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Pepperdine University
Graduate School of Education and Psychology

SUPERVISORY ALLIANCE AND COUNTERTRANSFERENCE
DISCLOSURE OF SOCIAL WORK TRAINEES

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Payam Kharazi

August, 2016

Edward Shafranske, Ph.D., ABPP - Dissertation Chairperson

This clinical dissertation, written by

Payam Kharazi

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

DOCTOR OF PSYCHOLOGY

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DEDICATION

To my grandmother, who taught me the meaning of unconditional love and showed me the virtue of being selfless. To my family, who instilled in me the importance of education and supported me throughout this process.

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ABSTRACT

The purpose of this study was to examine the relationship between the supervisory alliance and countertransference disclosure of social work trainees in direct practice. Eighty-six social work trainees in direct practice, receiving supervision in field placement, ($N = 86$; 89.5% female, 8.1% male; 73.3% White, 11.6% Hispanic\Latino; 5.8% Asian/Pacific Islander, 4.7% bi-racial; 3.5% African American/Black) completed Internet-administered self-report questionnaires assessing comfort with and likelihood of countertransference disclosure in supervision, supervisory alliance bond, and demographic items. Analyses revealed statistically significant positive correlations between the supervisory alliance and comfort with and likelihood of countertransference disclosure among trainees. These results build on past findings regarding the importance of the supervisory alliance in relation to trainee disclosure among various mental health practitioners. The results of this study have significance for clinical supervision practices in developing supervisee competencies and promoting client welfare.

Keywords: Supervisory Alliance, Countertransference Disclosure, Social Work, Use of Self

Introduction

Clinical supervision is one of the primary ways clinical trainees in mental health, i.e., psychology, social work, counseling, learn and develop clinical skills in graduate school. It serves as the centerpiece of clinical training in which trainees at various levels of professional development refine their skills in applying science-derived knowledge and practices to solve human problems (Falender & Shafranske, 2015). An essential competency developed in supervision is greater awareness of the role of personal factors such as countertransference affecting professional practice. This competency may help enhance client welfare and advance the clinical skills of trainees. Countertransference, or emotional reactivity, which suspends empathetic engagement with a client, may be addressed in supervision by reviewing recorded sessions or by supervisee self-report or self-disclosure (Falender & Shafranske, 2015). However, since direct observation of recorded sessions are often limited or simply not available, supervisors largely rely on supervisees' self-disclosure to identify and to teach the management of countertransference. While self-disclosure is an effective way of identifying and teaching the proper use of countertransference, previous studies have demonstrated that trainees do not disclose significant and clinically relevant information during supervision (Hess et al., 2008; Mehr, Ladany, & Caskie, 2015; Yourman & Farber, 1996). Teaching trainees how to navigate personal issues and to manage countertransference reactions by increasing the likelihood of self-disclosure therefore plays an integral part in providing effective supervision, which has the potential to directly influence therapeutic process, treatment outcomes, and client welfare (Bambling & King, 2014; C. E. Watkins, 2014).

The literature suggests that a significant factor contributing to greater supervisee disclosure, including increased likelihood of trainee disclosure of countertransference reactions

(Daniel, 2008; Pakdaman, 2011), is the supervisory alliance (Bernard & Goodyear, 2014; Falender, Shafranske & Ofek, 2014). The supervisory alliance literature suggests that trainees report a higher willingness to disclose when they perceive that the supervisory alliance is strong (Ladany, Mori & Mehr, 2013; Mehr et al., 2015). Given how the supervisory alliance significantly impacts effective clinical supervision, which ensures client welfare and develops trainee competencies, it is not surprising that clinical training is moving towards a competency-based supervision model that has recently received increased attention in the supervisory literature (Kaslow, Falender, & Grus, 2012).

Although some studies have supported the relationship between supervisory alliance and trainee disclosure of countertransference among psychology graduate trainees, little is known about this area of increased importance in other mental health disciplines as well as how other professions (and their unique clinical approaches) address countertransference in supervision. In the current study, the likelihood and comfort in disclosing countertransference in supervision as mediated by the supervisory alliance, considers how this is approached within social work training. Such inquiry may shed light on how a discipline's unique perspectives and training culture and tradition may impact the supervision process. This may also be useful in considering (by virtue of contrast) the influence of psychology in shaping the training process, respective of countertransference. As we will learn, the field of social work places particular emphasis on "the use of the self." It is of interest whether such emphasis impacts the consideration of countertransference in contrast with psychology training in which such an emphasis is not universally applied.

Given the centrality of clinical supervision for education and training in the broader mental health profession, this study investigates countertransference disclosure of social work

trainees and how disclosure of countertransference reactions relates to the supervisory working alliance. A strong correlation between countertransference disclosure and supervisory working alliance among social workers would enhance and broaden the scope of the supervisory literature and would support future research endeavors informing effective supervision. The following presents a review of the major areas under investigation in this study.

Background

Social Work Practice

Social work practice consists of the professional application of social work values, principles, and techniques that encompass a wide range of services including direct or micro and indirect or macro practice. While social work services vary in scope and encompass practice skills ranging from policy and advocacy in community settings to psychosocial assessments and case management in direct practice settings, professional social work practice and the foundation of core competencies includes the dynamic and interactive processes of assessment, intervention, and evaluation at multiple levels with individuals, families, groups, organizations, and communities (National Association of Social Workers & Association of Social Work Boards, 2013). Micro level or direct practice skills are the foundational building blocks of social work practice, which are essential competencies even developed by trainees intending to work in macro or indirect service settings (Kharazi, 2008).

In addition to psychosocial assessments, case management, and counseling, a significant aspect of direct services includes the practice of clinical social work. Existing definitions of clinical social work slightly vary in emphasis but have in common the broad goal of restoring and improving bio-psychosocial functioning of individuals, couples, families, and groups through prevention, diagnosis, and treatment (American Board of Examiners in Clinical Social Work, 2002; National Association of Social Workers & Association of Social Work Boards, 2013). Clinical Social Workers provide 41% of the outpatient mental health services in the United States, and 70% of master's level and 40% of doctoral level social workers describe their primary function as direct service (Simpson, Williams, & Segall, 2007). The task of providing clinical training to social work trainees in direct practice falls primarily on MSW programs, with

an increased role of the supervisor and emphasis on supervision (Williams, 1997), to promote excellence in social work practice through development and advancement of the profession for the benefit of clients and clinicians who serve them.

Clinical Supervision

In the field of psychology, clinical supervision is at the centerpiece of clinical training. Falender and Shafranske (2004) define clinical supervision as:

A distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involves observation, evaluation, feedback, facilitation of supervisee self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving. (p. 3)

In addition to facilitating trainee competence and professionalism, clinical supervision includes ensuring client welfare and safeguarding the public and profession (Bernard & Goodyear, 2014; Falender & Shafranske, 2015). While clinical supervision in psychology has been traditionally unsystematic and based heavily on clinical theory, there has recently been a shift towards a competency-based approach (Falender & Shafranske, 2004; C. J. Watkins, 2011) in the hope of setting standards for effective supervision that develops trainee competence, ensures client welfare, and protects society and the profession.

Supervision in Social Work

Similar to the field of clinical psychology, the supervision standards in social work maintain that supervision is an integral part of training required for the skillful development of social workers. The National Association of Social Workers (NASW) and the Association of

Social Work Boards (ASWB) have developed best practice standards in social work supervision (supervision standards) to support and strengthen supervision for professional social workers. The standards provide a general framework that promotes uniformity and serves as a resource for issues related to supervision in the social work supervisory community. Supervision in social work is defined as:

The relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place. The supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency, and applicable ethical content in the practice setting. The supervisor and the supervisee both share responsibility for carrying out their role in this collaborative process. (National Association of Social Workers & Association of Social Work Boards, 2013, p. 6)

Again, similar to the field of psychology, in addition to ensuring that social workers have the necessary skills to deliver competent and ethical services to clients, the standards further state that supervision is also meant to protect clients, and to support practitioners.

Countertransference

Although defined and understood differently by various theoretical schools throughout the history of psychology, countertransference has long been recognized as influential in the therapeutic process. The traditional view, first addressed by Freud (1910), saw countertransference as emotional reactions that stem from the unresolved and unconscious conflicts of the therapist in response to the client. Freud believed that this negative impediment on the therapeutic process belonged solely to the therapist, who had to “recognize and overcome” this obstacle or simply renounce the ability to treat clients (Raines, 1996, p. 358). The

classical view was eventually challenged, and emotional reactions of the therapist towards a client were seen as either “subjective countertransference” (i.e., stemming from unresolved conflict of the therapist) or as “objective countertransference” (i.e., a therapist’s reactions based on the actual personality of the patient), representing one of the most important tools to be used in the therapeutic process. A more contemporary and universal view regards countertransference as an intersubjective process in the therapeutic relationship that consists of the entire repertoire of the therapist’s emotional responses to the client (in conjunction with the client’s responses to the therapist) that may help or hinder treatment (Gibbons, Murphy, & Joseph, 2011). As the theoretical understanding of countertransference has evolved (see Appendix A for a review of literature on countertransference), it is acknowledged that countertransference is ever present in the therapeutic process and must be constantly examined by psychotherapists, as it is an important influence on therapeutic outcome (Stearns, 1999; see Appendix A for a review of the literature on countertransference).

Countertransference in Social Work

Social work has historically understood the concept of countertransference similarly to that in clinical psychology. Based on Freudian influence, the training of clinical social workers or direct practitioners was initially heavily grounded in psychodynamic and psychoanalytic principles (Abbott, 2003). However, as the field of social work also began to view countertransference as an inevitable aspect of the therapeutic process, the humanness and subjectivity of the clinical social worker was embraced (Abbott, 2003). Additionally, as a variety of other forces (e.g., budgeting constraints of managed care, limited resources of delivery systems) emerged, the field of social work moved from a more psychodynamic and psychoanalytic approach to an emphasis on teaching generalist social work practice (Abbott &

Rosen, 2002). Consequently, although MSW programs differ somewhat in the basic practice skills that are taught, there are some clinical skills that are fundamental to clinical social work practice, and among these is the use of self through engagement and development of the therapeutic relationship.

