1-1-1981

Psychotherapy supervision : some perceived influences on supervision experiences.

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PSYCHOTHERAPY SUPERVISION:

SOME PERCEIVED INFLUENCES ON SUPERVISION EXPERIENCES

A Dissertation Presented

By

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Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

February 1981

Psychology Department

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ACKNOWLEDGEMENTS

I wish to express my deepest appreciation to Dr. Castellano Turner, the chairperson of my committee. His guidance, support and patience have made this study possible.

I also wish to thank the members of my committee, Dr. Harold Raush, Dr. Howard Gadlin, and Dr. Douglas Forsyth for their helpful comments and suggestions.

I would also like to add a work of thanks to all those colleagues who participated in this study.

I would like to express my appreciation to Rick Mooney, Randy Howe, and Nancy O'Reilly for their critical readings of the various drafts of this study, and to Sally Ives and Helen Lanoue for their skillful preparation of this manuscript.

I am indebted to the Austen Riggs Center for generously allowing me to work in their library. I would particularly like to thank Dr. Elizabeth Oakes, Jane Haase and Eileen Linton for their encouragement.

Finally, I would like to thank Rick Mooney for his friendship which has been a support through all stages of this project.

ABSTRACT

Psychotherapy Supervision:

Some Perceived Influences on Supervision Experiences

(February 1981)

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The aim of this study was to examine student-therapists' experiences of psychotherapy supervision. It was hypothesized that each of four elements would discriminate between helpful and unhelpful supervision experiences. These included: 1) the learning alliance--the initial working relationship established between student and supervisor; 2) the topics discussed in supervision--the content issues dealt with in the supervision sessions; 3) the setting--the structural aspects of the training program, including the general work atmosphere; and 4) the working alliance--the relationship developed between student and patient, which allows the patient to work purposefully in treatment. In addition, supervision was conceptualized as a triadic system, made up of two dyadic subsystems, existing within the setting of the training program.

One-hundred-forty-one students from twenty-five clinical psychology and psychiatry training programs in Massachusetts and Connecticut completed a questionnaire which asked about both helpful and unhelpful

supervision experiences. The questionnaire included items concerning demographic and background characteristics, a short section on contracting, and four sections representing each of the four elements. The data were analyzed using primarily t-tests, chi-square, factor analysis, and discriminant analysis. The one background difference between the helpful and unhelpful supervision experiences indicated that in helpful supervision experiences, the triadic systems worked together longer than those in the unhelpful supervision experiences. This may have been a function of the premature endings in the unhelpful experiences. With regard to contracting, the results indicated that students established significantly more explicit contracts with their supervisors in helpful supervision experiences than in unhelpful experiences.

A series of factor analyses on the items reflecting the four elements was performed to reduce the number of variables for subsequent analyses and also to determine the cognitive structure of supervision experiences among these students. Using the derived factor scales, a discriminant analysis was performed to determine the relative contribution of the factor scales in differentiating between helpful and unhelpful supervision experiences. The results supported the original hypothesis that each of the four elements would influence students' views of their supervision experiences. At least two factor scales derived from each of the four elements were represented among the reduced group of variables which differentiated the helpful from unhelpful supervision experiences. The quality of the learning alliance was found to be the

major determinant of students' evaluations of their supervision experiences. These results challenged the notion that either a didactic or process orientation to supervision is superior. From the students' perspective it seems more useful to consider helpful supervision as a combination of these approaches, which would be used according to students' needs. The administrative aspects of the setting appeared to influence students' perceptions of their supervision experiences. Finally, student-therapists reported that they created relationships in which their patients regarded them much as they regarded their supervisors.

The results of this study suggest that psychotherapy supervision from the students' perspective cannot be understood by studying isolated aspects of the supervision relationship. Indeed, the results suggest that it is important to consider psychotherapy supervision in terms of the four elements identified in this study and found to influence students' evaluations of psychotherapy supervision. A number of implications for training programs emerged from this study. Among these were the suggestions that there be more free choice in student-supervisor matchings, and that more explicit contracts be established. Supervisors could use a combination of didactic and process-oriented approaches according to the needs of the student. Regarding the setting, administrators might consider the value of a staff unified in both treatment and training philosophies. This unity among staff seems primary in determining a feeling of esprit-de-corps.

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CHAPTER I

INTRODUCTION

Students learn to do psychotherapy through psychotherapy supervision, yet little has been written about this subject. Even less systematic research has been done which attempts to understand psychotherapy supervision. Because supervisors have written most of the literature about supervision, the literature reflects the supervisor's experience and point of view. What research exists is largely based on case studies. This study has attempted to systematically explore students' experiences of psychotherapy supervision and their views of what contributes to making supervision helpful. In particular this study looked at the impact of four elements on students' evaluations of their supervision experiences: the learning alliance developed between student and supervisor; the topics discussed in supervision; the setting where the training took place; and the working alliance developed between student and patient. In this study it was hypothesized that each of these four elements would influence students' perceptions of helpful supervision. Further, the investigator sought to make a specific determination or ask a particular question in regard to the element's influence on students' views of their supervision experiences. In this study "helpful" supervision was not defined for students. Rather it was left open with the presumption students would share a common definition.

