactions.

Table A5

Descriptive Table for CRDQ by Type of Countertransference Reactions

	Trainees		Interns	
Variable	M	SD	M	SD
	Parental/Protective Countertransference			
CD	5.68	1.21	5.49	1.36
LD	5.64	1.00	5.45	1.32
	Overwhelmed/Disorganized Countertransference			
CD	5.57	1.10	5.41	1.24
LD	5.71	1.01	5.39	1.42
	Positive Countertransference			
CD	6.10	.953	5.96	.986
LD	5.90	.958	5.83	1.08
	Special/Overinvolved Countertransference			
CD	5.43	1.03	5.41	1.30
LD	5.52	.833	5.53	1.25
	Sexualized Countertransference			
CD	4.00	1.90	4.03	1.77
LD	5.00	1.74	4.73	1.79
	Disengaged Countertransference			
CD	6.00	1.16	5.45	1.40
LD	6.00	.897	5.61	1.40
	Helpless/Inadequate Countertransference			
CD	6.10	.692	5.53	1.36
LD	6.12	.832	5.95	1.32
	Mistreated/Criticized Countertransference			
CD	5.79	.983	5.66	1.35
LD	6.19	.958	5.70	1.13

Note. CD= Comfort in disclosing countertransference reactions. LD= Likelihood to disclose countertransference reactions.

Table A6

Correlations Between the WAI-S Subscales and the CRDQ

Variable	WAI-S Task	WAI-S Bond	WAI-S Goal	CRDQ Level of Comfort	CRDQ Level of Likelihood
WAI-S Task	-	.798**	.875**	.427**	.466**
WAI-S Bond	.849**	-	.830**	.589**	.639**
WAI-S Goal	.918**	.851**	-	.385**	.414**
CRDQ Level of Comfort	.449**	.521**	.476**	-	.898**
CRDQ Level of Likelihood	.491**	.569**	.461**	.853**	-

Note. Correlations for Interns are above the diagonal. Correlations for Trainees are below the diagonal.** Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table A7

Correlations Between the WAI-S Subscales and the 8 item CRDQ Trainees

Variable	WAI-S Task	WAI-S Bond	WAI-S Goal	CRDQ Level of Comfort	CRDQ Level of Likelihood
WAI-S Task	-	.798**	.875**	.417**	.449**
WAI-S Bond	.849**	-	.830**	.578**	.632**
WAI-S Goal	.918**	.851**	-	.371**	.400**
CRDQ Level of Comfort	.438**	.529**	.486**	-	.874**
CRDQ Level of Likelihood	.485**	.602**	.487**	.842**	-

Note. Correlations for Interns are above the diagonal. Correlations for Trainees and below the diagonal. ** Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table A8

Correlations Between the WAI-S Subscales and isomorphism and parallel process questions on the CRDQ

Variable	WAI-S Task	WAI-S Bond	WAI-S Goal	CRDQ Level of Comfort	CRDQ Level of Likelihood
WAI-S Task	-	.798**	.875**	.405**	.464**
WAI-S Bond	.849**	-	.830**	.516**	.562**
WAI-S Goal	.918**	.851**	-	.562**	.405**
CRDQ Level of Comfort	.381**	.429**	.371**	-	.894**
CRDQ Level of Likelihood	.416**	.400**	.329**	.869**	-

Note. Correlations for Interns are above the diagonal. Correlations for Trainees and below the diagonal. ** Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table A9

Correlations Between the WAI-S Subscales and the 8 item CRDQ for the Whole Sample

Variable	WAI-S Task	WAI-S Bond	WAI-S Goal	CRDQ Level of Comfort	CRDQ Level of Likelihood
WAI-S Task	-				
WAI-S Bond	809**	-			
WAI-S Goal	.890**	.835**	-		
CRDQ Level of Comfort	.427**	.566*	.413**	-	
CRDQ Level of Likelihood	.458**	.625**	.427**	866**	-

Note. ** Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table A10

Correlations Between the WAI-S Subscales and the 11 item CRDQ

Variable	WAI-S Task	WAI-S Bond	WAI-S Goal	CRDQ Level of Comfort	CRDQ Level of Likelihood
WAI-S Task	1.00				
WAI-S Bond	.809**	1.00			
WAI-S Goal	.890**	.835**	1.00		
CRDQ Level of Comfort	.436**	.570*	.420**	1.00	
CRDQ Level of Likelihood	.472**	.621**	.430**	.866**	1.00

Note. ** Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table A11

Correlations Between the WAI-S Subscales and The Isomorphism and Parallel Process Questions on the CRDQ

Variable	WAI-S Task	WAI-S Bond	WAI-S Goal	CRDQ Level of Comfort	CRDQ Level of Likelihood
WAI-S Task	1.00				
WAI-S Bond	.809**	1.00			
WAI-S Goal	.890**	.835**	1.00		
CRDQ Level of Comfort	.397**	.485**	.376**	1.00	
CRDQ Level of Likelihood	.448**	.515**	.384**	.866**	1.00

Note. ** Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table A12

Comparison Between Daniel (2008), Pakdaman, Shafranske, and Falender (2014) and Busse (2015)

	Daniel (2008)	Pakdaman, Shafranske and Falender (2014)	Busse (2015)
N=	175	332	Total N= 162 Trainees N= 57 Interns N= 105
H1: There is a positive association between supervisory alliance and reported comfort in supervisee CT (countertransference) disclosure.	Confirmed	Confirmed	Trainees- Confirmed CA Interns- Confirmed
H2: There is a positive association between supervisory alliance and reported likelihood in supervisee CT disclosure.	Confirmed	Confirmed	Trainees- Confirmed Interns- Confirmed
Do matches in demographic characteristics (i.e., gender, ethnicity, or theoretical orientation) between supervisor and supervisee influence CT disclosure?	No significant relationships found.	No significant relationships found. The sample was not diverse enough to make comparisons.	Trainees- No significant relationships found. Interns- No significant relationships found.

(continued)

	Daniel (2008)	Pakdaman, Shafranske and Falender (2014)	Busse (2015)
Does the number of years of supervised experience in psychotherapy a supervisee has received influence reported comfort or likelihood in CT disclosure?	N/A	No	Trainees- No significant relationships found. Interns- No significant relationships found.
Does the type of degree program of the intern affect comfort with CT disclosure and likelihood of disclosure?	No	No	N/A
Does theoretical orientation affect comfort with CT disclosure and likelihood of disclosure?	The sample's theoretical diversity was not large enough to make comparisons.	There were differences in comfort with countertransference disclosure in regards to theoretical orientation.	Trainees- No significant relationships found. CA Interns- No significant relationships found.

APPENDIX B

Supervision Literature Review

APPENDIX B

Supervision Literature Review

The studies below include studies focused on supervision research. These studies focus on MFT interns and trainees, as well as psychology interns and psychology predoctoral trainees. These studies range in focus, but are important to note. These studies focus on describing trainees opinions of what makes a supervisor a *good* supervisor and an unfavorable supervisor, role induction in training, how supervisees and supervisors approach supervision, needs of supervisees and effectiveness of different methods of supervision. Studies primarily focused on supervisory alliance are described in Appendix B.

Citation	Sample	Findings
Allen, Williams, & Szollos, (1986)	142 predoctoral students in APA accredited programs	Best quality supervision was related to expertise, trustworthiness of the supervisor, and duration of training. Supervisors who placed emphasis on personal growth over teaching and supervisors who established supportive relationships, communicated expectations and provided clear feedback were also rated to be better supervisors. Poor supervision was related to authoritarian treatment of the supervisee and sexist behaviors. Psychodynamically oriented supervisors were rated as better supervisors than supervisors with behavioral orientations.

(continued)

Citation	Sample	Findings
Anderson, Schlossberg, & Rigazio-DiGilio, (2000)	52 Masters and doctoral programs. COAMFTE programs	Research regarding MFT supervision was sparse from the 80s to 2000. "worst" supervision experiences took place in practicum rather than internship. Three times as many subjects reported having best experience in group supervision, rather than individual. Worst supervision included reliance on verbal reports, whereas live supervision was experienced as better experience. Videotape did not yield significant results. More supervisors with a behavioral orientation were rated as worst supervisors. Male supervisors were more likely to be rated as worst supervisors. Best supervisors were rater higher in "interpersonal attractiveness, trustworthiness, and expertise" (p.86). Four dimensions of best supervision experiences included openness, emphasis of communicating respect support and encouragement, emphasis of personal growth, and highlighted conceptual and technical guidance.
Bahrick, Russell, &Salmi, (1991)	23 counselor trainees in a graduate program in counseling psychology. 20 in their first practicum.	Trainees who didn't participate in role induction were less likely to be open with the supervisors and less likely to view the supervisor was a teacher or counselor. Role induction has positive impacts on how a supervisee views and experiences supervision. Trainees who participated in role induction were more likely to recognize and express their needs to their supervisors, more likely to perceive the supervisory relationship as paralleling the client- counselor relationship, had a clearer concept of supervision, and felt the supervision had more structure. Overall, role induction increases the trainees knowledge about the supervision process.
Carifio & Hess, (1987)	Review of literature to date/Critical Analysis	Ideal supervisors seem to have the same characteristics as the "ideal psychotherapist", due to the similarities between the therapist-client relationship and the supervisee-supervisor relationship (p. 244). Qualities of ideal therapists include "empathy, understanding, unconditional positive regard" (p.245). Characteristics of a good supervisor include "flexibility, concern, attention, investment, curiosity, and openness" (p. 245). Good supervisors are knowledgeable and experienced therapists. The relationship should be dyadic and "involve openness, trust, mutual understanding, two-way communication, and collaboration" (p. 245).