Use of Self

Social work has long appreciated that the “use of self” is the primary vehicle for intervention and change. The social work literature defines the use of self as the social worker’s honesty and spontaneity, his or her genuineness, as well as the mindful use of one’s belief system, ability to be empathetic, a willingness to model and share one’s self, and the ability and willingness to thoughtfully self-disclose (Arnd-Caddigan & Pozutto, 2008). This fundamental and core skill of social workers includes an appreciation for the importance of self-awareness and attunement to the intersubjectivities of the relationship that involve both conscious and unconscious processes, including transference and countertransference dynamics (Simpson et al., 2007). The use of self is so strongly imbedded in social work education and practice that the Council on Social Work Education (CSWE; 2008) includes the proper use of self as a core competency in its education policy and accreditation standards. The CSWE states in its educational policy the significance of gaining sufficient self-awareness and recognizing and managing personal values in a way that allows for the conscious use of self. Furthermore, the American Board of Examiners in Clinical Social Work (2002) also highlights the clinical processes of transference and countertransference phenomenon as a practice competency in relation to the proper use of self. Accordingly, a prerequisite for the therapeutic use of self is self-awareness, which involves an ability to accurately recognize one’s emotions, beliefs and motivations (Reupert, 2007). Since social work practice involves the conscious and deliberate

use of oneself, the clinician becomes the medium through which knowledge, attitudes and skill are conveyed. Implicit in the clinician's use of self is that its use will be positive and directed at facilitating functional change for clients rather than being self gratifying for the clinician (Reupert, 2007).

Managing Countertransference

Social workers who are most likely to have difficulty in managing the experience of countertransference associated with strong emotional distress are those with less self awareness and little understanding of the theory and concept of countertransference (Latts & Gelso, 1995) or have minimal support available to them outside of the helping relationship. Poor management of countertransference reactions may have numerous adverse consequences in therapeutic and supervisory relationships and outcomes:

Ethical violations. Herb Stern who was a major advocate for increasing transference and countertransference components in social work education believed that the understanding of these key concepts and the ability for managing countertransference reactions were instrumental for minimizing therapist-client boundary violations, in particular sexual misconduct (Abbott, 2003). In a study by Pope, Keith-Spiegel, & Tabachnick (1986), which looked at the rate of sexual attraction of clinician's to their clients, 95% of male clinicians that participated in the study and 76% of female clinician's reported feeling sexually attracted to at least one of their clients. Furthermore, the study suggests that the remaining 5% of male clinicians and the 24% of female clinician's may have not been aware of their countertransference reactions towards their clients (Pope et al., 1986).

In every clinical situation, both the social worker and the client bring their own unique dynamics and history to the therapeutic relationship. Being aware of countertransference

reactions (such as sexual feelings), and understanding their origins may contribute significantly to the development of appropriate control and ethically responsible treatment (Strean, 1993). Conversely, denying or avoiding their existence may impede therapeutic progress and lead to boundary violations described in the Social Work Code of Ethics (Strean, 1993).

Cultural countertransference. The NASW (2008) Code of Ethics and the Council of Social Work Education (2008) Educational Policy and Accreditation Standards state that social workers have an ethical responsibility to be aware of their own clinical biases and how these biases may interfere with the therapeutic process. With an emphasis on providing culturally congruent treatment to clients, it is imperative that social workers are aware of their own cultural biases and that they recognize how cultural biases may impact the therapeutic process. The term “cultural-based countertransference” is conceptualized by Stampley (2008) to be the “clinician’s culturally held assumptions, values, attitudes, standards, worldviews, and intergenerational messages along with their feelings and thoughts about the client” (p. 40). When social workers are able recognize their cultural countertransference and its impact on the therapeutic process and outcomes, they are able to expand their understanding to better appreciate client diversity and to provide culturally congruent treatment. However, social work practitioners are often not aware of or able to process their own cultural biases that may prove to create an impasse in the therapeutic relationship, halt exploration of particular dynamics, and lead to premature termination and high dropout rates of ethnic minorities in therapy (Foster, 1998; Sue, 1988).

Disclosing countertransference in therapy. Like many authors in the field, Renik (1993) has demonstrated that the clinician “cannot eliminate, or even diminish his or her subjectivity” (p. 562 as cited by Strean, 1999). Clinicians are always personally involved as they make professional assessments, therapeutic interventions, clinical decisions, and choices of

theoretical models. It is even argued that therapeutic technique and interventions are always a countertransference enactment even at times when the technical procedure is considered to be a valid and acceptable (Strean, 1999). Accordingly, as clinical social workers' subjectivity has moved towards a more acceptable occurrence and even a necessary requirement for delivering proper interventions, clinical decisions surrounding disclosure and non-disclosure of countertransference reactions in therapy have become increasingly significant (Maroda, 2003). Strean (1999), for example, proposed throughout his work that self-disclosure of the countertransference is the key to resolving therapeutic impasse with clients. However, others argue that self-disclosure in therapy may in part reflect a lack of self-awareness on the part of the clinician and is a manifestation of countertransference (Knight, 2012). Carl Rogers, an early theorist who wrote about the use of self, acknowledged that therapist genuineness would inevitably include a self even in ways that are not regarded as ideal for psychotherapy. He recognized the impact that countertransference may have in the use of self and argued that the more the clinician is aware of her or his reactions the less likely it is that these reactions will compromise the therapeutic relationship (Knight, 2012). Shulman's interactional model of social work practice builds upon and expands Rogers' earlier understanding by including both therapist transparency and self-disclosure as elements of use of self. Like Rogers, he acknowledges that the therapist will at times disclose feelings and reactions to the client that are inconsistent with the purpose of the intervention and might reflect countertransference, and he therefore also cautions that appropriate disclosure requires a high level of self-awareness. Although there continues to be disagreement about the usefulness or appropriateness of self-disclosure as a technique in psychotherapy, many authors agree that it is impossible not to self-disclose (Knight, 2012).

In summary, most theorists agree that the disciplined use of self is an essential element in becoming an effective psychotherapist and in providing quality client care and welfare (Edwards & Bess, 1998). However, research indicates that trainees often have difficulty acquiring this essential competency (Edwards & Bess, 1998). For example, in a study that measured social worker's attitudes towards engagement of self-disclosure in therapy revealed that one half of the respondents "disagreed" or "strongly disagreed" that their education prepared them to engage in self disclosure, and more than 60% of the respondents "disagreed" or "strongly disagreed" that they were comfortable seeking guidance from a supervisor or a colleague regarding self-disclosure (Knight, 2012).

Importance of Effective Supervision

Social workers acknowledge that they bring more to their work than just their professional knowledge and skill (Reupert, 2006). Each individual's unique self that is brought to the clinical hour contributes to the effectiveness of a psychotherapy session. This notion highlights the point that the training of clinician's should not only focus on technique and theory, but also on the personal qualities clinician's bring to practice (Reupert, 2006). Among the greatest challenges for a social worker in training is the process of learning to incorporate and make sense of the immense amount of information that is communicated and received throughout the course of even a single psychotherapy session (McTighe, 2011). At a time in training when a trainees emerging sense of professional identity is often delicate, the task of sorting out the internal responses evoked by a patient while attempting to conceptualize case material can seem impossible (McTighe, 2011). While the classroom may serve as a place for students to learn about the proper use of self, self-awareness, and countertransference, the clinical supervisor serves as a key role and may be in the best position to guide the trainee

through this process (McTighe, 2011). It is in large part through supervision that a therapist trainee is guided in the process of growth, discovery, integration, and proper use of self (McTighe, 2011). The NASW (2013) even explicitly states in their supervisory best practice standards that it is important for supervisors to “identify feelings that supervisees have about their clients that can interfere with or limit the process of professional services” (p. 13).

Trainee Non-Disclosure in Supervision

In order for supervisors to promote the proper development of trainees’ clinical competence, trainees must disclose information about their clients, clinical interactions, and their own experiences in the supervisory relationship (Mehr, Ladany, & Caskie, 2010). While supervisors often and readily have access to client charts, diagnosis, attendance, and even recorded sessions, they heavily rely on trainee disclosure to develop core competencies, such as managing countertransference reactions, in their supervisees. However, the literature on trainee self-disclosure and supervision indicates that trainees often do not disclose clinically relevant and significant events in supervision (Mehr et al., 2015). For example, a study that examined the extent of non-disclosure in supervision found that 97.2% of supervisees surveyed reported withholding information from their supervisors (Ladany, Hill, Corbett, & Nutt, 1996). Consistent with this study among psychology students, the social work literature further indicates that clinician’s are more likely to attempt to manage personal reactions in therapy themselves rather than discussing them with a supervisor, even though consultation with another professional is more likely to lead to a positive resolution (Knight, 2012).

In addition to the loss of potential learning experiences, non-disclosure in supervision by trainees can contribute to significantly diminish clinical effectiveness and to compromise the quality of the therapeutic and supervisory relationship (Mehr et al., 2015). The empirical

evidence indicates that trainee non-disclosure most often surrounds concerns regarding supervision related issues, although it also involves clinical issues and personal values (Mehr et al., 2010; Yourman & Farber, 1996). Research that has investigated common factors leading to trainee non-disclosure in supervision suggests that non-disclosure is related to concerns such as negative reactions to the supervisor, evaluation concerns, disagreement with supervisor, attraction to supervisor, impression management, shame, anxiety, potential for negative reactions by supervisors, and supervisee's view that the issue was unimportant or irrelevant (Banks & Ladany, 2006; Hess et al., 2008; Ladany et al., 1996; Mehr et al., 2010; Pisani, 2005). Even with these numerous factors that are associated to non-disclosure, which understandably contribute to a trainee's hesitation in disclosing personal and significant reactions or events in supervision, it seems likely that given the right conditions, supervisees have a desire to disclose personal and relevant information to supervisors in order to receive feedback and to develop as competent clinicians (Gard & Lewis, 2008). For example, in a study of doctoral psychology students in training that were given questionnaires to evaluate their supervisors, the highest percentage in the below average category was the awareness of countertransference in supervision. Trainees generally seemed to indicate that a core limitation of their supervision experience was discussions surrounding counter-transference (Bucky, Marques, Dalley, Alley, & Karp, 2010). In general, studies suggest that knowledgeable or competency-based supervision is not readily available to either clinicians or students in training (Knight, 2012) in order to promote supervisee self-disclosure in supervision.