Evidence indicates that whether supervision is helpful is deter-

mined in part by the supervision relationship initially established between student and supervisor. Those who have written about supervision state that the learning alliance must be developed between the student and supervisor before true learning can take place (Berger and Freebury, 1973; Bury, Labrie, and Pomerleau, 1973; Gardner, 1953; Wolberg, 1967). It is, therefore, reasonable to assume that in supervision relationships described by students as helpful, relatively strong learning alliances would be present. A question this study posed was which of the dimensions of the learning alliance would be more closely linked with helpful supervision experiences.

A second potential influence on effective supervision is the content of the supervision, e.g., didactic issues or process issues (Ekstein and Wallerstein, 1972; Wolberg, 1967; Fleming and Benedek, 1966). Some people argue that more helpful or effective supervision experiences stress didactic learning, the acquisition of clinical techniques (Bibring, 1937; Tarachow, 1963). Others think that an interpersonal or process-oriented approach focusing on the relationship between student and supervisor is more helpful (Ekstein and Wallerstein, 1973; Wagner, 1957). This study aimed to determine if one approach or some combination of approaches would be more closely associated with helpful supervision.

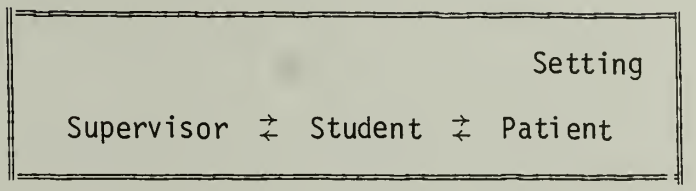
Factors not directly a part of the student-supervisor dyad may also influence the student's view of supervision. Supervision usually takes place within a training setting composed of a complex network of relationships which affect and are affected by the supervision relationship (Ekstein and Wallerstein, 1972). The setting, the basic organizational

structure and atmosphere characteristic of the training program, has been thought to have direct bearing on the supervision relationship (Ekstein and Wallerstein, 1972). This study asked which characteristics of training settings would be more closely associated with helpful supervision.

The fourth element, hypothesized to relate to the helpfulness of supervision, was the working alliance developed between student and patient. The working alliance is the rational relationship between the patient and therapist which allows the patient to work purposefully in psychotherapy (Greenson and Wexler, 1969). A number of individuals who have written about supervision have expressed the idea that the relationship between student and patient is reflected in the supervision relationship (Ekstein and Wallerstein, 1972; Doehrman, 1976; Searles, 1955). Therefore, students' evaluations of their supervision experiences might be influenced by the quality of the relationship established between themselves and their patients. In conjunction with studying the learning alliance between student and supervisor, the working alliance developed between student and patient, and the aspects of that alliance which are associated with helpful supervision, were also to be examined in this study.

Fleming and Benedek (1966) conceptualize the supervision situation as a triadic system made up of dyadic subsystems, each in relation to the other. Each dyadic subsystem functions independently of the third, i.e., supervisor and student in supervision and student and patient in psychotherapy. Conceptually, the investigator has diagrammed the supervisory situation below. The learning alliance and topics in supervision

are elements of the supervisor-student dyad, and the working alliance is an element of the student-patient dyad.



Thus, it was hypothesized in this study that, in the view of student-therapists, the helpfulness of their psychotherapy supervision experiences would be determined both by elements existing within the supervision relationship and by elements within the broader social context of which supervision is one part. In addition, this study sought to determine the relative impact of each of these elements on students' views of the helpfulness of psychotherapy supervision.

The learning alliance. The development of a learning alliance is widely recognized as an essential first step in supervision (Berger and Freebury, 1973; Bury, Labrie, and Pomerleau, 1973; Chessick, 1971; Ekstein and Wallerstein, 1972; Fleming and Benedek, 1966; Greben, Markson and Sadavoy, 1973; Mueller and Kell, 1972; Muslin et al., 1967). Learning alliance is defined as an acceptance by student and supervisor of mutually held educational goals and a shared confidence that expectations of both parties can be met (Fleming and Benedek, 1966). The learning alliance forms the basis for further learning and teaching, and is the first and foremost task of supervisory sessions (Chessick, 1971). This alliance frequently begins with a meeting between student and supervisor in which they discuss one another's expectations of the

supervision. The student and supervisor formulate an explicit contract making clear their goals and methods of working together (Greben, Markson, and Sadavoy, 1973). Meeting hours are arranged and the student's method of recording therapy sessions is discussed. The method of presentation of material to the supervisor (Wolberg, 1967), and the goals of the supervision are also considered (Wolberg, 1967; Greben, Markson, and Sadavoy, 1973). Student and supervisor share past clinical experiences in an effort to get to know one another professionally (Allen, D. W., 1958; Wolberg, 1967), and to some extent they get to know each other personally (Gardner, 1953). Students discover how they can best learn from their teachers, while teachers discover how they can best teach their students (Ekstein and Wallerstein, 1972). For example, a student may discover his supervisor leaves much of the learning initiative to him, expecting him to organize and plan how the supervision will be used. The supervisor may discover that the student is a beginner who needs didactic information and guidelines about recording process notes. Sometimes students would like more than their allotted time for supervision, but they usually realize they can learn within the designated supervision time. The supervisor and student also come to see how they can work effectively within the structure of their clinical setting (Ekstein and Wallerstein, 1972).