(continued)

Citation	Sample	Findings
Carlozzi, Romans, Boswell, Ferguson, & Whisenhunt, (1997)	48 students from CACREP accredited programs and 37 from COAMFTE accredited programs	Marriage and Family Therapy supervisors lean toward a systemic theoretical orientation and prefer to track supervisee progress through live supervision and video (p.52). Videotape is the most used modality of supervision, then "live, process/self-report, co-therapy, then audiotape"(p. 52).
Cook & Helms, (1988)	225 counseling and clinical supervisees that identify as Asian, Black, Hispanic and Native American	In comparison to Asian trainees, black trainees, Hispanic trainees and Native American trainees felt they were less liked by their supervisors. Black trainees, Hispanic trainees, and Asian trainees reported discomfort in supervision because of racial differences.
Gard & Lewis, (2008)	Literature Review	Supervisors have the responsibility of not only developing the supervisee as a mentor and evaluator, but also for the client's treatment. To build an alliance the supervisor should focus on decreasing "normative self-criticism" that most supervisees experience (p. 41). The supervisee attends supervision with anxiety and self-criticism, which can affect the rapport and connection with the supervisor. The supervisee attempts to escape from the supervisor seeing her or his weaknesses. The supervisor's task is to heighten or diminish these feelings so the supervisee can better attend to the therapeutic relationship. Self criticism can lead to a lack of movement toward growth and defensiveness about feedback.
Goodyear & Bernard, (1998)	Literature Review	Novice trainees tend to express need for more "support, structure, and encouragement" (p. 13), whereas more experienced trainees focus more in personal issues that are affecting their clinical work. Research indicates that gender most likely affects supervisory relationship, but results on studies have been varied. Studies have shown that culture and race affect supervisory relationships. Trainees with more self-efficacy tend to expect supervision to be worthwhile and require less structure. Additionally, trainees with more self-efficacy may have more reactance potential, which is a tendency too be defensive when freedom is perceived to be restricted. Trainees with higher ability in conceptualization were less concerned about being evaluated and sought more feedback from supervisors

(continued)

Citation	Sample	Findings
Guest & Beutler, (1988)	8 trainees in a doctoral program in clinical psychology	Hess's 5 models of the supervisory relationship: teacher, case review consultant, collegial peer, monitor and therapist. The authors noted research that supervisor expertise and trustworthiness led to trainee's evaluating the supervisory relationship positively. Supervisor attractiveness was related to positive evaluations of the supervisory relationship. Supervisees tend to adopt the theoretical orientations of their supervisors. Supervisees who have the same theoretical orientation as their supervisors tended to have more positive views of supervision. As trainees progressed they began to be more concerned about countertransference.
Nelson & Friedlander, (2001)	13students in doctorate and masters programs in psychology.	Role conflict and ambiguity is related to dissatisfaction with clinical work and supervision. Role conflict occurs when there are conflicting expectations in supervision. Role ambiguity occurs when the expectations are unclear.
Noelle (2003)	Literature review	Self-report methods of supervision are considered the least attractive due to thinking that supervisees wont recall all happenings in a session and the question of veracity. Therapy requires multitasking and it has been claimed that trainees aren't able to multitask sufficiently. They may not be able to recall the session accurately because it may be based upon interpretation. The author notes that research has found that supervisees are afraid of being found inadequate and supervisees withhold information to gain power in the relationship. Strength of self-report is that with only gaining information from audio/video or live supervision then other information is missed such as parallel process and the "feeling" in the room (p.130). The author claims that giving the supervisee the choice on how they want to present information will foster empowerment and trust. Flexibility in modality will aid in creating a good relationship.

(continued)

Citation	Sample	Findings
Reichelt & Skjerve, (2001)	18 supervisor-student dyads	Many supervisors focused on increasing the trainees ability to reflect and think about how they influence the client, "integrating knowledge to increase understanding" (p.30). Some focused on the therapeutic relationship, the working alliance and building the trainee's confidence. They preferred exploring how the trainee worked with the client rather than teaching. Supervisors generally tried to not impose their orientation or treatment plans, as well as didn't want to be didactic or instructive. Despite those wishes they found that when they viewed the tapes of them doing supervision they were actually being more didactic and imposed their own ideas or solutions. "Most of the trainees experienced their supervisor as supportive, accepting, affirmative and caring, and felt that the supervisor had confidence in their work" (p.32). A majority of trainees were concerned about feedback, either were appreciated they have received feedback, but two wanted more.
Scaturo & Watkins, (2013)	Literature Review	Primary theories of supervision include "psychotherapy focused, developmental, and social role or process" (p.76). Psychotherapy models are based upon theory. Two issues with psychotherapy based supervision are: supervision not being integrative and the "lack of a common language to guide and unify understanding and practice" (p.76). Psychotherapy based supervision can lead to "ideological isolation, construct confusion and compromised clinical insights and research findings" (p.76). The authors assert that psychotherapy based models should be more linked to learning theory. The authors propose a supervision theory based on 3 different learning styles and outline how to form an alliance, use interventions and consider learning stages throughout supervision. These learning styles are cognitive, affective and psychomotor.
Worthington (1987)	Literature Review	Most supervision in the early part of a trainees training is proactive, but as the trainee gains more experience, the supervisor is reactive. Beginning of training, trainees are taught the theoretical orientation of the supervisor but as they progress they should have more freedom in their orientation.

(continued)

The above table represents the range of studies focused on supervision of trainees in psychology and marriage and family therapy. What is clear from reviewing the literature, is that there is a lack of literature focused on how race and cultural differences between supervisor and supervisee affect the supervisory experience.

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APPENDIX C

Working Alliance Literature Review

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Working Alliance Literature Review

Carl Roger's view of an effective therapeutic relationship was based on the therapist's ability to have a stance of congruency, empathy and unconditional regard toward the client (Horvath and Symonds, 1991). Bordin's theory goes beyond Rogers and asserts that in order for an effective relationship to transpire, collaboration from both the therapist and client's must occur. Bordin does not assert that the relationship itself is therapeutic like Rogers, but the working alliance makes it possible for change to occur through collaboration in treatment (Horvath and Symonds, 1991). Bordin (1979) believed that therapy effectiveness depends on the strength of the working alliance. Bordin (1979) also stated that the therapeutic alliance is the main vehicle of change in therapy. Although the concept of working alliance is based in analytic theory (Gard and Lewis, 2008), Bordin (1979) states that the concept of working alliance is generalizable to all approaches to psychotherapy.

Alliance "describes the degree to which the therapy dyad is engaged in collaborative, purposeful work" (Hatcher and Barends, 2006, p. 293). The alliance is not focused solely on therapeutic technique but focuses on collaboration and purposeful work (Hatcher and Barends, 2006). The core of the work is to help the clients work through interpersonal relationship patterns while building and negotiating an alliance with the therapist. The two core assumptions of the theory are that the work is purposeful, and the alliance is "interpersonal developed and expressed as a reciprocal, interactive relationship" (Hatcher and Barends, 2006, p. 293). The working alliance has been found to be related the therapy outcome. (Horvath and Symonds, 1991; Horvath, 2006). Horvath and Greenberg (1989) note that the working alliance makes it possible for the patient to follow treatment.

Bordin (1979) outlined the therapeutic alliance to be comprised on goals, tasks and the emotional bond between therapist and client. The first step of working alliance is laying out the goals of therapy or the aim of treatment (Bordin, 1979). The task component includes the agreed-upon contract between the therapist and client (Bordin, 1979) and "form the substance of the counseling process" (Horvath and Greenberg ,1989, p.254). Tasks are different depending on which theory is being used in treatment (Bordin, 1979). In psychoanalytic therapy, those tasks include free association, sitting on the couch, and the "blank screen" (Bordin, 1979). In behavioral therapy it involves honesty of the patient's report of assigned out of session tasks done such as tracking behaviors (1979). The bonds component refers to the trust and attachment of the therapeutic relationship (Bordin, 1979). The bond will look different depending approach used as well. For example, in behavior therapy a bond may be developed by a therapist providing a behavior log and realized by a patient completing his or her behavior log (Bordin, 1979). Another example is that a bond also may be made when the therapist provides feedback to the client or shares his or her emotions with the client (Bordin, 1979). Bordin (1979) described that the bond needs to be strong enough to withstand the tasks of therapy.