Supervisory Alliance

It is widely acknowledged that effective supervision is developed by a collaborative supervisory relationship and characterized by a strong supervisory working alliance, which is a

significant factor contributing to greater supervisee disclosure (Falender & Shafranske, 2015). Of the various elements that contribute to the supervision relationship, none seems to be more powerful and influential on supervisor and supervisee than the supervisory alliance (Gard & Lewis, 2008). The supervisory alliance, which is thought of as the supervision equivalent of the psychotherapy alliance, has emerged as extremely significant in the conduct of an effective supervision experience, which is the common factor affecting the process and outcomes of clinical supervision (C. E. Watkins, 2014). The construct of the supervisory working alliance, first addressed by Bordin (1983), is commonly used by mental health professionals, particularly psychologists and social workers (C. E. Watkins, 2014). The alliance was initially described as forming from a mutual agreement on goals, the means to achieve the goals, and a relational bond between partners (Falender & Shafranske, 2004). Interpersonal qualities of the supervisor such as warmth, empathy, respect, trust, genuineness, flexibility, and competence also seem to be associated with a strong supervisory alliance (Falender & Shafranske, 2015). Bernard and Goodyear (2014) further indicate that factors related to supervisors such as appropriate self-disclosure, use of power differential, attachment style, emotional intelligence, and ethical behavior in addition to factors related to supervisees such as attachment style, emotional intelligence, previous negative supervisee experiences, and stress and coping also affect the alliance (see Appendix B for a review of the literature on supervisory alliance).

Supervisory Alliance and Social Work

A significant work published on supervision in social work by Kadushin and Harkness (2014) describes the process of supervision in the context of a relationship. Kadushin and Harkness emphasize that the interaction of supervisor and supervisee is a significant aspect of supervision that at its best is cooperative, democratic, participatory, mutual, respectful, and open.

As noted earlier, the task of guiding a trainee social worker in developing the proper use of self, with awareness for self-knowledge and countertransference reactions, falls largely to the clinical supervisor who must therefore pay close attention to the supervisory relationship (McTighe, 2011). The supervisor is largely in a unique position to teach the proper use of self because they have the opportunity to model and to demonstrate its use in the supervisory relationship (McTighe, 2011). For example, Knox, Burkard, Edwards, Smith, & Schlosser (2008) found that a supervisor's proper self-disclosure of personal reactions to supervisees' patients helped to normalize supervisees' feelings towards personal reactions, served as a teaching tool, and strengthened the supervisory alliance. The identification and exploration of personal reactions to the patient by the supervisor helps supervisees translate that insight into clinically useful interventions that will advance treatment (McTighe, 2010). Research suggests that a supervisor's deliberate transparency and openness about therapeutic mistakes and challenges has been found to foster the supervisory alliance and to encourage supervisee honesty and openness (Knight, 2012).

Importance of Supervisory Alliance

The supervisory literature suggests that a strong supervisory working alliance is associated with factors in trainees such as greater self-report of satisfaction with supervision, improved cultural competence, internalization of supervisor, trainees' perceived self-efficacy, supervisee therapeutic alliance, adherence to treatment protocols, and increased likelihood of trainee disclosure (Bernard & Goodyear, 2014; Falender & Shafranske, 2015; Falender, Shafranske & Ofek, 2014; Inman et al., 2011), including disclosure of countertransference reactions (Daniel, 2008; Pakdaman, 2011). Conversely, a weaker supervisory alliance has been associated with supervisee self-report of supervisor ethical violations, negative or

counterproductive events in supervision, greater supervisee role conflict, and trainee non-disclosure (Gray, Ladany, Walker, & Ancis, 2001; Mehr et al., 2015; Ramos-Sanchez et al., 2002).

Limitations in Supervisory Research

Among competency standards that promote effective supervision, building and maintaining the supervisory working alliance may be the most essential competency to establish with supervisees. While the literature on supervision has tremendously grown over the recent years and the supervisory working alliance has received increased attention, widely being acknowledged as significant to treatment outcomes, there is still a need for further illuminating the research in this area. As C. E. Watkins (2014) stated in his review of the supervisory alliance literature over the past half century, “compared to psychotherapy alliance research, which a decade ago was then identified as involving well over 1000 empirical findings, the number of supervision alliance research findings pales pitifully by comparison” (p. 48). With a limited number of investigations per year for supervision study output, research on supervisory working alliance is still at an early phase and needs to be further established. Furthermore, very few large sample quantitative studies have specifically investigated the relationship between disclosure and non-disclosure of personal or countertransference reactions and the supervisory alliance. Since supervisors largely rely on supervisee self-disclosure to develop competencies in their trainees, it is critical to extend the current literature by conducting additional studies that examine the relationship between trainee disclosure and the supervisory alliance.

Purpose of Study

Building upon the research of Daniel (2008) and Pakdaman (2011), the current study aimed to expand upon the understanding of countertransference disclosure and the supervisory

alliance with social work trainees providing clinical services. Given the significant role that clinical social workers play in direct mental health services, studying countertransference disclosure and supervisory alliance with this population will broaden the scope of the current research available in the mental health discipline, thereby supporting social work supervisors and trainees in developing stronger working alliances. Additionally, it will provide information regarding possible differences for trainee disclosure and supervisory alliance between social work trainees in clinical practice, psychology trainees, and psychology interns.

Methods

Research Approach

This study uniquely researched the effects of the supervisory alliance on self-reported comfort and likelihood of countertransference disclosure among social work trainees in direct practice. Given the significance of social workers in direct practice among mental health practitioners, it is important to understand the relationship between supervisory alliance and countertransference disclosure among this population. As the first known study of its kind within the field of social work, this research will help social work supervisors provide effective supervision in order to build trainee competencies in managing countertransference reactions. The study replicated the same hypotheses as Daniel (2008) and Pakdaman's (2011) studies but with a different sample population and included a revised demographics section and addition of items to the survey instruments specific to social work training. While previous research studied psychology interns and trainees, this study looked at social work trainees in direct practice.

Replication studies are a significant aspect of scientific research because they help determine whether results are reliable and generalizable in addition to determining whether or not a study is sound by its ability to be replicated (Chow, 2010). Therefore, if the results of this study are similar to Daniel and Pakdaman, then it can be determined that the supervisory alliance is also related to the self-reported comfort and likelihood of countertransference disclosure among social work trainees in direct practice.

This study used a survey approach to obtain self-reported data of supervisees. A survey approach was implemented because it provides the most economical option for sampling a large population in addition to helping protect participants' anonymity and to enhance honest reporting at their own convenience.

Research Hypotheses and Questions

The following research hypotheses were tested:

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

In addition to the research hypotheses, the following research questions were explored:

1. Is there a positive association between supervisors' use of self and reported comfort in supervisee disclosure of countertransference reactions in therapy?
2. Is there a positive association between supervisors' use of self and reported likelihood of supervisee disclosure of countertransference reactions in therapy?

Participants

Participants recruited for this study were masters level social work students enrolled in graduate programs accredited by the Council on Social Work Education (CSWE). Social work trainees providing direct services under supervision in field placement were invited to participate in this survey. Information regarding the scope of participants' training and experiences including services offered and supervision received, was gathered through the surveys. Overall, 101 social work students responded to the recruitment email and accessed the survey. Of the 101 respondents, 1 respondent was excluded from the analysis for disagreeing with the opening question to obtain informed consent, "You have read the information provided above and have been given a chance to ask questions. Your questions have been answered to your satisfaction and you agree to participate in this study." In addition, another 13 respondents (12.9%) who consented to participate were excluded, as they did not complete any further survey questions,

and 1 respondent was excluded as they indicated that they were not an MSW student seeking a doctorate in Social Work, yielding a final dataset of 86 subjects.

General characteristics of participants. Demographic characteristics of the 86 participants are displayed in Table 1 and demographic characteristics of participant's supervisors are displayed in Table 2. Of the 86 participants, 77 (89.5%) were female, 7 (8.1%) were male, and 1 (1.2%) was transgender. It is significant to note that the breakdown in gender among the respondents of this survey are not surprising given that the majority of students in master's level social work programs appear to identify as female. According to a 2014 annual survey by the Council on Social Work Education, 84.1% of full-time and part-time social work master's students identified as female. In regards to racial/ethnic identification, 73.3% of participants identified as White (non-Hispanic), 11.6% as Hispanic/Latino, 5.8% as Asian/Pacific Islander, 4.7% as bi-racial, 3.5% as African American/Black, and 1.2% did not report their racial/ethnic identification. In terms of various direct services rendered at field placement, 79.1% reported providing counseling\psychotherapy services, 46.5% reported providing case management services, and 27.9% reported other (e.g., advocacy, education workshops). For primary theoretical orientation, 49.4% described their orientation as cognitive behavioral, 16.5% as family systems, 15.3% as psychodynamic, 7.8% as eclectic/integrative, 11.8% as other (e.g., Adlerian, feminist), and 7.1% as existential\humanistic. For their future practice in the field of social work, 79.1% indicated pursuing a macro level of practice, 27.9% indicated pursuing a micro level practice, and 11.6% were undecided.

Instrumentation

Previous survey instruments already established by Daniel (2008) and Pakdaman (2011) were used to collect anonymous information for this study. The survey included three

questionnaires: 1) The Working Alliance Inventory-Supervisee Form (WAI-S); 2) the Countertransference Reaction Disclosure Questionnaire; and 3) the participant demographic questionnaire.

Working Alliance Inventory Supervisory Form. Modeled after Horvath and Greenberg's Working Alliance Inventory (WAI; 1989), Bahrnick (1990) created the Working Alliance Inventory-Supervisee Form (WAI-S). While the WAI is used to assess therapeutic alliance between client and therapist, the WAI-S was adapted in 1990 by Bahrnick in order to assess alliance between supervisee and supervisor. The WAI Supervisory version is a 36-item Likert scale, which includes three components of the alliance (goals, tasks, and bond) that have been assigned 12 items each (see Appendix C). Bahrnick (1990) found an inter-rater reliability rate of 97.6% for items assessing the bond component of the alliance, 64% for items assessing the task component, and 60% for items assessing the bond component. Permission to use this instrument was granted by Audrey Bahrnick.