Both students and supervisors need to assume responsibility in the task of the students' learning (Bury, Labrie, and Pomerleau, 1973; Wolberg, 1967). Wolberg (1967) points out several requirements of supervisors and students for the development of a learning alliance. Supervisors should: 1) express interest in the patient's and student's

growth; 2) teach decisively and praise their students when they make important gains; 3) neither overprotect their students nor reject their dependence; and 4) encourage their students to express criticisms and disagreements. In addition, students who possess an enthusiasm for learning and a willingness to try new approaches to treatment contribute to the development of a learning alliance. Students and supervisors need to establish clear communication. For example, the supervisor should not use psychological terms the student cannot understand (Wolberg, 1967).

Several authors who write about supervision describe qualities which promote and support the development of a learning alliance (Wolberg, 1967; Fleming and Benedek, 1966; Gardner, 1953; Greben, Markson, and Sadavoy, 1973). Among these qualities are supervisors' and students' mutual respect and trust (Wolberg, 1967) and supervisors' acceptance and support of students without being either irritable or punitive (Searles, 1962; Greben, Markson, and Sadavoy, 1973; Barnat, 1973). In addition, supervisors need to be warm, empathic and available to their students. It is helpful if they are interested in their students and inquire about their feelings. It is useful, too, if students feel able to talk openly with their supervisors, which includes the ability to discuss emotional subjects as they arise, and to share and examine perceived weaknesses (Wolberg, 1967).

Sometimes a student and supervisor are unable to work out an adequate learning alliance. This may lead either or both party to react to the problems in their relationship by losing interest in the supervision. For example, students and supervisors may sometimes act out their

problems by coming late to supervisory sessions and by "forgetting" sessions (Chessick, 1971). All possible avenues should be pursued to rectify the problems in the supervision. These might include consultation with other supervisors or with the director of training. If these measures fail to resolve the blocks in the relationship, the student, if possible, should change supervisors (Wolberg, 1967).

According to Ekstein and Wallerstein (1972), as a solid learning alliance develops, students usually feel relatively comfortable revealing themselves and their work in order to learn. Students also become interested in resolving problems that may hinder this process. Students frequently identify with their supervisors and sometimes experience a feeling of colleagueship (Berger and Freebury, 1973). If supervisors encourage students to ask questions and convey the view that there is strength in being open about their work, the students' willingness to expose their weaknesses can be facilitated. It is important that supervisors communicate that these weaknesses do not constitute the students' complete professional selves. For example, the supervisor might share a personal experience similar to the one that student is presenting. Within the same supervisory session though, the supervisor may also need to comment on some aspect of the therapy which is going well. Some students, especially beginning students, are extremely sensitive to discussion of problems they are having. They may experience discussions of such weaknesses as criticisms of themselves. Much of this discomfort can be avoided if the supervisor is sensitive to the student's need for support (Ekstein and Wallerstein, 1972).

Students tend to conceptualize working alliances with their

patients in terms of the learning alliances they establish with their supervisors. For this reason learning alliances are an important influence on the working alliances students develop with their patients (Greben, Markson, and Sadavoy, 1973). For example, if a supervisor makes a self-disclosure in the supervision it can have a freeing effect on the student, who may feel more able to utilize an appropriate self-disclosure within the therapeutic situation. And if a student cannot express his weaknesses in his supervision sessions, what does this imply about the student's feelings about the patient's expressing his weaknesses? Thus, the learning alliance can serve to facilitate tolerance for self-expression.

Given that the learning alliance is thought to form the necessary basis for all further learning, it was hypothesized that students' evaluations of their supervision experiences would be influenced by the learning alliances associated with those experiences. This study also sought to determine which aspects of the learning alliance were more closely associated with helpful supervision experiences.

The topics discussed in supervision. While there is consensus on the necessity and nature of the learning alliance, there is much debate about what should be taught in supervision. Those who have written about individual psychotherapy supervision differ about which issues supervisors should focus on. The major views of supervision seem to lie along a single dimension. At one end of the continuum are those who orient supervision around didactic content (Bibring, 1937; Tarachow, 1963), while at the other end are those who focus

primarily on process and self-awareness issues (Ekstein and Wallerstein, 1972; Wagner, 1957). Bridging these polar positions, Fleming and Benedek (1966) suggest a method of supervision which involves a hierarchy of supervisory tasks extending over time. The supervisor's role is viewed as a therapist/teacher combination. Didactic and self-awareness approaches are used according to the demands of the particular situation.

The various schools of analysis have long disagreed about whether supervision should focus on diadctic issues or on self-awareness and process issues. In 1922 The International Psychoanalytic Society formalized standards for psychoanalytic training which included: 1) the student's own analysis; 2) a series of academic courses; and 3) the supervised analysis or "control analysis" of several patients for a specified period of time. Following the institution of the "control" or "supervisory" analysis, differences developed within psychoanalytic schools as to whether the supervisory analyst should also be the student's personal analyst. In the 1930s the Hungarian School, represented by Kovacs and Herman, maintained the position that the student's personal analyst was best suited to supervise the student and work with the student's countertransference issues because the analyst knew the student well. The Berlin-Viennese School, represented by Anna Freud, Helene Deutch, Eitingon, and Bibring, expressed an opposing view through a paper presented by Bibring. They felt that someone unfamiliar with the student should supervise him/her, using only a didactic approach. In 1937 at The Second Four Countries Conference in Budapest, The Hungarian School and The Berlin-Viennese School worked toward compromise

and a resolution of their differences. The Hungarian School agreed that the training and the control analyst should not be the same person, while the Berlin-Viennese School agreed that the control analysis could begin while the student was still engaged in training analysis (summarized from Doehrman, 1976; and Fleming and Benedek, 1966).