The key to the construction of the working alliance is collaboration, as Bordin (1979) elucidated the importance of the therapist and client collaboratively by agreeing on goals and engaging in the tasks to form the bond. Factors such as personality and situational pressures may affect client's readiness to agree on goals. The therapist must work with the client in a collaborative manner to create meaningful and appropriate goals with the client (Bordin, 1979). Finally, the therapist and client, labeled the "change seeker and change agent" by Bordin (1979, p. 225), when readied with faith, hope and experience, can forge a strong working alliance.

As can be seen in the table below, there are many studies focused on the supervisory

working alliance. These studies and critical analyses focus on factors that lead to a strong or weak alliance, the relationship between therapy effectiveness and supervisory alliance and the theory of the alliance.

Studies about working alliance

Author(s) and Year	Sample	Main Contributions
Chen, E., Bernstein, B. (2000).	10 supervision dyads comprised of doctoral students and master level counselor trainees.	For the dyad with a high working alliance top four critical incidents in supervision that emerged were issues within the supervisory relationship, competence, emotional awareness and autonomy. For the low working alliance dyad, personal issues, competence, emotional awareness and purpose and direction were the most common issues. The personal issues theme was most critical to the low working alliance dyad but the 4th most important in the high working alliance dyad. This may be due to the dyad not paying sufficient attention to the supervisory relationship, over-exploration of personal issues and a poor collaborative relationship. The authors assert that exploration of personal issues should occur only when safety and trust has been built in the relationship to protect the supervisee. By waiting until that trust and safety is built, the supervisor is less likely to experience supervisee resistance. In high working alliance dyads, the supervisor had high profiles on attractiveness, interpersonal sensitivity, and task oriented (p.493). As alliance grows, the supervisor and supervisee should have consistent perceptions of the supervision process and outcome. A correlation between years of supervisor experience and working alliance was found. More experienced supervisors had higher working alliances with their supervisees.

(continued)

Author(s) and Year	Sample	Main Contributions
Efstation, J., Patton, M., and Kardash, C. (1990).	185 Supervisors, 178 Trainees	The authors assert that measurements focused on counselor supervision have not examined the interactive features of the supervisory relationship. Therefore, this mechanism of change is not fully understood. The supervisor alliance is "that sector of the overall relationship between the participants in which supervisors act purposefully to influence trainees through their use of technical knowledge and skill and in which trainees act willingly to display their acquisition of that knowledge and skill" (p.323). The Supervisory Working Alliance Inventory had acceptable inter-item consistency. Supervisors and supervisees had differing perceptions of the supervisory relationship. To effectively measure alliance and development the same dyad must be measured several times throughout training.

(continued)

Author(s) and Year	Sample	Main Contributions
Gard, D., & Lewis, J. (2008).	Critical Analysis	Alliance based supervision is based in ego-analytic therapy, which "hold that feelings of unentitlement to one's experience or to having a problem, lies at the source or root or a particular problem" (p. 42). This leads to self-criticism and distance in relationships. In terms of supervision, the supervisee attends supervision with anxiety and self-criticism, which can affect the rapport and connection with the supervisor. The supervisee attempts to escape from the supervisor seeing her or his weaknesses. The supervisor's task is to heighten or diminish these feelings so the supervisee can better attend to the therapeutic relationship. Self criticism can lead to a lack of movement toward growth and defensiveness about feedback. Authors also note that paying attention to countertransference is important in understanding the client. "Beginning therapists need and want suggestions on how to behave and interact as a therapist, substantive feedback on their progress and development, and constructive criticism when things are not going well" (p.47). Authors recommend the supervisors disclose judiciously about his or her practice to decrease the power differential in the supervisory relationship. They assert that many supervisees make the assumption that other therapists are inherently skilled and forget that each therapist endures their own learning process.

(continued)

Author(s) and Year	Sample	Main Contributions
Hatcher, R. & Barends, A. (2006).	Critical Analysis	The authors claim that over time, the alliance theory has "lost its definition" and therefore, a reassessment of the theory is necessary. Alliance "describes the degree to which the therapy dyad is engaged in collaborative, purposeful work" (p. 293). The two core assumptions of the theory are that the work is purposeful, and the alliance is "interpersonal developed and expressed as a reciprocal, interactive relationship" (p. 293). An example of good alliance would be a well-timed, accurate therapist intervention directed toward an important client concern that is met with an appropriate and relevant client response, demonstrating goal agreement (joint aim to resolve an important concern) and task agreement (both actively engaged in the therapeutic task), supported by the client's trust in the therapist (allowing substantive client engagement) (p.293). The authors point out that Bordin's theory "does not equate alliance and relationship", but investigates how the relationship is related to purposeful and collaborative work. The alliance isn't about technique but may be an even more effective means of collaboration and purposeful work than techniques used. The core of the work is to help the clients work out interpersonal relationship patterns while building and negotiating the alliance.
Horvath, A., & Greenberg, L. (1989).	Critical Analysis	The working alliance makes it possible for the patient to follow treatment and taps into client self-defeating behavior. Bordin's theory is distinct from Rogers and Strong because he emphasized collaboration and focus on purposeful work. "The quality of mutuality in the working alliance is a primary ingredient in its effectiveness" (p. 255). The alliance is the vehicle for technique, not an intervention itself.

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Author(s) and Year	Sample	Main Contributions
Horvath, A., & Symonds, B. (1991).	Meta-analysis of 24 studies focused on the working alliance and therapy outcome.	"Client rated outcome is somewhat better predicted than therapist reported outcome, which, in turn, is better forecasted than the outcome rated by observers" (p.144). Conclusion- working alliance is related the therapy outcome.
Horvath, A. (2006).	Critical Analysis	Early analysts view the alliance as a facilitator of the relationship but not necessarily the factor that produces change. Rogers asserted that the relationship itself can produce change. Since Rogers, Luborsky and Bordin readdressed the concept of alliance. Horvath noted that the function of the alliance is still not clear. Bordin viewed the alliance as the "active ingredient", whereas Luborsky viewed the alliance as a facilitator of therapy. The list of the elements of the therapy relationships was as follows: the alliance, cohesion, empathy, goal consensus and collaboration, positive regard, congruence, feedback, repair of alliance ruptures, self disclosure, countertransference (management of), and relational interpretation.
Inman, A., Ladany, N., Boyd, D., Schlosse, L., Howard, E., Altman, A., & Stein, E. (2011).	109 doctoral level advisees	Supervisory working alliance has been found to be related with "research self-efficacy, research competence, and interest in science and practice" (p.150). Supervisees are concerned about the power differential in the supervisor-supervisee relationship, concerned about evaluation, and if the supervisor will respect confidentiality.
Kennard, B., Stewart, S., & Gluck, M. (1987).	26 trainees, 47 supervisors	There is a match between the supervisor's perception of the relationship and the trainee's perception of the relationship. When supervisees are more open to feedback they have better supervision experiences. Supervisors who are perceived as more instructional, supportive and provide interpretations are experienced more positively in supervision. Supervisors and trainees with similar orientations report to be better matched.

(continued)

Author(s) and Year	Sample	Main Contributions
Ladany, N. (2004).	Literature review	Trainees benefit from a strong working alliance by having enhanced multicultural competence. A weak supervisory alliance is related to conflict and ambiguity in the trainee's role in supervision. Additionally, a weak supervisory alliance is related to alleged unethical behaviors from the supervisor and counterproductive events in supervision. These counterproductive events and ethical violations include not allowing the trainee to work within their theoretical orientation, violating confidentiality and inadequate evaluations of the trainee's performance.

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Author(s) and Year	Sample	Main Contributions
Ladany, N., Ellism M., & Friedlander, M. (1999).	107 counselor trainees, both doctoral and masters level	If working alliance becomes weaker then the goals, bond, and tasks decrease. Changes in bond were related to trainee satisfaction with supervision. Agreement on tasks or goals were related to satisfaction. No relationship was found between changes in supervisory alliance and self-efficacy, self-efficacy changed over time. As trainees viewed their supervisors more positively they judged their behavior in supervision more positively. Similarly, if they judged their supervisors personal qualities more negatively, they judged their own behavior negatively and were "less comfortable in supervision" (p.452). The authors note that since supervision is mandatory, trainees may perceive that they have less control in the process, which may affect the emotional bond and "trainee's involvement in negotiating the goals and tasks of supervision" (p.452). They note that a stronger bond seems to be related with comfort in self-disclosure during supervision. Changes in bond and agreement on tasks or goals are related to trainee satisfaction with supervision. Most supervisors use more than one model of supervision, but the supervisory alliance is a common factor in supervision. They hypothesized those counselor trainees perceptions of the quality in their self efficacy expectations would be related to satisfaction with supervision. Examination of working alliance requires multiples assessments throughout supervision because the alliance fluctuates throughout the process of learning in supervision. Bordin outlined 8 goals or outcomes from a strong supervisory alliance. Mastering counseling skills, one of those goals, involves self-efficacy. Bandura's self-efficacy theory asserts that there is a relationship between the confidence one feels in doing a behavior and the performance.