For the purpose of this study, only the Bond Scale of the WAI-S was used as a measure of the supervisory working alliance (see Appendix D). As mentioned earlier, the Bond Scale has the highest known psychometric properties (97.6% inter-rater agreement) as compared with the other subscales and previous studies have found that the Bond Scale of the WAI-S was most related to trainee self-reported feelings of comfort in supervision whereas the goals and tasks agreement subscales did not uniquely contribute to trainees feeling of comfort (Ladany, Ellis, & Friedlander, 1999). Furthermore, by only using the Bond Scale, the WAI-S condensed from 36 to 12 items and may have likely reduced burden on participants, increasing participation in the study.

Countertransference Reaction Disclosure Questionnaire. The Countertransference Reaction Disclosure Questionnaire was developed by Daniel (2008) to assess supervisees' comfort in disclosing countertransference reactions to their supervisors. Hypothetical countertransference situations were created in order to avoid the intensity and discomfort of personal reactions that would arise as a result of trainees using their own experiences based on previous scenarios. The comfort in disclosure is measured through 8 hypothetical situations that were adapted from a factor analysis of Betan, Heim, Conklin, & Westen's (2005) Countertransference Questionnaire. The eight manifestations of countertransference reflected in the hypothetical situations include: 1) overwhelmed/disorganized; 2) helpless/inadequate; 3) positive; 4) special/overinvolved; 5) sexualized; 6) disengaged; 7) parental/protective; and 8) mistreated/criticized. After reading each scenario, the participant rates how comfortable and likely they are to disclose countertransference reactions on a 7-point Likert scale ranging from 1 (*extremely uncomfortable*) to 7 (*extremely comfortable*; see Appendix E). One additional question was added to this questionnaire in order to reflect the extent of which social work trainees may implement self-disclosure in therapy associated with the use of self, a core skill identified among social workers (Arnd-Caddigan & Pozutto, 2008).

Demographic Questionnaire. Pakdaman's (2011) Demographic Questionnaire was adapted and used to survey social work trainees in direct service (see Appendix F). Since it is common for social workers to be supervised by allied mental health professionals, a question regarding the type of degree and license held by trainee's supervisor has been added to the demographic questionnaire along with questions regarding education components of countertransference and the implementation of use of self by supervisors in supervision.

Research Procedures

The survey was administered online using an electronic survey posted on the Internet. The following sections describe the participant recruitment process, human subjects protection, and survey administration.

Participant recruitment. The investigator contacted directors of field education from programs accredited by The Council on Social Work Education by email. There were a total of 254 CSWE accredited Master's programs in social work. Directors of field training were also contacted for recruitment.

The recruitment letter to the directors (see Appendix G) included the purpose of the study, possible risks of study, and information on how to contact the researcher, dissertation chair, and chairperson of the Institutional Review Board. Directors of field education were asked to send the link with the survey to students (see Appendix H) in their respective programs via email. One follow-up reminder after approximately two weeks was also sent to directors (see Appendix I) asking to forward the letter and survey to students if they had not already done so (see Appendix J). Directors were not notified if their students completed the survey and in order to protect the confidentiality of participants, the researcher in connection to the survey did not obtain email addresses of participants. Furthermore, participants were given the option of being informed of the results summary of the study. No participants contacted investigator for summary results or for any other purpose.

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 to 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 of Individually Identifiable Health Information and the California Protection of Human Subjects in Medical Experimentation Act (U.S. Department of Health & Human Services). An expedited review was sought because there only exists a minimal possibility that participants will experience discomfort in response to answering questions about the hypothetical scenarios and because this is a replication of previous studies that were granted approval by the Institutional Review Board. The Pepperdine Institutional Review Board approved the study for investigation.

Consent for participation. Potential participants that received the survey were informed of the study's purpose and intent, the potential risks and benefits, and the procedures on the website that contains the study instruments. Participants were notified in the informed consent (see Appendix K) that they have the option of withdrawing and refusing participation in the study at any point along with being informed of the steps the researcher is taking to ensure their anonymity and confidentiality. By checking a box at the end of the electronic consent form, participants confirmed and demonstrated that they had read the consent information, understood the nature, risks, and benefits of the study, and agreed to participate.

Potential benefits and risks. This study is designed to pose the least amount of potential risk for participants. Minimal risk may include inconvenience due to time spent participating in the study, fatigue, and the potential for distress associated to responding to questions of the survey. Steps for minimizing risk associated with this study was taken by attempting to make administration as convenient as possible and by suggesting that participants seek assistance to deal with any distress related to answering questions on the survey. While the risk of this study eliciting distressful emotional reactions among participants will be reduced through the use of

hypothetical scenarios and by sampling social work trainees familiar with supervision issues, it is possible that participants may have felt discomfort by recalling personal scenarios that may be a source of distress in their supervisory relationships. Consequently, participants were provided the name and contact information of the researcher, the project advisor, and advised to contact a trusted mentor, supervisor, or clinician in the event that participation in this study resulted in distress. No participants contacted the investigator regarding distress associated to this study or for any other purpose.

Additionally, while there may be no direct benefit for participating in this study, participants may have derived satisfaction from contributing to scientific knowledge of mental health practice and clinical supervision. Participation in this study provided valuable information related to effective supervision that may help mental health trainees gain greater competence in providing clinical services to clients. Lastly, participation in this study may have also facilitated a process of reflection on the supervisory relationship and work with clients, which is described as a foundational competency for clinical practice (Fouad et al., 2009 as cited by Ofek, 2013).

Data collection and recording. Researcher contacted the director of field education for all CSWE accredited programs and directors of field training via email and asked them to forward the email request for participation to their students. The directors of field did not receive information regarding any student's participation status in the study or regarding their survey results. Participants in the survey remained anonymous, as will the data. All files regarding study results are stored on the researcher's computer in a password-protected file and all data will be destroyed 3 years after completion of the research analysis.

Data Analysis and Description of Study Variables

After the closure of the web-based survey, the raw data was first examined for missing

data and errors and a determination was then made for final inclusion in data analysis. The final dataset was converted from the web-based survey to data analysis software and a combination of descriptive statistics and correlational analyses were used to analyze the data. Descriptive statistics were used to report the variables of participant and supervisor demographics and one-tailed correlational analyses were used to report the relationship between the variables of comfort and likelihood of trainee countertransference disclosure and the supervisory alliance, which were the primary hypotheses under study. Additional post-hoc analyses were also considered after further reviewing the data and statistical analyses.

Definitions

The following definitions used by Pakdaman (2011) and Daniel (2008) for countertransference and the supervisory alliance will be used for the purpose of this study. Countertransference is defined 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” (Kiesler, 2001, p. 1062). Supervisory alliance and working alliance is described as the “relationship between the supervisor and supervisee” (Pakdaman, 2011, p. 30) based on the agreement on goals, tasks, and bond in the relationship.

Results

The purpose of this study was to test the relationship between the bond component of the supervisory alliance and supervisee comfort with and likelihood of countertransference disclosure. The distribution of the bond variable was inspected prior to running analyses, as it was anticipated that bond scale scores would show a slight left skew reflecting most supervisees reporting a strong bond with their supervisors.

Examination of the descriptive statistics for the WAI Bond subscale supported this prediction. Scores were non-normally distributed, with skewness of -1.11 ($SE = 0.26$) and kurtosis of 0.74 ($SE = 0.55$). Because of the skewness and kurtosis associated with the supervisory alliance bond variable, a Spearman rank correlation analysis was performed, since it does not assume a normal distribution among variables. Although it was found that the data for the supervisory alliance bond component did not reflect a normal distribution, the skew and kurtosis were determined to be acceptable for performing further data analyses.

Hypothesis 1

The first research hypothesis was that there is a positive association between supervisory alliance and reported comfort in supervisee disclosure of countertransference reactions in therapy. Results supported this hypothesis. Because the bond component of the supervisory alliance was not normally distributed, correlational analysis using Spearman's rank correlation was performed and found a moderate, positive correlation between the two variables (bond $r_s = .48, p = 0.01$).

Hypothesis 2

The second research hypothesis was that there is a positive association between supervisory alliance and reported likelihood of supervisee disclosure of countertransference

reactions in therapy. Results supported this hypothesis. Because the bond component of the supervisory alliance was not normally distributed, correlational analysis using Spearman's rank correlation was performed and found a moderate, positive correlation between the two variables (bond $r_s = .48, p = 0.01$). Both analyses yielded the same result, as respondents answered "comfort" and "likelihood" very similarly.

Additional Research Hypotheses

After further reviewing the data and statistical analyses in addition to the primary hypotheses, post-hoc analyses were considered. Specifically, two additional research questions were investigated. The first research question examined the relationship between supervisors' use of self and reported comfort in supervisee disclosure of countertransference reactions in therapy. The Supervisor Use of Self scale was not markedly skewed (skew = $-.85, SE = .26$); therefore, correlational analyses using Pearson's R was performed and revealed that there was a moderate, positive correlation between the two variables (bond $r = .53, p = 0.01$). Furthermore, the second research question examined the relationship between supervisors' use of self and reported likelihood of supervisee disclosure of countertransference reactions in therapy. Correlational analyses using Pearson's R was performed and revealed that there was a moderate, positive correlation between the two variables (bond $r = .54, p = 0.01$).

Discussion

The current study proposed to expand upon the understanding of countertransference disclosure and the supervisory alliance with social work trainees. Given the significant role that social workers play in direct mental health services, studying countertransference disclosure and supervisory alliance with this population was intended to broaden the scope of the current research available in the mental health discipline, thereby supporting supervision practices and trainee competencies. Specifically, this study examined the relationship between the supervisory working alliance bond component and social work trainees' comfort with and likelihood of countertransference reaction disclosure. As explained earlier, the bond component of the WAI-S was exclusively used because past studies have shown that the bond scale was most related to self-reported feelings of comfort by trainees in supervision (Ladany et. al., 1999). This implication is of relevance to the hypotheses of this study that measures the extent of disclosure in supervision among trainees and captures the overall alliance between supervisor and supervisee, as it is believed that the goals and tasks scales of the WAI-S are captured in the bond scale since agreement on goals and tasks contribute to a relational bond over time (Bordin, 1983).

Results in this study supported both research hypotheses. A positive correlation was found between the supervisory alliance bond component and comfort with countertransference disclosure, indicating that with a stronger alliance, comfort with disclosure increases. Additionally, a positive correlation was found between the supervisory alliance bond component and likelihood of countertransference disclosure, indicating that with a stronger alliance, the likelihood of disclosure increases. The significant findings in this study are consistent with previous research on the positive association between alliance and disclosure in supervision

(Daniel, 2008; Ladany et al., 1996; Ofek, 2013; Pakdaman, 2011).