Following the decision to separate the training analysis from the control analysis, difficulties arose regarding the method of handling interpersonal problems inherent in the psychotherapy situation. The student-therapist's emotional reactions to the patient as they arose in the control analysis was an area of contention that continues to be debated to this day. For example, Gustin (1958) thinks that unconscious interactions between the student and supervisor which take the form of resistances should be discussed before more objective work on the case can proceed. More frequently, control analysts will refer students to their training analysts to work out issues. Historically, the relationship between the student and control analyst has been so controversial that little of the literature has been devoted to it. DeBell (1963) utilizes a clinical example from Ekstein and Wallerstein (1958) to exemplify the various supervisory approaches. In this example the student did not realize, nor was he capable of interpreting, his patient's disdain of himself (the therapist) as expressing the patient's transference neurosis. DeBell (1963) outlined several possible approaches to this problem: 1) the problem could be referred back to the training analyst for further analysis; 2) the student could be given more didactic information, a position Bibring would support; 3) the problem could be interpreted by the supervisor as a countertransference problem and left at

that; or 4) the problem could be seen as stemming from the student-supervisor relationship, in which case the distortion could be resolved by tactful confrontation and clarification within the student-supervisor dyad.

The controversy between didactic supervision versus process-oriented supervision takes on a somewhat different meaning in psychotherapy training centers. Unlike analytic candidates, graduate students in clinical psychology are not required to be in their own personal analyses or, for that matter, any form of personal psychotherapy. When problematic interpersonal issues arise in the supervision such as a countertransference reaction to the patient, supervisors do not necessarily have the option of referring their students to their personal analysts. Supervisors may feel responsible to intervene on some level with a student's personal problem especially when the student is not in therapy, not likely to work it out elsewhere, and would like to explore the problem with the supervisor. Thus, the boundaries between therapy and supervision are sometimes blurred. According to Ekstein and Wallerstein (1972), this is a defensive maneuver on the part of the student and a pitfall supervisors should be careful to avoid. While working on the student's personal problems the supervisor can lose track of the patient and treatment. Ekstein and Wallerstein (1972) suggest that supervisors should function to help their students help their patients. Only when interpersonal problems are directly relevant to the psychotherapy being supervised are they appropriate material for supervision.

How didactic supervisors should be is debatable. Clinical psychology programs offer varying degrees of didactic information in course

work and supervision. According to Ekstein and Wallerstein (1972), supervisors should provide just enough didactic information as is necessary for the case to proceed. The beginning student has less clinical knowledge and thus may require a fair amount of didactic information. Ekstein and Wallerstein (1972) think that interpretations of the material which have been missed by the student but which are crucial to the treatment are of foremost importance. Other sorts of important didactic information include crisis intervention methods, and information about medication.

The following is a review of a number of approaches to supervision that have been developed and presented in the literature.

Didactic supervision. Among the didactic approaches are imitative teaching, patient-centered teaching, and corrective teaching. In the imitative approach students present their material and supervisors indicate what they would have done in a similar situation. This approach takes the view that teaching psychotherapy or psychoanalysis is essentially a matter of demonstrating imitatable techniques. Supervisors indicate what interpretations they would have made and how they would have behaved. Supervisors focus on the practical management of the patient and pay relatively little attention to either the patient-therapist relationship or the student-supervisor relationship (Fleming, 1953).

A problem with this approach is that supervisors are sometimes unclear about the rationale supporting their actions in a given situation, and cannot explain their techniques to their students. According to Fleming (1953), students must have a genuine understanding of the

rationale for the supervisors' suggestions, or it may be of little help to know the supervisors' techniques.

Tarachow (1963) describes another type of didactic supervision called patient-centered supervision. In patient-centered supervision the focus rests exclusively on the patient's behavior, psychodynamics, and therapeutic needs. Students are instructed according to their patients' needs. Tarachow (1963) summarized his viewpoint in this way:

> The basic rule is that. . .the resident should be instructed in terms of problems and needs of the patient, as expressed in the specific clinical phenomena of the patient. . . . The supervisor is an instructor, not a psychotherapist (p. 303).

Still under the rubric of didactic teaching, but less limited, is the corrective approach described by Fleming (1953). As in patient-centered supervision, supervisors using this approach help students better understand their patients, as well as take responsibility for formulating the patient's dynamics and suggesting clinical interventions. Supervisors also point out evidence of countertransference and discuss the student-therapist's errors in relation to the patient's dynamics. This method broadens the patient-centered focus by taking into account the student's learning difficulties as well as the supervisor's role in making the student aware of these problems. Issues of countertransference and blind spots are dealt with by confrontation and interpretation. Thus, students gain insight into themselves and what they do to obstruct their therapies. The success of this approach depends on the students' ability to convey accurate reports of their own behavior as well as the patients' behavior in the therapy sessions.

Process-oriented supervision. Ekstein and Wallerstein (1972) stress self-awareness issues as the major focus of process-oriented supervision. They write:

> Supervision, like psychotherapy, is an intense and time consuming process designed to effect inner changes, although the nature of these changes is different in each process. In supervision we aim at a change in the use of the professional self, while in psychotherapy we aim at changes which embrace the total adaptive functioning of the individual (p. 92).