(continued)

Author(s) and Year	Sample	Main Contributions
Ligiero, D., & Gelso, C. (2002).		Research suggests that more secure clinicians are able to use countertransference positively rather than acting it out. (p.5). Research has also shown that adults with insecure attachment are less able to regulate their affect. Negative countertransference was related to quality of working alliance. Positive countertransference was negatively related to the supervisor ratings of the bond. The authors suggest that the alliance can be affected by positive countertransference because therapists tend to be less aware of positive countertransference. They also assert that inability to agree on goals and tasks could affect the bond and elicit countertransference.
Mahaffey, B. & Granello, P. (2007).	Metaanalysis	11 0f 19 of the studies about working alliance lacked adequate sample sizes. Samples were not diverse and focused on "young, adult, verbal, intelligent and stable" Research shows therapeutic alliance is an "integral part of marital and family counseling, theory and assessment." (p. 209).

(continued)

Author(s) and Year	Sample	Main Contributions
Murphy, M. & Wright, D. (2005).	11 MFT supervisees	Supervisors should use their power to empower trainees in assuming power in their roles. Minimizing hierarchy can lead to collaboration. Discussions of power can also lead to collaboration and a trusting relationship. Research has indicated that misuse of power, by both the supervisor and supervisee, can lead to supervisees not sharing pertinent information about a case. Common abuses of power include forcing a supervisee to disclose, providing therapy, focusing in on mistakes, pathologizing the supervisee, forcing a certain theoretical framework, and using supervision time to discuss personal issues. More experienced supervisees tend to feel they have more power in supervision. Power is also experienced in terms of evaluations. When supervisees were treated as colleagues to an extent and the supervisors were open and flexible, supervisees felt they respected the power differential moreso. When expectations were clear, the supervisees felt the use of power was more positive and upheld them to be responsible. Negative uses of power include favoritism, imposition of orientation, violating confidentiality. Supervisee's positive use of power include giving feedback to supervisors, sharing information with peers, and viewing themselves as consumers. Supervisee's negative use of power includes violating supervisors confidentiality, and not directly addressing concerns with supervisors. In all, abuses of power were rare, with only 2 supervisees reporting abuse of power. The authors delineate how supervisors can appropriately handle power and empower trainees.

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Author(s) and Year	Sample	Main Contributions
Nelson, M, Friedlander, M., Walker, J., Gray, L., & Ladany, N. (2001).	Literature review	Expectations about the evaluative aspect of supervision, when congruent, can lead to a strong alliance.
Patton, M., & Kivilighan, D. (1997).	75 clients, 75 grad students (pre-practicum, first experiences as counselors), 25 supervisors.	A significant relationship was found between trainee perception of supervisory working alliance and supervisors perception of the working alliance. Characteristics of the counselor and client were related to alliance strength.
Scaturo, D., & Watkins, E. (2013).		Primary theories of supervision include "psychotherapy focused, developmental, and social role or process" (p.76). Psychotherapy models are based upon theory. Two issues with psychotherapy based supervision are: supervision not being integrative and the "lack of a common language to guide and unify understanding and practice" (p.76). Psychotherapy based supervision can lead to "ideological isolation, construct confusion and compromised clinical insights and research findings" (p.76). The authors assert that psychotherapy based models should be more linked to learning theory. The authors propose a supervision theory based on 3 different learning styles and outline how to form an alliance, use interventions and consider learning stages throughout supervision. These learning styles are cognitive, affective and psychomotor.

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Author(s) and Year	Sample	Main Contributions
Weiling, E. & Marshall, J.(1999).	N=50 (24 clinical members, 22 students, 4 associate members of AAMFT)	The majority of respondents said they were supervised by someone of the same race, but 15 responded they have been supervised by someone from a different race or ethnic background. Those people reported their experience was good and excellent, and supervisors as competent. A majority had never been supervised by someone from a different race or ethnicity. 79% wished they had the experience of being supervised by someone from a different background and felt it would have benefited them. Specifically, they felt it would "give them a greater sense of awareness, insight, and perspective into multicultural issues". Supervisors reported they benefited from supervising supervisees who were from different backgrounds and that they realized that discussing cultural differences with clients was important.

It is clear from the research that working alliance is important in both therapy and supervision. A strong working alliance breeds trust, comfort and facilitates an open relationship in both therapy and supervision. It also can enhance a supervisees feeling of competence and self-efficacy. According to these articles, a strong alliance is one in which the supervisor and supervisee agree on goals and tasks of supervision, and the trainee and supervisor agree about how their relationship is going. Weak alliances are created when supervisees do not feel safe to share their thoughts in supervision, are concerned about evaluation, or do not know what their role in supervision is. As noted by Mahaffey and Granello (2007), there is a lack of research on supervisory working alliance with adequate sample sizes. This is a topic that should be explored moreso in mental health research.

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APPENDIX D

Countertransference Literature Review

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Countertransference Literature Review

Origins of countertransference can be viewed as developmental (Hayes and Gelso, 2001). Research has indicated that common conflicts of therapists include "therapist's family of origin, sex roles, professional self-concept, unmet needs, parenting roles and responsibilities, and homophobia" (Hayes and Gelso, 2001, p.1042). Hayes and Gelso (2001) differentiate between acute countertransference and chronic countertransference. Chronic countertransference is countertransference that is played out with a multitude of clients, much like the concept of repetition compulsion, wherein a person repeats an experience over and over again either through reenactment or play (as seen in children). Acute countertransference is a sporadic occurrence of countertransference and "uncharacteristic of the therapist" (p. 1044). As previously stated, not all countertransference is harmful to clients if managed properly. Therefore, it is important to distinguish countertransference reactions and behavior. Countertransference reaction is the experience of countertransference, whereas countertransference behaviors occur when the therapists acts upon the reactions in treatment.

Halperin (1991) identifies six common experiences that trainees struggle with in regards to countertransference with both the supervision relationship and the client-trainee relationship. These include struggle for control or either join the family, feeling incompetent or very competent, giving into unreasonable demands or over-identifying with the scapegoat, not seeing the actual problem of the family, or trying to save the family, wanting to be thought of well, not acting autonomously, or rejecting learning from the supervisor, and not recognizing clues of countertransference which can include feeling intense feelings, atypical behaviors, guilty, and feeling vulnerable (Halperin, 1991).

Implications of Countertransference Behavior

Williams, Judge, Hill, and Hoffman (1997) found 6 common in-session feelings from trainees; "anxious and uncomfortable, distracted-unengaged or self-focused, empathic-caring, comfortable-pleased, frustrated angry and inadequate-unsure of self" (p.394). Trainees reported being concerned about their "therapeutic skills and performance, therapeutic role" (p.395) and ability to handle difficult clients and their reactions to clients (Williams, et. al., 1997). Trainees often share the issues that clients have. Williams, et. al. (1997) found that in order to handle this similarity of experience, trainees attempt to use self-awareness, focus on the client rather than themselves or "suppressed their feelings or reactions" (p. 397). When investigating all reports of trainees difficulties in managing feelings and reactions from clients, Williams, et. al. (1997) identified three categories of how they managed these feelings and reactions, including "displaying negative or incongruent behaviors, avoiding affect or issues, and over focusing" (p. 396) or becoming too involved and losing objectivity in therapy.

Southern (2007) also identified common countertransference reactions. These reactions are clustered in two types. The first type reaction includes moving away and distancing from the client and the second involves moving toward the client, idealizing the client and becoming overly involved with the client (Southern, 2007, p.287). These reactions have also been termed as positive and negative countertransference. Positive countertransference can be as equally harmful as negative countertransference if it causes the therapist to engage in countertransference behaviors such as becoming over-involved with a client (Friedman and Gelso, 2000). Ambivalence toward the client may be a result when both positive and negative countertransference exists, which can negatively affect treatment (Friedman and Gelso, 2000).

Ladany, Miller, Muse-Burke, Constatine, and Erickson, (2000) found "supervisor countertransference can contribute to trainee learning difficulties and client failure to advance in therapy" (p.102). Ladany, et. al. (2000) summarized that supervisory countertransference can lead to trainees not bringing up issues in supervision, which can in turn affect trainees growth and ability to help their clients. To manage countertransference, Ladany, et. al. (2000) cite research that encourages supervisor consultation, and disclosure of reactions to supervisees clients. Sources of supervisor countertransference included reactions to the intern's interpersonal style, supervisor unresolved issues, intern-environment interactions, problematic client-intern interactions, intern-supervisor interactions, and supervisor-supervision environment interactions (Ladany, et. al., 2000). Emotions supervisors had when experiencing supervisory countertransference included frustration, anger, resentment, anxiety or nervousness, negative self view, surprise, and confusion (Ladany, et. al., 2000). In supervisory countertransference, supervisors tend to have similar reactions to countertransference as trainees have had; the majority of supervisors would discuss the countertransference with the supervisee, but others became more distant in supervision (Ladany, et. al., 2000).