The Supervisory Working Alliance and Trainee Disclosure

The supervisory alliance has been commonly cited in the literature as an integral component of clinical supervision (Bordin, 1983; Falender & Shafranske, 2015; Mehr et al., 2015). The findings of this study further highlight the significance for the relationship between the supervisory alliance and disclosure. Furthermore, this study is the first known study to explicitly examine the relationship between the supervisory working alliance bond scale and the comfort with and likelihood of countertransference disclosure among social work trainees. As a result, the study supports the notion that similar to other mental disciplines, social work trainees may be more comfortable and likely to disclose countertransference reaction in supervision when the supervisor and supervisee alliance is strong. Moreover, the study provides a better understanding into the discipline of social work that emphasizes a different conceptual model for viewing countertransference. In particular, the use of self described as a core competency in social work may provide further insight for attaining alliance in supervision, as discussed below.

Supervisor Use of Self

Use of self has been cited in the literature as a core competency and skill in social work practice (Arnd-Caddigan & Pozutto, 2008). As such, it is significant to note that this study also examined the relationship between supervisors' use of self and the comfort with and likelihood of countertransference disclosure among social work trainees. The results indicate that a positive relationship exists between these two variables and interestingly; the results are almost identical to the findings between the relationship of the supervisory alliance and the comfort and likelihood of countertransference disclosure. The use of self, so heavily emphasized in social work practice, may have significant implications for clinical training.

Implications for Clinical Training

The likelihood of self-disclosure by trainees plays an integral part in providing effective supervision, which has the potential to directly influence therapeutic process, treatment outcomes, and client welfare (Bambling & King, 2014; C. E. Watkins, 2014). When supervisees perceive that supervisors like and support them, they are less likely to be concerned with being negatively judged and are therefore more likely to disclose countertransference reactions. It is therefore important for supervisors to provide an environment that fosters a positive working alliance with supervisees, thereby increasing the likelihood of self-disclosure among their trainees. However, although the supervisory alliance is widely acknowledged as an integral part of supervision, the research is still sparse as to what constitutes the alliance (C. E. Watkins, 2014). It could therefore be a challenging task for supervisors to know what constitutes a strong supervisory working alliance in order to foster a positive alliance with supervisees. Supervisors' use of self, as defined in this study by honesty and spontaneity, genuineness, the mindful use of one's belief system, ability to be empathetic, and the ability and willingness to thoughtfully self-disclose (Arnd-Caddigan & Pozutto, 2008) may begin to answer this question. This study is therefore unique in the sense that the examination of supervisor use of self in relation to comfort and likelihood of disclosure may further contribute to better understanding alliance. In addition to building strong alliance with supervisees, supervisors may consider explicitly discussing the importance of examining countertransference disclosure with trainees in their supervision contracts. Setting standards in a collaborative way with supervisees at the start of the supervisory relationships will likely contribute to overall alliance (i.e., goals, tasks, and bond) thereby facilitating greater disclosure of countertransference among trainees.

Limitations

The following are limitations of this study that have been identified and noteworthy to consider. This study exclusively used self-report instruments when sampling trainees and may have therefore resulted in self-report bias. Additionally, since a non-experimental approach was used, it is not possible to make causal conclusions about the relationship between the supervisory alliance and disclosure. These variables may exist in a bidirectional relationship where alliance positively influences disclosure and disclosure positively influences alliance. Also, it was not possible to determine the response rate since it is unknown how many directors or supervisors actually received the survey invitations and who forwarded the survey to social work trainees. Lastly, external validity may be in question due to sample size. The study also did not yield a large sample, making it difficult to generalize the results to the social work trainee population. Similarly, the skewness in the results across the bond component of the supervisory alliance somewhat limits the conclusion that can be established based on the data. Despite the limitations, the significant findings and consistency in replication results as compared to previous studies within other mental health disciplines, makes this study meaningful.

Directions for Future Research

Since this is the first known study to examine the relationship between the supervisory working alliance and comfort and likelihood of disclosure among social work trainees, further studies may aim to replicate this study with the social work population. It would also be important for future studies to attempt to gain a larger sample size, thereby making the result more generalizable to the larger social work population. Additionally, upon comparing the means among the nine-countertransference hypothetical scenarios in the survey, it was revealed that the item indicating sexual attraction to one's client had the lowest mean as compared to the other

scenarios. This indicates that trainees may be less comfortable and less likely to disclose sexual attraction to their client's in supervision as compared to other scenarios even when the alliance is reported to be strong. The implications of these findings regarding disclosure surrounding a sexualized scenario are consistent with a previous study conducted by Ofek (2013) with disclosure among psychology doctoral students in training. Future research endeavors may therefore also focus on better understanding this phenomenon, as sexual attraction in therapy is common and important for learning how to manage in the welfare of client care (Abbott, 2003). Furthermore, these results suggest that supervisors should be particularly attentive to sexualized transference that may rise in a supervisees work with clients. Lastly, as mentioned earlier, future studies may focus further on the use of self in relation to disclosure in order to better inform understanding of the supervisory alliance. Specifically, it is of utmost interest and significance to further study how supervisor use of self may influence the bond component of the supervisory alliance. Based on the theoretical understanding of use of self in the social work literature, as written about and cited in this research, it may be hypothesized that higher use of self among supervisor's correlates with a greater alliance among supervisor and supervisee. Studying this hypothesis further in future studies will significantly contribute to the social work literature on supervision practices and lend a useful theory and practical application for supervisors in other mental health disciplines for attaining greater alliance with their supervisees.

Conclusion

The relationship between the working alliance and countertransference disclosure of trainees has not been widely researched or studied. In this study, based on Pakdaman's (2011) and Daniel's (2008) hypotheses, the relationship between the supervisory alliance and countertransference disclosure of supervisee's among social work trainees was studied. 86 social work trainees provided responses to the study instruments regarding their most recent social work field placement experience. Results supported the hypotheses that the bond component of the supervisory working alliance was significantly related to trainee comfort with and likelihood of countertransference disclosure to supervisors.

The importance for understanding the relationship between supervisory alliance and trainees' self-disclosure of countertransference reactions is of great significance because supervisors rely on supervisees' self-disclosure to develop trainees' competencies (Falender & Shafranske, 2015). By being one of the first known studies to examine this relationship among social work trainees, this study will provide a greater knowledge base for contributing valuable information in support of promoting effective supervision and training practices among mental health supervisees and supervisors in addition to advancing future research endeavors.

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Table 1

Participant Demographics (N = 83-86)

	<i>n</i>	Valid %
Gender		
Female	77	89.5
Male	7	8.1
Other (transgender)	1	1.2
Race/Ethnicity		
African-American/Black	3	3.5
American Indian/Alaska Native	0	0
Asian/Pacific Islander	5	5.8
Hispanic/Latino	10	11.6
White (non-Hispanic)	63	73.3
Bi-Racial	4	4.7
Unknown	1	1.2
Year in MSW program		
1 st year	24	27.9
2 nd year	45	52.3
3 rd year	8	9.3
4 th year	1	1.2
Advanced Standing, 1-year program	7	8.2
Field Placement, Population Served		
Adults	31	36.9
Children/Adolescents	31	36.9
Geriatrics	5	6.0
Family	5	6.0
Combined	12	14.3
Field Placement, Direct Services Rendered		
Case Management	40	46.5
Counseling	68	79.1
Other (ex: Advocacy, Education Workshops, etc.)	24	27.9
Field Placement, Hours of Direct Services Rendered		
1 - 3 hours	19	22.9
4 - 6 hours	17	20.5
7 - 9 hours	15	18.1
10+ hours	32	38.6
Field Placement, Time conducting individual therapy		
100%	3	4.3
99-75%	22	31.9
74-50%	16	23.3
49-25%	12	17.4
< 25%	16	23.2

(continued)

Field Placement, Experience		
< 1 month	1	1.2
1-2 months	3	3.5
3-4 months	48	56.5
5+ months	33	38.8
Theoretical Orientation, Primary		
Cognitive-Behavioral	42	49.4
Existential/Humanistic	6	7.1
Family Systems	14	16.5
Psychodynamic	13	15.3
Other (ex: Adlerian, Eclectic, Feminist Theory, etc.)	10	11.8
Theoretical Orientation, Secondary		
Cognitive-Behavioral	24	28.6
Existential/Humanistic	6	7.1
Family Systems	29	34.5
Psychodynamic	11	13.1
Other (ex: Mindfulness, TF-CBT, etc.)	14	16.7
Future Practice		
Macro	68	79.1
Micro	24	27.9
Undecided	10	11.6

Table 2

Supervisor Demographics (N =82 - 85)

	<i>n</i>	Valid %
Gender		
Female	64	77.1
Male	19	22.9
Other (transgender)	0	0
Race/Ethnicity		
African-American/Black	5	5.9
American Indian/Alaska Native	0	0
Asian/Pacific Islander	2	2.4
Hispanic/Latino	13	15.3
White (non-Hispanic)	62	72.9
Bi-Racial	1	1.2
Unknown	2	2.4
Hours of Supervisee Supervision, Weekly		
< 30 minutes	16	18.8
1 hour	45	52.9
1.5 hours	17	20.0
2+ hours	7	8.2
Theoretical Orientation		
Cognitive-Behavioral	47	56.5
Existential/Humanistic	5	6.0
Family Systems	14	16.9
Psychodynamic	9	10.8
Other (ex: DBT, Trauma Theory, etc.)	8	9.6
Degrees Held*		
PhD	4	4.9
MSW	78	95.1
MSS	3	3.7
MBA	2	2.4
Master in Mental Health Counseling	1	1.2
Licenses Held*		
Psychologist	2	2.4
LCSW	49	59.8
LMSW	18	22.0
None	6	7.3
Other (ex: ASW, LCPC, LISW)	6	7.3

Note. Categories were not mutually exclusive; some supervisors held multiple degrees/licenses.