In this method of supervision which Wagner (1957) calls "process-centered," students' difficulties in receiving help from their supervisors are worked through to facilitate the students' understanding of their patients. Bonn and Schiff (1963) also use this method of supervision but only when other, more didactic methods, such as focusing on the patient or on the patient-therapist relationship, have failed. Bonn and Schiff (1963) use the process-oriented approach to clear up blocks in the student-therapist relationship which are preventing learning through didactic approaches. Once this is accomplished they return to a didactic method.

Process-oriented supervision assumes that one's professional development depends on strategies for acquiring and giving help. These strategies are reflected in the psychotherapy students do and in their style of learning in supervision. Since these are interpersonal processes, the teaching method is made more explicit if it is based on the observations of these processes. Ekstein and Wallerstein (1972) conclude that the interpersonal orientation of supervision is the most useful.

Students who enter this kind of supervision agree to study their

professional selves and also their professional functioning in supervision. Students also discuss their problems in acquiring psychotherapeutic skills. According to Doehrman (1976) supervisors become "active participants in an affectively charged helping process, the focus of which is learning and personal growth for the student" (Doehrman, p. 17).

Searles (1955) also indicates that the supervisory orientation he finds most effective is one that focuses on the relationship between patient and therapist. He adds that this sometimes necessitates attending to what transpires between supervisor and student. Unlike Ekstein and Wallerstein, however, Searles (1955) usually does not make this latter focus explicit to his student.

Mueller and Kell (1972) also find process-oriented supervision useful. Their method of supervision deals at times with the students' personal problems lying outside the sphere of their clinical work. In their view of process-oriented supervision, the boundaries between supervision and psychotherapy may sometimes be one and the same. Mueller and Kell (1972) value the intensity and intimate involvement reflected in their approach to supervision: "The heart of supervision consists of a series of deepening, recycling excursions into personality and the anxiety and conflicts generated through intense interaction" (p. viii).

Didactic and process-orientations combined. Fleming and Benedek (1966) bridge the didactic and self-awareness models of supervision in two ways: 1) They view supervision as consisting of a series of ordered tasks extending over a period of time; and 2) They view the supervisor

as a person who combines the role of therapist and teacher and uses these qualities depending on the needs of the situation. They describe the basis of their approach this way:

> We would base our theory of supervision and philosophy of psychoanalytic education on three broad assumptions. . .1) The analyst's education is necessarily more experiential than cognitive; 2) The basic objective of the educational experience is the development of himself as an analytic instrument; and 3) Each phase of his training contributes to this objective . . . (Fleming and Benedek, 1966, p. 238).

The complete educational experience combines students' learning by experience (training analysis) and learning about experience (studying theory). The combination of these processes become learning-from-experience.

Fleming (1953) describes three types of teaching which represent stages of learning which she uses according to the needs of the student. The first two are the imitative and corrective approaches presented earlier, and the third includes a new dimension--creative teaching and learning. Used with more advanced students, the supervisor works toward a greater understanding of the interpersonal dynamics involved in both the student-patient relationship and supervisor-student relationship. Supervisors help students to ask themselves important questions which they may not have asked themselves in the treatment sessions. These include questions as: Why is the patient telling me this; why is he telling me this now; and what is my reaction to what he is telling me? (Fleming, 1953).

Fleming and Benedek conclude by emphasising the students' personal growth in the supervision:

> . . .a good learning experience in supervision goes beyond following rules of thumb or imitation of what someone else did or might have done in similar circumstances. It increases the student analyst's awareness of himself in the interaction with his patient (p. 32).

Nash (1975) found in her study that the didactic/process-oriented content issue was not perceived by students as a primary determinant of the helpfulness of their supervision experiences. A question this study addressed was whether one approach or some combination of approaches to supervision would be more closely linked to helpful supervision than others. In an effort to study the supervision approach, the topics dealt with in the supervision reflecting the didactic and process-oriented approaches were explored. It was hypothesized that the supervision approach would depend on the supervisor's theoretical orientation. Behaviorally oriented supervisors would focus more frequently on didactic topics that psychoanalytically oriented supervisors. Psychoanalytically oriented supervisors would stress didactic issues as well as countertransference and process topics.

The setting. In addition to looking at the influence of the learning alliance and the content of supervision on the perceived usefulness of the supervisory experience, the impact of the training setting on students' evaluations of their supervision experiences was also investigated. Training setting is defined as the organizational structure and atmosphere of the training program and includes the expectations, conditions, attitudes, and feelings which characterize the clinical setting. While Berlin (1960), Chessick (1971), and Greben, Markson and Sadavoy (1973) have commented on the importance of the training setting, only

Ekstein and Wallerstein (1972) have attempted to outline the requirements of an effective setting. Most clinical psychology training takes place in imperfect clinical settings in the sense that they do not provide the organizational structures that maximally support teaching and learning. Adequate funding, for example, might not be available for educational colloquia. However, setting structures are usually stable enough to provide training programs suitable to the individual needs of students. This includes the need for students and supervisors to be able to make arrangements between themselves which are both binding yet also amenable to mutually accepted alterations (Ekstein and Wallerstein, 1972).