As explained in the background section, the theory of countertransference has greatly evolved over time, from Freud's one-person unidirectional understanding of countertransference, to intersubjective, two-person, and bi-directional understandings of the phenomenon. The table below describes how different theorists understood countertransference. It is organized by year, as to provide a timeline of how the theory of countertransference has changed.

Theories of Countertransference

Author(s) and Year	Main Contributions
Freud (1910)	Countertransference is to be recognized and overcome. No analyst can help his patients go father and overcome resistance than he has done himself.
Ferenczi (1911, 1913)	Countertransference can be induced by patients. Countertransference should be overcome by the analyst.
Stern (1924)	The patient displaces emotions onto the analyst, which are rooted in the patient's childhood experience. Stern defines countertransference as "transference that the analyst makes to the patient" (p. 166). Countertransference in the analyst has the same origin of the patient which is the repressed infantile material. "The ultimate purpose of the analysis itself is to open gradually the closed pathways from the infantile or early childhood periods to the present, thus enabling the patient, by living over again in the transference, to see his past repeated therein; gaining in the process a more objective view of both periods, approaching thereby nearer to reality" (p. 165). Therefore, the ability of the analyst to handle the transference and countertransference is crucial to treatment.
Glover (1927)	The patient will reenact neurosis in analysis. Psychosexual conflicts occur with the patient and the analyst alike.
Fromm-Reichmann (1939)	The analyst should identify his reactions without becoming involved with them.
Winnicott (1949)	Abnormal countertransference is a sign that the analyst is in need of more analysis. Winnicott distinguishes objective counter-transference and the analysts love and hate in reaction to the patient. Countertransference can be an objective response to the patient and not necessarily a product of the analyst's neurosis.
Heimann (1950)	Heimann defines countertransference as "all the feelings the analyst experiences toward the patient" (p. 81). Countertransference is created by the patient's unconscious and personality. The analyst's response to the patient is a key to understanding the patient's unconscious. Heimann does not recommend sharing countertransference with patients.

(continued)

Author(s) and Year	Main Contributions
Reich (1951)	The analyst listens with "free-floating attention" and allows the material to enter his/her unconscious. Tasks for the analyst include being the "object of the patient's transference" (p. 25), maintaining neutrality so transference can occur, and tolerate the patient's projections. When countertransference occurs the patient becomes an object of the analyst's past and feelings are projected onto the patient, which compromises the analysts' understanding of the patient and technique. Reich differentiates between permanent countertransference and acute countertransference, with acute being easier to manage and the permanent more ingrained. "Counter-transference is a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest is lacking. But it has to remain shadowy and in the background" (p. 31).
Racker (1953, 1988)	Countertransference can affect the analyst's understanding of a patient and behaviors with that patient. Therefore, it influences the patient's object-relations and personality transformation in treatment. The analyst and patient bring their whole selves to treatment, but the difference is that through analysis, the analyst is "free of neuroses" (p. 313). Pathological expression of counter-transference is called counter-transference neurosis, which should be investigated through analysis. The roots of countertransference neuroses lie in the Oedipus complex. Countertransference is always present in therapy.
Tower (1956)	Countertransference is always present and therefore, it is normal to experience. Countertransference is unconscious, and based on repetition compulsion and childhood experiences. Every analyst has experienced erotic transference and is uncomfortable and fearful about it. "the term countertransference should be reserved for transferences of the analyst—in the treatment situation—and nothing else. As such, they are syntheses of the analyst's unconscious ego, and together with the patient's transferences, both are products of the combined unconscious work of patient and analyst." (p. 253).
Winnicott (1960)	Countertransference involves the neurotic features of the clinician that stop the clinician from maintaining his/her professionalism. Two types of clients who affect the therapist's professionalism are those that are antisocial and those who need to regress in treatment in order to pass through a phase of development.

(continued)

Author(s) and Year	Main Contributions
Kernberg (1965)	The totalistic view of countertransference is defined as the analyst's conscious and unconscious reactions to the client that are due to the patients' transference as well as the analyst's reality and needs. Countertransference is useful in understanding the patient, as it can be a diagnostic tool, help the analyst understand how regressed a patient is, and the emotions between the analyst and patient. Kernberg notes that patients that are more severely regressed patients or patients with borderline characterology, the therapist is more often experiencing countertransference early on in treatment because of the patient's difficulties in withstanding transference and psychological stress and anxiety. These types of countertransference have more to do with the patient's problem than the analysts past because most analysts will react the same way to these patients. Kernberg asserted that sometimes the analyst's pathology is involved in the therapy and is similar to the patient's pathology, which can lead to a "chronic countertransference bind" (p. 50).
Kohut (1968)	By vicarious introspection and empathy, the analyst can understand the patient. In treatment, the therapist becomes a self-object for the patient and therefore, will help patient change. Countertransference is a tool in which to understand the patient.
Sandler (1976)	Transference can be the unconscious attempts to create situations in which earlier life experiences are repeated. The person that the transference is directed toward either rejects or accepts the transference role. This interaction is called the "intrapsychic role-relationship" and in this relationship "each party tries to impose on the other" (p. 44). The role-relationship not only is a means in which the patient gains "instinctual gratification", but is related to many other unconscious and preconscious "needs, gratifications, and defenses" (p. 45). Analyst's reactions to the patient can be called role-responsiveness. Not all countertransference responses are due to role-responsiveness, as the analyst may respond to the patient based on his own unresolved issues. Compromise-formation occurs when both the analysts' responses are present as well as the role imposed by the patient.
Joseph (1985)	We understand transference through countertransference. The patient responds to the analyst's interpretations based on his psychic make-up. The original intentions of verbal communications are often not directly responded to because the patient and analyst respond based on the patient's psychic organization. Therefore, use of countertransference can be helpful in gaining understanding.

(continued)

Author(s) and Year	Main Contributions
Racker (1988)	Countertransference assists the analyst in interpretation, aids him in understanding the patient, and affects the behavior of the analyst. Countertransference occurs when the analyst identifies with the patient's id, ego and internal objects. Concordant identifications occur when analyst's ego identifies with patients ego, which is based on introjection and projection. Complementary identifications occur when the analyst's ego identifies with patient's internal objects. The patient treats analyst like an internal object. Complementary identification occurs when concordant identification doesn't occur because analyst doesn't allow it. If the analyst isn't aware of his reactions then he/she can reinforce the patient's neurosis.
Stolorow (1988)	"A specific bond with the analyst is required for maintaining, restoring, or consolidating the organization of the patient's self-experience" (p. 246). The analyst's empathy can be experienced as a "functional component" of the patient's self-organization. Interpretation serves as a means to "demonstrate the analysts attunement to the patient's emotional states and developmental needs" (p. 247). The patient seeks to experience the analyst as a self-object in treatment, which can help him resolve an arrest in development. On the other hand, the patient may fear that this self-object will fail in resolving the arrest. Therefore, the analyst's interpretations demonstrate attunement to the patient and the patient's affect, as well as experience the bond with the analyst as "a source of requisite self object functions" (p. 252).
Hoffman (1991)	The analyst's understanding of the patient is affected by the analyst's personality, resistances, and unconscious. The interaction is always evolving because the patient and analyst is evolving.
Renik (1993)	The analyst is a participant observer. Awareness of motivation of the reaction is useful but expression is not, which is opposite of what we ask patients to do. Enactment of countertransference hinders treatment. Awareness of countertransference usually occurs when countertransference is enacted. The analyst can never be objective in the analytic situation because we cannot escape our own personal experience and motivation. "Unconscious personal motivations expressed in action by the analyst are not only unavoidable, but necessary to the analytic process" (p. 564). The analyst shouldn't avoid countertransference but acknowledge it, "identify and question ways in which the analyst is idealized and his or her constructions given undeserved authority by the patient." (p. 569).