APPENDIX A

Extended Review of Countertransference Literature

An undeniable aspect of psychotherapy, regardless of theory and technique, is its interpersonal nature. Therefore, a critical aspect in becoming an effective psychotherapist is the ability for developing competency in the appropriate use of self (McTigeh, 2011). The appropriate use of self naturally hinges on numerous personal factors a psychotherapist brings to the therapeutic relationship, which has great impact on a therapist's ability to emphatically engage with a client. Providing effective treatment relies on both professional and personal competencies that ultimately create change for clients (Falender & Shafranske, 2012).

Throughout the history of psychology, the importance for identifying and attending to personal factors that may negatively impact treatment have been highlighted and conceptualized. Freud (1910) first introduced the notion of countertransference to refer to a psychotherapist's emotional response towards a client that may be rooted in unresolved and unconscious conflict. According to Freud, countertransference is an obstacle to clinician objectivity that interferes with treatment and must therefore be resolved by the therapist in his or her own analysis in order to ultimately provide effective treatment. Since Freud, the construct of countertransference has been largely re-conceptualized and developed over time. The following provides a brief overview for the historical and contemporary perspectives on countertransference that have evolved since Freud first introduced the idea in 1910.

While Freud largely viewed countertransference as a negative impediment rooted in the clinician, Heimann (1950) provided a significantly different understanding that viewed countertransference as the clinician's total responsiveness to the client. In his influential paper (1950), Heimann explained that countertransference is rooted in the client and is not an impediment but rather a highly informative tool for understanding clients (Hinshelwood, 1999). Klein, concerned about clinicians claiming that clients perhaps cause their own emotional

difficulties, stayed closer to Freud's original understanding and viewed countertransference as an intrapsychic process in which the client's mental contents are projected onto the psychotherapist, evoking emotional reactions in the therapist (projective identification). Still broadening this view, the postmodern perspective views countertransference as an expression of intersubjectivity, co-constructed by conscious and unconscious dynamics between the client and psychotherapist. This perspective highlights the unique interaction in each relationship that subjectively creates meaning within the interaction (Hinshelwood, 1999).

While primarily rooted in psychoanalytic thought, the concept of countertransference has been largely acknowledged across orientations. For example, cognitive theorists identified countertransference as schemas, which are cognitive representations of one's past experiences or situations. Schemas, stemming from a therapist's personal history may trigger maladaptive emotional reactivity towards a given client and may even trigger a client's own maladaptive schemas (Ivey, 2013). In summary, personal factors undoubtedly influence therapeutic process through a clinician's countertransference. Regardless of the various definitions that have been offered for countertransference or the language used to describe this phenomenon, it is important for all therapists to engage in a process of self-discovery to better understand personal factors and to gain competencies in providing effective treatment (Falender & Shafranske, 2012). The following table highlights and expands upon the major historical and contemporary views of countertransference that have been identified.

Table A1

Summary Table of Selected Literature: Countertransference

Theorist	Main Contributions
Freud (1910)	CT stems from the clinician's unresolved and unconscious conflict, which must be worked through in order to provide effective treatment.
Ferenczi (1952)	Completely trying to overcome CT may hinder a clinician's emotional responsiveness. Sharing CT with a patient may therefore be helpful.
Stern (1924)	CT may stem from a clinician's own unresolved conflicts or may be in response to a patient's transference. Therapist can use CT to better understand the unconscious workings of a client.
Glover (1927)	Clients' psychosexual conflicts can evoke similar developmental conflicts in the clinician.
Klein (1946)	Introduced CT as Projective Identification: an intrapsychic process in which the client's mental contents are projected onto the therapist, evoking emotional reactions.
Winnicott (1949)	Introduced CT as Objective CT: emotional reactions towards a client that others similarly experience; sharing such information with client can be very instrumental in therapy.
Heimann (1950)	CT is the total emotional responsiveness to the client, which originates in the client and is useful information for therapy.
Reich (1951)	CT is not a therapeutic tool and was not useful for understanding or communicating with the patient.
Racker (1953)	Distinguished between complementary and concordant CT. Complementary referring to reactions to a client that are detrimental because they are similar to how client's early objects reacted vs. Concordant that identifies with client's experience with empathy.
Kernberg (1965)	CT is influenced by the object relations of both therapist and client. It could be helpful in understanding transference of clients that

	regress to use of primitive defenses.
Bion (1988)	A clinician brings with them prior understanding of client into the room, which influences material surfacing by client in therapy. This hinders the therapeutic process.
Kohut (1968)	Through empathy and vicarious introspection, therapist understands a client's unconscious communications and CT helpful to accomplish this goal.
Sandler (1976)	Suggests that the pressure of the interpersonal relationship applied by the client influences the therapist to further identify with a client's projections.
Stolorow (1988)	CT stems from the intersubjectivity of the unique interaction between client and therapist.
Hoffman (1991)	Clinicians understanding of a client is influenced by his or her dynamics and the interaction is constantly evolving.
Renik (1993)	CT is inevitable and can only be understood in retrospect but not in the moment.
Ogden (1994)	Introduced the concept of the Analytic Third: an all-present and evolving co-construction of meaning between client, therapist, and the interaction in the relationship.
Levine (1997)	Material that resonates within a therapist will likely evoke therapist's similar memories or psychological experiences.
Gabbard (2001)	CT, created by both therapist and client, is inevitable and ultimately useful in therapy because the client will unconsciously draw therapist to play a role representative of his or her internal workings.

APPENDIX B

Extended Review of Supervisory Alliance Literature

In its early inception, psychology training and clinical supervision were largely unsystematic and relied significantly on clinical theory to inform its practice (Falender & Shafranske, 2015). As the field of clinical psychology developed and moved towards a more systematic approach for training and for providing effective treatment, factors influencing effective supervision also began to be identified. Similar to the therapeutic relationship that has been identified as a common factor instrumental in the change process, so too is the supervisory relationship widely acknowledged to be essential in effective supervision, influencing supervisory and treatment outcomes (C. E. Watkins, 2014). Of the many factors that contribute to the supervisory relationship (e.g., supervisory style, supervisee anxiety, transference and countertransference issues, attachment style, and diversity), none seem to be more influential than the supervisory alliance. The notion of alliance, first alluded to by Freud, has a longstanding history in psychology (C. E. Watkins, 2014). However, it was Bordin who addressed the construct of the working alliance first in regards to the therapeutic relationship and subsequently to the supervisory relationship (1983). In his construct of the supervisory working alliance, Bordin (1983) identified three core elements: the supervisor-supervisee bond, collaboratively established goals, and collaboratively established tasks to achieve supervision goals. The bond element of the supervisory working alliance was considered to involve supervisor and supervisee shared “feelings of liking, caring, and trusting” (Bordin, 1983, p. 36 as cited by C. E. Watkins, 2014) and the goals component included eight possible goals to guide supervision process: mastery of specific skills, enlarging one’s understanding of clients, enlarging one’s awareness of process issues, increasing awareness of self and impact on process, overcoming personal and intellectual obstacles toward learning and mastery, deepening one’s understanding of concepts and theory, providing a stimulus to research, and maintaining standards of service (pp. 37-38).

Lastly, Bordin (1983) identified three tasks in order to achieve these goals: oral or written report by the therapist to be reviewed in supervision, review of therapy sessions through audio, video, or live observation, and presentation of problem issues selected by supervisee to be discussed in supervision. Bordin's model of the supervisory working alliance has generally proven to be highly durable, paving the way for psychotherapy supervision practice and research (C. E. Watkins, 2014; Ladany & Inman, 2012). Building upon Bordin's conceptual model, additional interpersonal and professional factors have been associated to the alliance, which have been identified through various studies conducted on supervisory alliance (Falender and Shafranske, 2015). The following table summarizes the major findings in the supervisory working alliance literature.

Table B1

Summary Table of Selected Literature: Supervisory Alliance

Author(s) and Year	Sample	Selected Findings
Bambling & King (2014)	40 Supervisors and 50 Supervisees	Supervisor interpersonal skill predicted supervisory alliance and outcome.
Bennett, BrintzenhofeSzok, Mohr, & Saks (2008)	72 MSW Students	The attachment component in supervision was a strong predictor for perceived supervisory alliance.
Bordin (1983)	Theoretical/Conceptual	The supervisory working alliance, which was built upon the therapeutic alliance, includes three components: bond, goals, and tasks to achieve the goals.
Bucky, Marques, Daly, Alley, & Karp (2010)	86 clinical psychology interns	Factors identified by supervisees related to quality supervision and alliance included supervisors' above average intelligence, a positive attitude towards themselves, ethical integrity, strong listening skills, and attractiveness.
Carey, Williams, & Wells (1988)	7 post-doctoral students, 10 doctoral students, 31 Masters level students	Perceived supervisor level of expertise, attractiveness, and trustworthiness was significantly correlated to supervisee performance ratings.
Carifio & Hess (1987)	Literature Review	Identified ideal supervisors as having high levels of empathy, respect, genuineness, flexibility, concern, investment, and openness. Ideal supervisory alliance parallels strong therapeutic relationship
Cooper & Ng (2009)	64 supervisees on internship	Higher level of emotional intelligence was related to stronger perceived supervisory alliance.
Daniel (2008)	175 pre-doctoral interns	Strong supervisory alliance

(Dissertation)		was correlated with increased comfort and likelihood of supervisee self-disclosure in supervision.
Davidson (2011)	184 MSW students	Indicated a strong correlation between supervisor self-disclosure and perceived supervisory alliance.
Dickson, Moberly, & Marshall, & Reilly (2011)	259 clinical psychology trainees	Ratings of supervisory working alliance by trainees were related to their perception of supervisor's attachment style.
Gard & Lewis (2008)	Literature Review	Indicates that the therapeutic relationship parallels the supervisory relationship and supervisors should therefore pay great attention to countertransference and parallel process issues in supervision. Attending to these issues with sensitivity for power differential and evaluation build supervisory alliance that in turn leads to positive therapeutic outcomes.
Gatmon, Jackson, Koshkarian, Martos-Perry, Molina, Patel, & Rodolfa (2001)	289 clinical psychology interns	Discussion of culture in supervision was associated with satisfaction of supervisee with supervision and supervisory alliance.
Gnilka, Chang, & Dew (2012)	232 supervisees	Supervisee stress was related to perception of weak supervisory alliance whereas increased coping resources was related to stronger alliance.
Hatcher & Barends (2006)	Literature Review	Highlights the reciprocal nature of the alliance between supervisor and supervisee that should include optimism and engagement with sensitivity for maintaining appropriate boundaries.