Clear rules and regulations are an important requirement of training programs. Some of these are summarized below from Ekstein and Wallerstein (1972): 1) guidelines for acceptance into the training program need to be established; 2) goals and guidelines for the training program must be clarified in order to determine what students shall be taught both in supervision and in seminars; 3) a system for matching students and supervisors should be worked out; 4) the number of patients students work with should be clear; 5) a procedure ought to be organized for assigning patients to students; 6) the length of time students and supervisors are to work together may be set; 7) the nature and frequency of evaluations should be delineated; and, finally 8) a process should be set up that allows students to change supervisors. In addition to the above, the training program needs to be integrated into the general clinical setting and monitored to ensure its high standards.

The training setting should also fulfill the needs of training

supervisors. Ekstein and Wallerstein (1972) recommend a regularly scheduled supervision seminar in which supervisors discuss supervisory techniques. Typically this seminar would be conducted by an in-house staff member, but expert consultants occasionally would be brought in. In this seminar discussion of students' learning problems and students' progress enables staff to arrange appropriate programs for their students (Berlin, 1960). All too often, supervisors have no idea what problems other supervisors are confronting in their work with the same students. Sharing the supervisory work in a group seminar promotes growth in the supervisors by allowing different opinions to be expressed (Chessick, 1971), thus placing the supervision in a broader perspective.

According to Ekstein and Wallerstein (1972) procedures to ensure the quality and completion of student training and methods of assuring a standard of good treatment for patients are inherent in the setting structure. Good treatment can be safeguarded by three rules and regulations: 1) an organized system of record keeping; 2) guidelines about confidentiality; and 3) procedures for handling crises.

Being in the position of having to learn while simultaneously functioning as a professional, student therapists require a certain educational climate (Ekstein and Wallerstein, 1972). Staff and supervisors can work together to provide an atmosphere of openness and sharing by showing support and availability to the student therapists. Excessive defensiveness and competition arise when students are overly criticized, and when supervisors are unavailable, possibly leaving students to fight for their time.

All student-therapists confront the issues of whether they are able

to work within the given clinical setting. In helping students deal with this issue, supervisors can derive strength from a well-structured supportive administration (Ekstein and Wallerstein, 1972).

> The full quality of the teacher will only be brought out at its best if he is supported by an understanding administration that skillfully provides a structure within which learning and teaching can take place (Ekstein and Wallerstein, 1972, p. 98).

Program structures which set limits for students facilitate the students' development of the necessary emotional distance from their work (Ekstein and Wallerstein, 1972). For example, an overly eager student who has rescue fantasies about a patient sometimes needs to be prohibited, via the structure of the setting, from arranging appointments with his patient on holidays. On the other hand, settings that do not provide organized structures, but are based on the chance that students might locate supervisors from whom they can learn, succeed less well in facilitating and promoting the students' growth.

Chessick (1971) suggests that esprit-de-corps is important to an institution. He mentions two prerequisites for esprit-de-corps including: 1) open communication between students, supervisors and other staff; and 2) frequent social contacts, and informal meetings among all staff members. Esprit-de-corps is also promoted if the supervisors are united by a common treatment and training philosophy on both pragmatic and theoretical levels (Ekstein and Wallerstein, 1972). Therapeutic communities in which staff and patients work together toward a common goal often evolve naturally from training programs with clear rules and expectations and a unified supervisory group (Ekstein and Wallerstein,

1972).

Thus, it was hypothesized that training settings would influence the students' perceptions of the usefulness of their supervision experiences. This study also asked which dimensions of the setting were more closely linked to helpful supervision experiences as described by student-therapists.

The working alliance. The student-patient dyad is also considered in this study because it is often reflected in the student-supervisor dyad (Ekstein and Wallerstein, 1972; Fleming and Benedek, 1966; Doehrman, 1976; Searles, 1955). In particular this study examined the working alliance developed between "the patient's reasonable ego and the therapist's analyzing ego" (Greenson, 1965, p. 157). The working alliance refers to the non-neurotic, rational relationship which the patient develops with his or her therapist; it enables the patient to work purposefully in psychotherapy despite his or her transference feelings (Greenson and Wexler, 1969). The working alliance has also been referred to as the rational transference, the mature transference and the analytic pact (Dickes, 1975; Greenson, 1965).

The difference between the working alliance and the therapeutic alliance should be noted, however. The therapeutic alliance encompasses all the dimensions of the working alliance as well as the "full-scale therapeutic rapport which includes all the elements favorable to the progress of therapy, including the patient's motivation for treatment based on ego-alien symptoms, positive transference, and the rational relationship between the patient and therapist" (Dickes, 1975, p. 1). Of

course this distinction is not absolute because the working alliance can contain some elements of an infantile neurosis which sooner or later will need to be dealt with in the therapy (Langs, 1975).

Because the working alliance serves as the basis of the rest of the psychotherapeutic work, its establishment is the first task of psychotherapy; all other therapeutic work should be subordinated to it (Wolberg, 1967). Without a working alliance the psychotherapeutic process will be compromised.

The successful establishment of a working alliance requires several things of patients (Wolberg, 1967). First, they need to acknowledge their emotional problems and be willing to accept help with them. Many patients are not convinced that they have problems and are brought for help by relatives, police or their doctors. In these cases the therapist and the patient together define the problem and focus on what they can do in the therapy to help. Patients frequently have misconceptions about how psychotherapy "works": They may see their therapists as mind-readers or as magical problem solvers. These misunderstandings must also be clarified (Wolberg, 1967).