(continued)

Author(s) and Year	Main Contributions
Ogden (1994)	There is “no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand” (p. 4). The analytic situation is comprised of the analyst, analysand, and the analytic third, which is the unconscious interplay between the analyst and analysand. The analytic third is the context for transference and countertransference. The therapist can use his/her thoughts and experiences as a means to understand the patient, as these reveries can be tied to the patient through the analytic third.
Levine (1997)	Countertransference is important for the analyst to understand the patient and the relationship, allows the patient to engage in actualization. The analyst understands the patient through his/her own experience and associations.
Gabbard (2001)	Countertransference is inevitable and useful for understanding the clinician and patient relationship. It is a phenomenon created by both the therapist and patient. The patient will "draw the therapist into playing a role that represents the patient's internal world" (p. 984).
Goodman (2005)	Goodman asserts that there are certain clients who do not improve in therapy, typically those with personality disorder such as narcissistic, borderline or antisocial personality disorders. These are the patients who are afraid of losing control and thus use mechanisms such as “omnipotent denial, mania, projection, and splitting” (p. 151) to avoid a loss of control. They believe they have killed their internal objects and therefore, will destroy the analyst as well. Through the countertransference, the clinician will then avoid emotion as to not lose control.
Southern (2007)	Countertransference provides the clinician an opportunity to understand the patient. Southern identifies two types of countertransference reactions; 1) "avoidance, counterphobia, distancing and detachment" (p. 287), and 2) "over identification, over idealization, enmeshment, and excessive advocacy” (p. 287). Counselors who have experienced trauma more often have reactions of empathic repression or empathic enmeshment. Type I countertransference should be dealt with in supervision by addressing the therapists characteristics, but type II elicits a need for the supervisor to educate the therapist and give suggestions for technique, such as boundary setting.

Through the above table it can clearly be seen that through time, theorists grew to understand that countertransference is not a one-person experience which should be rid of, as

Freud (1910) and Ferenczi (1911) believed. Countertransference is now believed by many theorists to be a informative experience, one that can show the therapist how others in the client's life think or feel towards the client. Now, countertransference is understood to be an "inevitable" (Satir, 1987; Gabbard, 2001) experience. Freud and Ferenczi's ideas that countertransference are a problem have not been discarded, as theorists now agree that if coutertransference feelings become behaviors, they can harm the client. Therefore, supervision is important to help supervisees learn to manage and use their countertransference.

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APPENDIX E

Consent Form sent to COAMFTE Students

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Consent Form sent to COAMFTE Students

Informed Consent

Statement of Consent to Participate

This survey examines the relationship between supervisory alliance and the disclosure of personal reactions to clients in supervision. The survey asks about your experience in supervision as well as your responses to several hypothetical situations. Survey completion time is approximately 20 minutes. This study is part of the dissertation scholarship conducted by Anneka Busse, MMFT, supervised by Edward Shafranske, Ph.D., ABPP, at Psy.D. Program, Pepperdine University. This study has been approved by Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University.

Consent to Participate

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

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

I understand that, although there are no direct benefits to all participants in this study, my participation will contribute to obtaining greater understanding of the impact that the supervisory relationship has on doctoral students' willingness to disclose personal reactions in supervision. Also, I may choose to enter a drawing for one of four $30 gift cards to Amazon.com upon completion of the study by sending my e-mail address to an address provided at the end of the survey. I understand that participation is not required to enter the drawing and participants may discontinue completing the survey at any time. Only the four winners will be notified by e-mail. Participants who do not win the drawing will not be notified. Drawing entrants' e-mail address will be kept confidential and will not be linked to survey responses. After the study is complete and the gift cards are sent to the drawing winners, the emails from participants will be deleted and the email account will be discontinued.

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

through Pepperdine University at (310) 568-5600 to assist in addressing any negative experiences should they arise.

I understand that the study has been approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board and that should I have any questions or comments regarding the study, I may the investigator at her email address, [investigator e-mail. I may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Thema Bryant-Davis, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at (310) 568-5600.

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

___ I voluntarily consent to participate in this study.

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

APPENDIX F

Informed Consent Sent to MFT Interns/Associates and MFT Trainees not in COAMFTE Programs

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Consent to Participate

MFT Trainees and MFT Interns/Associates who are currently practicing psychotherapy under the supervision by a licensed clinician are eligible to participate. All participants must be currently working at a training site under the supervision of a licensed supervisor. If you do not meet this criteria, please do not participate in this study.

Students who are currently trainees and have advanced to trainee status by completing the necessary coursework to begin to practice psychotherapy while under supervision by a licensed clinician and are currently working at training sites are eligible to participate. If you have not advanced to a trainee level, please do not take the survey. All MFT interns/Associates are invited to participate. Interns and associates are defined as those who have graduated from MFT programs and are currently accruing hours to be eligible for licensure. MFT interns/associates who are working in private practices under the supervision of a licensed clinician are also eligible.

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

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

I understand that, although there are no direct benefits to all participants in this study, my participation will contribute to obtaining greater understanding of the impact that the supervisory relationship has on willingness to disclose personal reactions in supervision. Also, I may choose to enter a drawing for one of four $30 gift cards to Amazon.com upon completion of the study by sending my e-mail address to an address provided at the end of the survey. I understand that

participation is not required to enter the drawing and participants may discontinue completing the survey at any time. Only the four winners will be notified by e-mail. Participants who do not win the drawing will not be notified. Drawing entrants' e-mail addresses will be kept confidential and will not be linked to survey responses. After the study is complete and the gift cards are sent to the drawing winners, the emails from participants will be deleted and the email account will be discontinued.

I understand that participation in this study poses no more than minimal risk and that I may decline to participate or discontinue participation at any time without any penalty. While the investigator does not anticipate that a participant would experience any harm as a result of participation, there is the possibility that describing current supervisory experiences or reflecting on the hypothetical examples might elicit discomfort. If such occurs, it is recommended that I consult with a trusted faculty member, clinical supervisor, or mental health professional to address any negative experiences. Also, I have been advised that I may consult with Dr. Falender or Dr. Shafranske through Pepperdine University at (310) 568-5600 to assist in addressing any negative experiences should they arise.

I understand that the study has been approved by the Pepperdine University Graduate and Professional Schools Institutional Review Board and that should I have any questions or comments regarding the study, I may the investigator at her email address, [investigator e-mail. I may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Thema Bryant-Davis, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at (310) 568-5600.

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

___ I voluntarily consent to participate in this study.

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

APPENDIX G

Part 1 of the Survey (Demographic Questionnaire) for COAMFTE Students

APPENDIX G

Part 1 of the Survey (Demographic Questionnaire) for COAMFTE Students

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

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

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

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

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

5. What percentage of your client contact hours is devoted to conducting couples psychotherapy?

A. 100%
B. 75-99%
C. 50-74%
D. 25-49%
E. Less than 25%

6. Which of the following best describes your primary theoretical orientation?

A. Cognitive-Behavioral (including cognitive and behavioral)
B. Existential/Humanistic
C. Psychodynamic
D. Family Systems- Bowenian
E. Family Systems- Strategic
F. Family Systems- Structural
G. Family Systems- Experiential
H. Family Systems- Narrative
I. Family Systems- Solution-Focused
J. Family Systems- Emotion-Focused
K. Other_____

7. Which of the following best describes your secondary theoretical orientation?

A. Cognitive-Behavioral (including cognitive and behavioral)
B. Existential/Humanistic
C. Psychodynamic
D. Family Systems- Bowenian
E. Family Systems- Strategic
F. Family Systems- Structural
G. Family Systems- Experiential
H. Family Systems- Narrative
I. Family Systems- Solution-Focused
J. Family Systems- Emotion-Focused
K. Other_____

8. How many months of supervised clinical experience do you have so far:

A. 0-3
B. 3-6
C. 6-9
D. 9-12
E. 12- 18
F. 18-24
G. Over 24 months
H. Other:_____

9. How many months have you worked at your current training site so far:

A. 0-3
B. 3-6
C. 6-9
D. 9-12
E. 12 or more

10. How many months have you worked with your current supervisor?
A. 0-3
B. 3-6
C. 6-9
D. 9-12
E. 12 or more

11. How many hours of individual supervision do you receive weekly?
A. 0.5 – 1 hour
B. 1-2 hours
C. More than 2 hours

12. How many hours of group supervision do you receive weekly?
A. 1-2 hours
B. more than 2 hours
C. Other

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

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

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

16. Which of the following best describes your primary supervisor's theoretical

orientation?