Horvath & Symonds (1991)	Literature Review	Strong supervisory alliance was determined to increase therapeutic outcomes of clients.
Inman, Ladany, Boyd, Schlosse, Howard, Altman, & Stein (2011)	109 doctoral level advisees	Indicated that Supervisees are concerned about the power differential in the supervisory relationship, including evaluation, and confidentiality.
Ladany (2004)	Literature Review	Multicultural Competence enhances supervisory working alliance whereas role conflict and ambiguity is associated to a weak supervisory alliance.
Ladany & Friedlander (1995)	123 supervisees	Role conflict and ambiguity in supervision was related to the supervisory working alliance.
Ladany & Lehrman-Waterman (1999)	105 supervisees	Strong correlation found between supervisors' self-disclosure and supervisory alliance.
Ladany & Lehrman-Waterman, Molinaro, & Wolgast (1999)	151 supervisees	Perception of supervisors' ethical behaviors was related to perception of supervisory alliance.
Ladany, Ellis, & Friedlander (1999)	107 supervisees	Specifically identified the emotional bond component of the supervisory alliance to be related to supervisees' satisfaction with supervision.
Ladany, Mori, and Mehr (2013)	128 supervisees	Supervisees indicated that the supervisory relationship and alliance was most important in determining the "best" and "worst" supervisor.
Ladany, Walker, and Melincoff (2001)	137 supervisors	Indicated a strong relationship between supervisory style and the components of the supervisory alliance.
Mehr, Ladany, & Caskie (2015)	201 psychology doctoral students	Found that higher counseling self-efficacy among supervisees predicted less

		anxiety in supervision, trainee perception of a stronger supervisory working alliance predicted less anxiety in supervision, and perception of a stronger alliance predicted higher willingness to self-disclose in supervision.
Nelson, M, Friedlander, M., Walker, J., Gray, L., & Ladany, N. (2001)	Literature Review	Indicates that when trainees' expectations of the evaluative process of supervision are congruent then a strong alliance may occur.
Renfro-Michel & Sheperis (2009)	117 graduate students	Indicated that supervisee attachment was correlated to supervisory alliance, with secure attachment related to stronger alliance.
Webb & Wheeler (1998)	96 counselors	Supervisees' willingness for self-disclosure in supervision was strong correlated to strong supervisory alliance.

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APPENDIX C

Working Alliance Inventory-Supervisee Form

WORKING ALLIANCE INVENTORY: SUPERVISEE FORM Instructions: On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her supervisor. As you read the sentences, mentally insert the name of your current primary supervisor at your field placement 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 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.

SCORING KEY FOR THE WORKING ALLIANCE INVENTORY

TASK Scale: 2, 4, 7, 11, 13, 15, 16, 18, 24, 31, 33, 35

Polarity + + - - + - + + + - - +

BOND Scale: 1, 5, 8, 17, 19, 20, 21, 23, 26, 28, 29, 36

Polarity - + + + + - + + + + - +

GOAL Scale: 3, 6, 9, 10, 12, 14, 22, 25, 27, 30, 32, 34

Polarity - + - - - + + + - + + -

APPENDIX D

Working Alliance Inventory--Supervision: Supervisee Bond Scale Only

Instructions: On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her supervisor. As you read the sentences, mentally insert the name of your current primary supervisor at your field placement 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 wanted.

1. I feel uncomfortable with _____.
2. _____ and I understand each other.
3. I believe _____ likes me.
4. I believe _____ is genuinely concerned for my welfare.
5. _____ and I respect each other.
6. I feel that _____ is not totally honest about his or her feelings towards me.
7. I am confident in _____’s ability to supervise me.
8. I feel that _____ appreciates me.
9. _____ and I trust one another.
10. My relationship with _____ is very important to me.
11. I have the feeling that it is important that I say or do the “right” things in supervision with _____.
12. I believe _____ cares about me even when I do things that he or she doesn’t approve of.

Scoring Key for the Working Alliance Inventory – Bond Scale

BOND Scale: 1, 5, 8, 17, 19, 20, 21, 23, 26, 28, 29, 36
 Polarity - + + + + - + + + + - +

APPENDIX E

Countertransference Reactions Questionnaire

Instructions: The following items include scenarios that may be encountered in the course of social work training. Please read each scenario and rate how comfortable you would be discussing these scenarios in supervision and the likelihood that you would discuss these scenarios in supervision. **When responding, please base your answers on your current primary supervisor at your field placement.**

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 tend to 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 this in supervision with your current supervisor?

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

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

2. After reviewing several audiotapes of your sessions with a particular client, you notice that you have been avoiding 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 discussing this in supervision with your current supervisor?

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

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

3. Your client has been making progress towards his or her goals, and you feel that you have developed a strong working alliance with him or her. Sessions flow smoothly, you are able to utilize interventions at appropriate times, and you tend to enjoy your work together.

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

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

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

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

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

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

What is the likelihood that you would actually discuss this in supervision 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 discussing this in supervision with your current supervisor?

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

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

6. Every session with a particular client results in you feeling bored. Before sessions, you feel slightly agitated and annoyed with this client for no reason. During sessions, you find yourself daydreaming, thinking about other things, and otherwise withdrawing from the client.

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

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

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

7. During session your client reveals to you that he or she is having problems accepting and understanding a close friend's homosexuality. You begin to feel anxious as they discuss this.

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

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

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

8. Over the course of treatment, your client has criticized you, repeatedly questioned your ability to help them, and told you that you are a terrible social worker. 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 discussing this in supervision with your current supervisor?

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

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

9. In your work with a client whose cultural background differs than your own, you notice that certain cultural differences may be interfering with the therapeutic process.

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

1 2 3 4 5 6 7

Extremely uncomfortable Very uncomfortable Uncomfortable Uncertain Comfortable Very comfortable Extremely comfortable

What is the likelihood that you would actually discuss this in supervision with your current supervisor?

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

10. For the items below, please consider your work with clients and rate to what extent you engage in the following behaviors in sessions with your clients at your current field placement.

A. Honestly disclose your reactions to topics discussed by your clients:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

B. Spontaneous in the way you relate to and interact with your clients:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

C. Genuine in the way you relate to and interact with your clients:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

D. Incorporate the use of your personal beliefs in your work with clients:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

E. Empathize with your clients:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

F. Use self-disclosure with your clients:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

G. Collaborate with your clients (i.e., establishing goals for your clients):

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

Permission to Use 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 wrote:

APPENDIX F

Demographic Questionnaire

Instructions: For each item, please select the answer choice that is most appropriate for you. If there is not an answer that is appropriate, select “other” and type your response in the box provided. **When responding to items about your supervisor and field placement, please base your answers on your current primary supervisor at your current field placement.**

1. What year in your MSW program are you currently enrolled in?

- A. First Year
- B. Second Year
- C. Other _____

2. Are you currently enrolled in a concentration area of practice in your MSW program? If so, please indicate which concentration?

- A. Yes.
Concentration Area: _____
- B. No

3. Which of the following best describes your current field placement?

- A. Veterans Affairs hospital or medical center
- B. Community counseling center
- C. University counseling center
- D. Social Service Agency
- E. Private general hospital
- F. State/county/other public hospital
- G. Correctional facility
- H. Public psychiatric hospital
- I. Private psychiatric hospital
- J. Private outpatient clinic
- K. School district
- L. Armed Forces medical center
- M. Child/Adolescent psychiatric or pediatrics
- N. Foster Care Agency
- O. Substance abuse treatment facility
- P. Child Welfare Organizations
- Q. Other _____

4. How many months have you been working at your current field placement?

- A. Less than 1 month
- B. 1 to 2 months
- C. 3 to 4 months
- D. 5 months or more

5. Which of the following best describes the population you are primarily working with at your current field placement?

- A. Adults
- B. Children/adolescents
- C. Geriatrics
- D. Family
- E. Combined

6. What type of direct services do you provide to clients at your current field placement? Please check all that apply.

- Case Management
- Counseling\Psychotherapy
- Other _____

7. How many hours of direct services (i.e., case management, counseling, psychotherapy) do you provide to clients weekly at your current field placement?

- A. 1 - 3 hours
- B. 4 - 6 hours
- C. 7 - 9 hours
- D. 10 hours or more

8. What percentage of your client contact hours at your current field placement is devoted to conducting individual psychotherapy\counseling?

- A. 100%
- B. 75-99%
- C. 50-74%
- D. 25-49%
- E. Less than 25%
- F. Did not conduct individual psychotherapy\counseling

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

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

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

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

- D. Psychodynamic
- E. Other _____

11. What type of Social Work do you intend to practice in the future? Please check all that apply.

- Micro Practice (i.e, case management, counseling, psychotherapy)
- Macro Practice (i.e., community organization, policy & administration)
- Other _____
- Undecided

12. Which of the following best describes your racial/ethnic identification? Please 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 _____

13. Which gender do you identify with?

- A. Female
- B. Male
- C. Other (trans., intersex)

14. How many hours of individual supervision do you receive weekly at your current field placement?

- A. 0.5 – 1 hour
- B. 1-2 hours
- C. More than 2 hours

15. Which of the following best describes your primary supervisor's theoretical orientation at your current field placement?

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

16. Is your primary supervisor's gender the same or different as yours at your current field placement?

- A. Same

B. Different

17. Which of the following best describes your primary supervisor's racial/ethnic identification at your current field placement? Please check all that apply.

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

18. What degree(s) does your primary supervisor have at your current field placement? Please select all that apply.

- A. Ph.D.
- B. Psy.D.
- C. M.D.
- D. M.F.T.
- E. M.A.
- F. MSW
- G. Other _____

19. What License(s) does your primary supervisor have at your current field placement? Please check all that apply.

- A. Psychologist
- B. LMFT
- C. MD
- D. LCSW
- E. LMSW
- F. Other _____

20. How familiar are you with the concept of *countertransference*?

- A. Very familiar
- B. Somewhat familiar
- C. Not familiar at all

21. To what extent does your current field placement teach concepts of *countertransference*?

- A. Very much
- B. Somewhat
- C. Not at all

22. To what extent has your graduate school education taught concepts of *countertransference*?

- A. Very much
- B. Somewhat
- C. Not at all

23. To what extent does your primary supervisor at your current field placement disclose his or her countertransference reactions to your clients in supervision?