If the patient decides that he/she wants treatment, the patient and therapist work out the practical arrangements: They agree on the time, session length, and fee for the treatment. The therapist clarifies with the patient how emergencies are to be handled and, at some point early in the treatment, the therapist and patient outline the objectives of the therapy and the approximate length of time needed to attain these goals (Wolberg, 1967).

The development of the working alliance requires that the therapist

meet certain of the patient's needs (Wolberg, 1967). First, to some extent all patients need to be dependent on their therapists; it is essential that therapists accept the patient's legitimate need to be dependent while at the same time requiring them to take as much responsibility as possible. Second, patients need nonjudgmental understanding and acceptance from their therapists. Third, patients need their therapists to tolerate their expressions of painful feelings, e.g., crying, angry assaults, psychotic disorganization, or regression (Wolberg, 1967).

In addition to meeting these needs, therapists also function in a number of roles in relation to their patients: They function as helping authorities, as idealized parental images, and as actual parental images. Therapists also represent other significant people in patients' histories, such as relatives or teachers. Finally, therapists should function as cooperative partners with their patients (Wolberg, 1967). Usually patients will partially identify with some of these roles (Greenson, 1965). For example, a young mother may identify with the idealized parental image she holds of her therapist, thus facilitating her ability to care for her child and to feel better about herself.

Resistances to the development of the working alliance commonly occur. These include, on the patient's part, irrational expectations, intense sexual desires for the therapist, and intense hostility. A borderline young woman, for example, may demand sexual relations with her therapist and refuse to discuss anything else. Therapists would, therefore, need to explore these resistances and work them through in order for the treatment to progress. In this example, the therapist would need to help the young woman to see that wanting to have sexual

relations would be an attempt to establish one kind of intimacy, but not a kind that would further the goals of the therapy. On the therapist's part, resistances could include his or her own personal problems, shortcomings, lack of technical understanding, and insurmountable countertransference feelings (Wolberg, 1967).

The formulation of a working alliance can take varying amounts of time, usually from one to twelve sessions (Wolberg, 1967). More difficult or regressed patients can take longer--sometimes as long as several years. According to Wolberg (1967), it is important that the therapist respects the patient's defenses and allow the patient to form the working alliance at his or her own rate. For example, a confused, paranoid-schizophrenic patient who denys that he requires psychotherapeutic help can be allowed the distance inherent in the denial. The therapist should not force himself on the patient. Instead, the therapist could meet with the patient for short sessions to gently and slowly build a relationship.

Major affective components in the working alliance are the inevitable transference and countertransference feelings. Therapists must work to prevent the transference from interfering with their being tolerant and warm with patients. For example, it is important that a therapist tolerate the attacks from a borderline patient who may defensively devalue the therapist and the therapy. To insure minimal interference therapists should thoroughly understand the transference relationship. Countertransference feelings can hinder the working alliance to varying degrees, and therapists need to find ways of managing them. Langs (1975) and Wolberg (1967) suggest countertransference feelings can be

worked out with colleagues, supervisors, or personal therapists.

There are a number of mutual feelings therapists and patients should strive to develop in the working alliance. These include trust, respect, and a feeling of liking one another (Wolberg, 1967). In addition, patients should usually feel relatively relaxed in their sessions and confident in their therapists; patients should also feel that their therapists understand them and are able to help them. Therapists generally feel empathic, accepting, and interested in their patients. Overall there is a feeling of hope and expectation in the therapy (Friedman, 1969). A working alliance has been established when the therapist and patient have developed a cooperative relationship, when the therapist feels he/she has made contact with the patient, and when the patient is responding well in the relationship (Wolberg, 1967). Therapists then must maintain the working alliance. This they do in a number of ways, such as being consistent in their pursuit of insight, and respecting and caring for both the healthy as well as the pathological aspects of their patients (Greenson and Wexler, 1969). The key to the working alliance is a patient's desire to master his problems, i.e., his conscious agreement to cooperate in treatment (Greenson, 1967).

In many ways the working alliance is similar to the learning alliance. The working alliance forms the base for therapeutic work, while the learning alliance forms the base for the supervisory work. These alliances have a common need for participants to be confident that mutually agreed upon goals can be met. Empathy on the parts of participants is also common to both types of alliance (Fleming and Benedek, 1966) as well as the need for the relationships to be free of excessive

anxiety (Chessick, 1971). However, the foci of these two alliances differ. Therapists must concentrate on the problems presented by their patients, while supervisors focus on the professional training of therapists.

As already mentioned in this chapter, the development of a learning alliance can have an important influence on a student's being able to develop a working alliance with his or her patient. In addition, the psychotherapy relationship can influence the supervision relationship (Ekstein and Wallerstein, 1962; Doehrman, 1976; Searles, 1955). These influences are revealed by the concomitant occurance of similar dynamics within the two relationships and are referred to as parallel process. Theorists who have written about the parallel process can be divided into two schools of thought: those who view the dynamics that arise between therapist and patient as mirrored in the supervisor-student relationship (one-way parallel process); and those who hold this position and, in addition, see the dynamics of the supervisory relationship as being reflected in the therapeutic relationship (two-way parallel process). Major proponents of the first position are Arlow (1963), Fleming and Benedek (1966), Hora (1957), and Searles (1955). Ekstein and Wallerstein (1972) and Doehrman (1976) endorse the "two-way" transaction of the parallel process. I will discuss both views of this facet of supervision.