A. Cognitive-Behavioral (including cognitive and behavioral)
B. Existential/Humanistic
C. Psychodynamic
D. Family Systems- Bowenian
E. Family Systems- Strategic
F. Family Systems- Structural
G. Family Systems- Experiential
H. Family Systems- Narrative
I. Family Systems- Solution-Focused
J. Family Systems- Emotion-Focused
K. Other_____

17. Which of the following best describes your primary supervisor's gender?

A. Female
B. Male
C. Other (transgender, intersex, androgynous)
D. I don't know

18. Do you believe that you and your supervisor are of the same sexual orientation?

A. Yes
B. No
C. I don't know

19. Which of the following best describes your primary supervisor's racial/ethnic identification? Check all that apply.

A. African-American/Black
B. American Indian/Alaska Native
C. Asian/Pacific Islander
D. Hispanic/Latino
E. White (non-Hispanic)
F. Other
G. I don't know

20. What degree(s) does your supervisor have? Please select all that apply.

A. Ph.D.
B. Psy.D.
C. M.D.
D. M.F.T.
E. M.A.
F. L.S.W.
G. Other_____

21. What License(s) does your supervisor have? Check all that apply.

A. Psychologist
B. LMFT

C. MD
D. Other_____

APPENDIX H

Part 1 of the Survey (Demographic Questionnaire) for Participants Recruited by Mail, AAMFT Forums and Facebook

APPENDIX H

Part 1 of the Survey (Demographic Questionnaire) for Participants Recruited by Mail, AAMFT Forums and Facebook

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

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

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

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

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   A. 100%
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   E. Less than 25%

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   E. Family Systems- Strategic
   F. Family Systems- Structural
   G. Family Systems- Experiential
   H. Family Systems- Narrative
   I. Family Systems- Solution-Focused
   J. Family Systems- Emotion-Focused
   K. Other_____

7. Which of the following best describes your secondary theoretical orientation?
   A. Cognitive-Behavioral (including cognitive and behavioral)
   B. Existential/Humanistic
   C. Psychodynamic
   D. Family Systems- Bowenian
   E. Family Systems- Strategic
   F. Family Systems- Structural
   G. Family Systems- Experiential
   H. Family Systems- Narrative
   I. Family Systems- Solution-Focused
   J. Family Systems- Emotion-Focused
   K. Other_____

8. How many months of supervised clinical experience do you have so far:
   A. 0-3
   B. 3-6
   C. 6-9
   D. 9-12
   E. 12- 18
   F. 18-24
   G. Over 24 months
   H. Other:_____

9. How many months have you worked at your current training site so far:

A. 0-3
B. 3-6
C. 6-9
D. 9-12
E. 12 or more

10. How many months have you worked with your current supervisor?
A. 0-3
B. 3-6
C. 6-9
D. 9-12
E. 12 or more

11. How many hours of individual supervision do you receive weekly?
A. 0.5 – 1 hour
B. 1-2 hours
C. More than 2 hours

12. How many hours of group supervision do you receive weekly?
A. 1-2 hours
B. more than 2 hours
C. Other

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

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

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

16. Which of the following best describes your primary supervisor's theoretical orientation?
A. Cognitive-Behavioral (including cognitive and behavioral)

B. Existential/Humanistic
C. Psychodynamic
D. Family Systems- Bowenian
E. Family Systems- Strategic
F. Family Systems- Structural
G. Family Systems- Experiential
H. Family Systems- Narrative
I. Family Systems- Solution-Focused
J. Family Systems- Emotion-Focused
K. Other_____

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

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

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

20. What degree(s) does your supervisor have? Please select all that apply.
A. Ph.D.
B. Psy.D.
C. M.D.
D. M.F.T.
E. M.A.
F. L.S.W.
G. Other_____

21. What License(s) does your supervisor have? Check all that apply.
A. Psychologist
B. LMFT
C. MD
D. Other_____

22. Was your MFT program accredited by COAMFTE?
    A. Yes
    B. No
    C. I don't know

23. Is your supervisor an AAMFT Approved Supervisor?
    A. Yes
    B. No
    C. I don't know

APPENDIX I

Parts 2-4 of the Survey (Working Alliance Inventory, Countertransference Reaction Questionnaire, prize information)

APPENDIX I

Parts 2-4 of the Survey (Working Alliance Inventory, Countertransference Reaction Questionnaire, prize information)

Part 2 of Participant Survey

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

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

If the statement describes the way you always feel (or think), 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 will help me to accomplish the changes that I want in order to be a more effective counselor.
16. I feel that what _____ and I are doing in supervision is unrelated to my concerns.
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 toward mutually agreed-upon 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.

Part 3 of Participant Survey

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

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

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

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

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

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

with your current supervisor?

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

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

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

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

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

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

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

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

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

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

1	2	3	4	5	6	7

Extremely unlikely	Very unlikely	Unlikely	Uncertain	Likely	Very Likely	Extremely Likely

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. You are working with a family who tends to not address or discuss conflict. You come from a family in which conflict is not openly discussed. You find that you are colluding with the family and not discussing pertinent issues that they are facing. How comfortable would you be with discussing this reaction in supervision with your current supervisor?

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

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

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

10. You find that while working with a family, you feel frustrated and confused about their goals in therapy. You realize that when you are talking about this family in supervision, your supervisor appears frustrated and confused about the goals as well, which is a different reaction that your supervisor usually has in supervision. How comfortable would you be with discussing your supervisor's reaction in supervision with your current supervisor?

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

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

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

11. You notice that when talking with the family they tend to rely on your judgment and feedback before providing their own. Your work with families usually feels more collaborative. Family members in other families you have worked with usually are more vocal in session. In supervision, when talking about this family you tend to wait for your supervisor's input before providing your own. When talking about other families, you are more apt to provide your own feedback in collaboration with your supervisor, rather than waiting for your supervisor's input.

How comfortable would you be with discussing this in supervision with your current supervisor?

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

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

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

Part 4 of Participant Survey

To enter the drawing for one of the four $30 gift cards, please send an email to personalreactionstudy@gmail.com with your name and address that the gift card can be sent to. Please insert the completed survey into the envelope provided and send to the investigator. Thank you for your participation!

APPENDIX J

Permission to use Working Alliance Inventory-S

APPENDIX J

Permission to use Working Alliance Inventory-S

RE: Permission to use the WAI-S
Bahrick, Audrey S [audrey-bahrick@uiowa.edu]
You replied on 9/29/2013 7:48 PM.
Sent: Tuesday, September 24, 2013 12:57 PM
To: Busse, Anneka (student)

Dear Anneka,
Yes, of course you may have permission to use the WAI-S for your dissertation.
Sounds like a most interesting study.
Best,
Audrey

Audrey S. Bahrick, Ph.D.
Staff Psychologist
University Counseling Service
3223 Westlawn S
The University of Iowa
Iowa City, IA 52242-1100
319 335-7294
audrey-bahrick@uiowa.edu

APPENDIX K

Scoring Key for The Working Alliance Inventory- Supervisee Form

APPENDIX K

Scoring Key for The Working Alliance Inventory- Supervisee Form

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	-	+	-	-	-	+	+	+	-	+	+	-

APPENDIX L

Permission to use the Countertransference Reaction Questionnaire

APPENDIX L

Permission to use the Countertransference Reaction Questionnaire

July 2, 2014

Dr. Shafranske,

Please allow for this letter to serve as my agreement for the use of my Countertransference Reaction measure to be used in future dissertation studies under your advisement.

Sincerely,

Colleen Daniel, Psy.D.

On Wednesday, July 2, 2014 11:56 AM, Colleen Daniel <colleendaniel22@gmail.com> wrote:

Hi Anneka,

Please allow for this email to serve as consent to use my Countertransference Reaction Questionnaire in your dissertation research.
Good luck!
Colleen Daniel, Psy.D.

APPENDIX M

Recruitment Letter to Training Directors

APPENDIX M

Recruitment Letter to Training Directors

Dear Director of Training,

I am a student in the Psy.D. Program in Clinical Psychology at Pepperdine University. My dissertation examines the relationship between supervisory alliance and disclosure of therapists' personal reactions about psychotherapy clients, isomorphism and use of self in therapy. Marriage and family therapy trainees who have advanced to trainee status by completing the necessary coursework to begin to practice psychotherapy while under supervision by a licensed clinician from all COAMFTE accredited programs are invited to participate in this study. Since names and addresses of MFT students are not available, I am requesting the assistance of academic directors of training to forward this e-mail to all students who are trainees to participate in the research.

Participation in the study entails completing an on-line survey that includes a demographic section, description of their current supervision experience, and likely comfort and willingness to disclose personal reactions or countertransference in supervision to brief hypothetical clinical scenarios. The approximate time to complete the survey is 20 minutes. In appreciation of their time, participants may choose to send an e-mail to an address provided at the end of the survey to enter a drawing for one of four $30 gift cards to Amazon.com. E-mail addresses collected for the raffle will in no way be connected to survey data.

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

Link to the survey: https://www.surveymonkey.com/s/2F2K7R6

An abstract of this study is available upon request, and your school does not need to participate in order to receive a copy of the abstract. If you have any questions about this study, I can be contacted at my e-mail address, anneka.busse@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Thema Bryant-Davis, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at (310) 568-5600. It would be much appreciated if you would kindly forward this e-mail to your students. Thank you again for your assistance.

Sincerely,
Anneka Busse, M.M.F.T.
Doctoral Student,

Pepperdine University

APPENDIX N

Recruitment Letter to COAMFTE Participants

APPENDIX N

Recruitment Letter to COAMFTE Participants

Dear MFT Trainee,

I am a student in the Psy.D. Program in Clinical Psychology at Pepperdine University. In my dissertation, I am studying the relationship between supervisory alliance, disclosure of personal reactions in therapy in supervision, and use of self in therapy. I would deeply appreciate your help in completing this study. Students who are currently trainees who have advanced to trainee status by completing the necessary coursework to begin to practice psychotherapy while under supervision by a licensed clinician are being asked to participate. If you have not advanced to a trainee level, please do not take the survey.