- A. Very much
- B. Somewhat
- C. Not at all
- D. Not Applicable

24. For the items below, please rate to what extent your primary supervisor at your current field placement engages in the following behaviors in your supervision.

A. Honestly discloses his or her reactions to topics you discuss in supervision:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

B. Is spontaneous in the way he or she relates to and interacts with you:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

C. Is genuine in the way he or she relates to and interacts with you:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

D. Incorporates his or her personal beliefs in supervision:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

E. Empathizes with you:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

F. Uses self-disclosure in supervision:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

G. Collaborates with you (i.e., supervisor and supervisee are flexible about setting agenda for supervision):

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

H. Is transparent and open about therapeutic mistakes and challenges he or she has experienced:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

APPENDIX G

Recruitment Letter to Director of Field Education

Dear Director of Field Training,

I am a doctoral student in clinical psychology at Pepperdine University. As part of my dissertation project, I am examining the relationship between supervisory alliance and disclosure of countertransference reactions, and use of self in social work practice. This study pertains to social work trainees from an institution accredited by the Council on Social Work Education, currently providing direct services to clients in field placement under supervision as part of their training. Your program has been identified as a CSWE accredited graduate social work program. I am contacting all CSWE accredited social work graduate programs and requesting their assistance with my study. It would be much appreciated if you would kindly forward this e-mail to your social work trainees.

Participation in this study entails completing an online survey about supervision experience in addition to rating comfort in disclosing to supervisors hypothetical scenarios that may be encountered in social work training. Information regarding participant demographics and program type will also be collected, although no identifying information is collected regarding academic or training programs as part of this study. Completion time for this study is approximately 15 to 20 minutes.

If you have any questions or comments, please do not hesitate to contact me, at payam.kharazi@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, at edward.shafranske@pepperdine.edu or Dr. Judy Ho, Chairperson of the Graduate & Professional School Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

Thank you in advance for your assistance with the completion of this study.

Sincerely,

Payam Kharazi, MSW
Clinical Psychology Doctoral Student
Pepperdine University

APPENDIX H
Recruitment Letter to Participants

Dear Social Work Trainee,

I am a clinical psychology doctoral candidate at Pepperdine University conducting a study to meet my dissertation requirements under the supervision of Edward Shafranske, Ph.D., ABPP, professor at Pepperdine's Graduate School of Education and Psychology. I am conducting a brief study examining the relationship between supervisory alliance and disclosure of countertransference reactions, and use of self in social work practice. Participation in this study entails completing an online survey about your supervision experience in addition to rating comfort in disclosing to supervisors hypothetical scenarios that may be encountered in social work training. Information about your demographics and program type will also be collected; however, no identifying information is collected regarding academic or training programs as part of this study.

I believe that as a social work trainee, you are in the unique position of offering invaluable insights about training experiences that may be helpful to future trainees and their supervisors. I would greatly appreciate your assistance with my study. Participation in this study is entirely voluntary and is expected to take no more than 20 minutes. Participation is open to all social work trainees currently providing direct services to clients under supervision at field placements. Please feel free to forward this invitation to any social work trainee you may know that is currently providing direct services to clients under supervision at field placement.

A link to the web address of the surveys can be found below this message.

Thank you in advance for your assistance with the completion of this study.

Sincerely,

Payam Kharazi, MSW
Clinical Psychology Doctoral Student
Pepperdine University

APPENDIX I

Follow-up Recruitment Letter to Director of Field Education

Dear Director of Field Training,

A few weeks ago, I sent you an invitation for study participation to be forwarded to your social work trainees. If you have not yet forwarded this invitation to your social work trainees, I hope that you will consider forwarding this invitation so your trainees may have the opportunity to inform supervision practices for future trainees and their supervisors. If you have already forwarded this invitation to your trainees, I truly appreciate you taking the time to do so. Information about the study sent in my previous correspondence can be found below.

I am a doctoral student in clinical psychology at Pepperdine University. As part of my dissertation project, I am examining the relationship between supervisory alliance and disclosure of countertransference reactions, and use of self in social work practice. This study pertains to social work trainees from an institution accredited by the Council on Social Work Education, currently providing direct services to clients in field placement under supervision as part of their training. Your program has been identified as a CSWE accredited graduate social work program. I am contacting all CSWE accredited social work graduate programs and requesting their assistance with my study. It would be much appreciated if you would kindly forward this e-mail to your social work trainees.

Participation in this study entails completing an online survey about supervision experience in addition to rating comfort in disclosing to supervisors hypothetical scenarios that may be encountered in social work training. Information regarding participant demographics and program type will also be collected, although no identifying information is collected regarding academic or training programs as part of this study. Completion time for this study is approximately 15 to 20 minutes.

If you have any questions or comments, please do not hesitate to contact me, at payam.kharazi@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, at edward.shafranske@pepperdine.edu or Dr. Judy Ho, Chairperson of the Graduate & Professional School Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

Thank you in advance for your assistance with the completion of this study.

Sincerely,

Payam Kharazi, MSW
Clinical Psychology Doctoral Student
Pepperdine University

APPENDIX J

Follow-up Recruitment Letter to Participants

Dear Social Work Trainee,

A few weeks ago, I sent you an invitation for study participation. If you have not completed this brief survey, I hope that you will consider participating in this opportunity to inform supervision practices for future trainees and their supervisors. If you have already completed this survey, I truly appreciate you taking the time to do so. The link to access the survey and information about the study sent in my previous correspondence can be found below.

I am a clinical psychology doctoral candidate at Pepperdine University conducting a study to meet my dissertation requirements under the supervision of Edward Shafranske, Ph.D., ABPP, professor at Pepperdine's Graduate School of Education and Psychology. I am conducting a brief study examining the relationship between supervisory alliance and disclosure of countertransference reactions, and use of self in social work practice. Participation in this study entails completing an online survey about your supervision experience in addition to rating comfort in disclosing to supervisors hypothetical scenarios that may be encountered in social work training. Information about your demographics and program type will also be collected; however, no identifying information is collected regarding academic or training programs as part of this study.

I believe that as a social work trainee, you are in the unique position of offering invaluable insights about training experiences that may be helpful to future trainees and their supervisors. I would greatly appreciate your assistance with my study. Participation in this study is entirely voluntary and is expected to take no more than 20 minutes. Participation is open to all social work trainees currently providing direct services to clients under supervision at field placements. Please feel free to forward this invitation to any social work trainee you may know that is currently providing direct services to clients under supervision at field placement.

A link to the web address of the surveys can be found below this message.

Thank you in advance for your assistance with the completion of this study.

Sincerely,

Payam Kharazi, MSW
Clinical Psychology Doctoral Student
Pepperdine University

APPENDIX K
Consent for Participation

PEPPERDINE UNIVERSITY
Graduate School of Education & Psychology

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Supervisory Alliance and Countertransference Disclosure of Social Work Trainees

You are invited to participate in a research study conducted by Payam Kharazi, MSW, doctoral candidate in clinical psychology under the supervision of Edward Shafranske, Ph.D., ABPP, professor at Pepperdine University, because you are currently a social work student in a CSWE accredited masters program. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. If you decide to participate, you will be asked to sign this form. Please print out the consent document if you would like to retain a copy for your records.

PURPOSE OF THE STUDY

The overall purpose of this research is to survey social work trainees' perceptions of the supervisory alliance and their comfort and likelihood of disclosing countertransference reactions to their current primary supervisor.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to complete one brief web-based questionnaire that is expected to take you no longer than 15-20 minutes to complete. As part of the questionnaire, you will be asked to respond to the following areas: degree of comfort with and likelihood of discussing hypothetical clinical scenarios with current primary supervisor, items assessing the supervisory alliance with current primary supervisor and demographic items (age, gender, primary theoretical orientation, etc.). If you would like to obtain a summary of the study results upon completion, you understand that you may contact Payam Kharazi at payam.kharazi@pepperdine.edu or Dr. Edward Shafranske at eshafran@pepperdine.edu in order to request a copy.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study involve no more than minimal risk. Such risk is similar to what is encountered in daily life or during the completion of routine psychological questionnaires. It is possible that you may experience some emotional discomfort in responding to certain questions about your supervisory relationship or to hypothetical clinical scenarios. You are free to not answer any questions that you do not want to answer. Contact information for the principal investigator and faculty supervisor will be

provided should you have any concerns you want to discuss further. Additionally, in the unlikely event that emotional distress continues well past the point of study participation, you may contact the principal investigator or faculty supervisor to help locate a psychotherapy referral in your area. If you experience any other adverse events, you may notify the principal investigator and/or discontinue participation.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, the results of the study may further understanding of supervision and be of benefit to future trainees and supervisors. You may feel a sense of satisfaction from contributing to research on social work training.

CONFIDENTIALITY

During data collection, data will be kept on the investigator's password protected computer and a USB flash drive. Following study completion, data will be stored on a USB flash drive and kept by the investigator in a locked file for a minimum of three years before being destroyed. There will be no identifiable information obtained in connection with this study. Your name, address or other identifiable information will not be collected.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. You may withdraw your consent at any time and discontinue participation without penalty.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items which you feel comfortable.

INVESTIGATOR'S CONTACT INFORMATION

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Payam Kharazi at payam.kharazi@pepperdine.edu or Dr. Edward Shafranske at eshafran@pepperdine.edu if you have any other questions or concerns about this research.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

AGREE TO PARTICATE:

You have read the information provided above and have been given a chance to ask questions. Your questions have been answered to your satisfaction and you agree to participate in this study.

APPENDIX L

Pepperdine University IRB Approval

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: November 05, 2015

Protocol Investigator Name: Payam Kharazi

Protocol #: 15-09-042

Project Title: Supervisory Alliance and Countertransference Disclosure of Social Work Trainees

School: Graduate School of Education and Psychology

Dear Payam Kharazi:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your 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 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today November 05, 2015, and expires on November 04, 2016.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the 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 an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond November 04, 2016, a continuing review 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 the 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 IRB as soon as possible. We will ask for a complete written explanation of the event and your written 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 IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require

clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Pepperdine University 24255 Pacific Coast Highway Malibu, CA 90263 TEL: 310-506-4000

Judy Ho, Ph.D., IRB Chairperson

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

Mr. Brett Leach, Regulatory Affairs Specialist