The survey asks about your experience in supervision as well as your responses to several hypothetical situations. The time to complete the survey is about 20 minutes.

Of course, your participation is voluntary. The survey information will be obtained anonymously, no identifying information will be asked, and results will be reported as aggregate data. As a participant, you would complete an online survey related to your experience with your current primary supervisor, your comfort in discussing reactions to therapy clients, and a brief demographics questionnaire. In appreciation of your time, you may choose to send an e-mail to an address provided at the end of the survey to enter a drawing for one of four a $30 gift cards to Amazon.com. Participation is not required to enter the drawing and participants may quit at any time. Four winners will be notified by e-mail. Drawing entrants' e-mail address will be kept confidential and will in no way be linked to survey responses.

Participation in the study poses no more than minimal risk. While I do not anticipate you to experience any harm as a result of participation, there is the possibility that some of the hypothetical examples may elicit discomfort or describing your current supervisory experience may potentially result in discomfort. If such occurs, I recommend that you consult with a trusted faculty member, clinical supervisor, or mental health professional to address any negative experiences. You may also consult with Drs. Falender or Shafranske through Pepperdine University at (310) 568-5600 to assist in addressing any negative experiences should they arise. Benefits for your participation will be contributing to a greater understanding of the impact that the supervisory relationship has on students' willingness to disclose reactions, and possibly winning a $30 gift card. Please be advised that participating indicates that you acknowledge that you have been informed of the nature of the study, and that you have voluntarily agreed to participate.

An abstract of the study is available upon request by e-mail, and you do not need to participate in order to receive the abstract. If you have any questions or comments regarding the study, you may contact me at my e-mail address, anneka.busse@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Thema Bryant-Davis, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at (310) 568-5600.

Thanks again for your help with the completion of this dissertation! Completion of the online survey by ----- is greatly appreciated.

Sincerely, Anneka Busse, M.M.F.T.

APPENDIX O

Recruitment Letter to Online Participants

APPENDIX O

Recruitment Letter to Online Participants

Dear MFT Trainee or Intern/Associate,

I am a student in the Psy.D. Program in Clinical Psychology at Pepperdine University. In my dissertation, I am studying the relationship between supervisory alliance, disclosure of personal reactions in therapy in supervision, and use of self in therapy. I would deeply appreciate your help in completing this study. Students who are currently trainees who have advanced to trainee status by completing the necessary coursework to begin to practice psychotherapy while under supervision by a licensed clinician and are currently working at training sites are being asked to participate. If you have not advanced to a trainee level, please do not take the survey. All MFT Interns/Associates are invited to participate. Interns and associates are defined as those who have graduated from MFT programs and are currently accruing hours to be eligible for licensure. All participants must be currently working at a training site under the supervision of a licensed supervisor. MFT interns/associates who are working in private practices under the supervision of a licensed supervisor are also eligible. If you do not meet this criteria, please do not participate in this study.

The survey asks about your experience in supervision as well as your responses to several hypothetical situations. The time to complete the survey is about 20 minutes.

Of course, your participation is voluntary. The survey information will be obtained anonymously, no identifying information will be asked, and results will be reported as aggregate data. As a participant, you would complete an online survey related to your experience with your current primary supervisor, your comfort in discussing reactions to therapy clients, and a brief demographics questionnaire. In appreciation of your time, you may choose to send an e-mail to an address provided at the end of the survey to enter a drawing for one of four a $30 gift cards to Amazon.com. Participation is not required to enter the drawing and participants may quit at any time. Four winners will be notified by e-mail. Drawing entrants' e-mail address will be kept confidential and will in no way be linked to survey responses.

Participation in the study poses no more than minimal risk. While I do not anticipate you to experience any harm as a result of participation, there is the possibility that some of the hypothetical examples may elicit discomfort or describing your current supervisory experience may potentially result in discomfort. If such occurs, I recommend that you consult with a trusted faculty member, clinical supervisor, or mental health professional to address any negative experiences. You may also consult with Drs. Falender or Shafranske through Pepperdine University at (310) 568-5600 to assist in addressing any negative experiences should they arise. Benefits for your participation will be contributing to a greater understanding of the impact that the supervisory relationship has on students' willingness to disclose reactions, and possibly winning a $30 gift card. Please be advised that participating indicates that you acknowledge that you have been informed of the nature of the study, and that you have voluntarily agreed to participate.

An abstract of the study is available upon request by e-mail, and you do not need to participate in order to receive the abstract. If you have any questions or comments regarding the study, you may contact me at my e-mail address, anneka.busse@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Thema Bryant-Davis, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at (310) 568-5600.

Thanks again for your help with the completion of this dissertation! Completion of the online survey by 12/10/14 is greatly appreciated.

Sincerely, Anneka Busse, M.M.F.T.

APPENDIX P

Recruitment Letter to Interns

APPENDIX P

Recruitment Letter to Interns

Dear MFT Intern/Associate,

I am a student in the Psy.D. Program in Clinical Psychology at Pepperdine University. In my dissertation, I am studying the relationship between supervisory alliance, disclosure of personal reactions in therapy in supervision, and use of self in therapy. I would deeply appreciate your help in completing this study.

All MFT interns/Associates are invited to participate. Interns and associates are defined as those who have graduated from MFT programs and are currently accruing hours to be eligible for licensure. All participants must be currently working at a training site under the supervision of a licensed supervisor. MFT interns/associates who are working in private practices under the supervision of a licensed supervisor are also eligible. If you do not meet this criteria, please do not participate in this study.

The survey asks about your experience in supervision as well as your responses to several hypothetical situations. The time to complete the survey is about 20 minutes. I have included in this packet a paper copy of the survey, as well as a stamped and addressed envelope so you may send the survey back to me. Please do not put any personally identifying information on the envelope or the survey so you can remain anonymous. If you would like to complete the survey online, rather than mail the survey, you may access the survey by visiting https://www.surveymonkey.com/s/V283YVV.

Of course, your participation is voluntary. The survey information will be obtained anonymously, no identifying information will be asked, and results will be reported as aggregate data. As a participant, you would complete a survey related to your experience with your current primary supervisor, your comfort in discussing reactions to therapy clients, and a brief demographics questionnaire. In appreciation of your time, you may choose to send an e-mail to an address provided at the end of the survey to enter a drawing for one of four a $30 gift cards to Amazon.com. Participation is not required to enter the drawing and participants may quit at any time. Four winners will be notified by e-mail. Drawing entrants' e-mail address will be kept confidential and will in no way be linked to survey responses.

Participation in the study poses no more than minimal risk. While I do not anticipate you to experience any harm as a result of participation, there is the possibility that some of the hypothetical examples may elicit discomfort or describing your current supervisory experience may potentially result in discomfort. If such occurs, I recommend that you consult with a trusted faculty member, clinical supervisor, or mental health professional to address any negative experiences. You may also consult with Drs. Falender or Shafranske through Pepperdine University at (310) 568-5600 to assist in addressing any negative experiences should they arise. Benefits for your participation will be contributing to a greater understanding of the impact that the supervisory relationship has on students' willingness to disclose reactions, and possibly winning a $30 gift card. Please be advised that participating indicates that you acknowledge that

you have been informed of the nature of the study, and that you have voluntarily agreed to participate.

An abstract of the study is available upon request by e-mail, and you do not need to participate in order to receive the abstract. If you have any questions or comments regarding the study, you may contact me at my e-mail address, anneka.busse@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, or Dr. Thema Bryant-Davis, Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB) at Pepperdine University at (310) 568-5600.

Thanks again for your help with the completion of this dissertation! Completion of the online survey by 12/10/14 or receipt of the paper survey by 12/10/14 is greatly appreciated.

Sincerely, Anneka Busse, M.M.F.T.

APPENDIX Q

Advertisement for the Study

APPENDIX Q

Advertisement for the Study

Are you an MFT Trainee or MFT Intern/Associate? Participate in research while having a chance to win an Amazon gift card! Participants are needed for a study focusing on supervisory alliance, personal reactions in therapy, and isomorphism. Click here for the survey link: (Survey link) Questions? Email anneka.busse@pepperdine.edu

APPENDIX R

IRB

APPENDIX R
IRB

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

November 3, 2014

Protocol #: P0514D01-AM1
Project Title: Disclosure of Personal Reactions to Supervisors that Occur During Therapy and Supervisory Alliance Among Marriage and Family Therapy Trainees and Interns

Dear Ms. Busse:

Thank you for submitting your application, *Disclosure of Personal Reactions to Supervisors that Occur During Therapy and Supervisory Alliance Among Marriage and Family Therapy Trainees and Interns*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Shafranske, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Full Approval**. The IRB approval begins today, **November 3, 2014**, and terminates on **November 3, 2015**. In addition, your application to waive documentation of informed consent has been **approved**.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For ***any*** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **July 29, 2015**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
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