One-way parallel process. One-way parallel process has been written about most extensively by Searles (1955). ". . .[T]he processes at work currently in the relationship between patient and therapist are often reflected in the relationship between therapist and supervisor"

(p. 157). He describes the parallel process as occuring mainly on an affective level. That is, supervisors typically grasp this phenomenon through their own affective experience. When supervisors sense strong affects in the supervision, they need to be aware of the strong possibility that the sources of those feelings may lie in the relationship between the patient and student, and particularly within the patient. Though this reflection process comprises only a small part of the total supervision experience, the information supervisors gain from it can be important in discovering problems within the student-patient relationship. While unsure of the exact mechanism for the reflection process, Searles (1955) suggests that, in part, it is made up of the anxiety generated by unconscious identifications on the part of therapists with their patients. He writes:

> It appears that the reflection process is initiated when the therapy touches upon an area of the patient's personality in which repressed or dissociated feelings are close to awareness, so that he simultaneously manifests anxiety and some defense against this anxiety. The therapist then, being exposed to the patient's anxiety, experiences a stirring up of his own anxiety with regard to the comparable area of his own personality. The therapist now, it seems, unconsciously copes with this anxiety in himself by either identifying with the defense-against-anxiety which the patient is utilizing, or by resorting to a defense which is complementary to that which the patient is utilizing. Next, when the therapist comes for supervision about this therapeutic relationship, the supervisor may intuitively realize,. . .that the therapist, in the anxiety and defense-against-anxiety which he is exhibiting, is unconsciously trying to express something about what is going on in the patient--something which the therapist's own anxiety prevents him from putting his finger on and consciously describing, to the supervisor. It is as if the therapist were unconsciously trying, in this fashion, to tell the supervisor what the therapeutic problem is (p. 172-173).

Thus, supervisors come to understand, through their students' anxieties

or their defenses against their anxieties, that their students are unconsciously attempting to communicate what is going on within their patients and/or within their therapies. Students are unable to articulate their problems because their own anxieties prevent them from clearly perceiving dynamics. Searles (1955) assumes anxiety is greatest within patients, less great within students, and even less so within supervisors.

Two-way parallel process. Although Searles (1955) acknowledges the possibility of a two-way parallel process, he does not explore it. Doehrman (1976) and Ekstein and Wallerstein (1972) are the main commentators on the two-way parallel process. They provide examples of the two-way process beginning both within the supervisory and within the therapeutic relationship. A more serious situation occurs when the interpersonal dynamics are reflected in the psychotherapy relationship.

Doehrman (1976) found in her study of four supervisory relationships and eight psychotherapy relationships that whatever occurred in the supervisory relationship, positive and/or negative, affected the therapeutic relationship. Doehrman (1976) views the supervisor in this process as being "pulled into a transference relationship" with the student. The student then, in response to the supervisor, "unwittingly assumes an attitude" in the psychotherapy which limits the possible relationship between the student and patient. As a result of the transference relationship with the supervisor, the student adopts a role in the therapy which acts out one of the poles dictated by the neurotic transference such as extreme passivity or extreme control. The transference paradigm, engaged in by the student with the patient or supervisor, is

in accord with one of the student's major neurotic conflicts and, to a lesser degree, with the neurotic disposition of the supervisor (Doehrman, 1976).

> The meshing of transference and resistance patterns of the therapist and supervisor leads the therapist to act out with his patients the effects of the conflict with his supervisor; the result is a two-way transference-countertransference bind that develops in the supervisory and therapeutic relationships (p. 73).

Doehrman (1976) views Searles' conceptualization of one-way parallel process as incomplete because he considers only what patients stir in therapists, who then reflect the conflicts in their supervisions. One-way parallel process theorists do not consider what supervisors stir in student therapists, who then act out the conflicts with their supervisors in the therapy. Sometimes it may not be possible to determine the direction of the parallel process. This is especially the case when the therapist and patient share the same defensive style.

Doehrman (1976) concludes that binds between students and patients can only be resolved after students and supervisors have resolved their binds. The complexities of the supervision process as it intermingles with the therapeutic process can be immense. An effective supervision takes into account, and attempts to work through, these built-in complications.

Though the therapy relationship affects and is reflected in the supervision relationship, this study is concerned with the former, that is to say, with the influence the working alliance has on the learning alliance. It has been shown that what occurs in the therapy relation-

ship can be reflected in the supervisory dyad (Doehrman, 1976). One could imagine that if the therapeutic relationship was a difficult one whose problems were acted out in the supervision and not resolved, the supervision work could be compromised. This study hypothesized that the working alliance would influence students' evaluations of their supervision relationships. This study also sought to determine which dimensions of the working alliance were more closely associated with helpful supervision experiences.

Hypothesis and research questions. Based upon this review of the literature, the author made the following general hypothesis: It was hypothesized that each of the four elements would influence students' evaluations of their supervision experiences. These elements included: 1) the learning alliance; 2) the topics discussed in supervision; 3) the setting; and 4) the working alliance. Also based on the literature review, the author sought to answer a number of questions. These were: Which dimensions of the learning alliance were more closely associated with helpful supervision? Was one approach or some combinations of approaches to supervision more closely linked to helpful supervision? Which characteristics of the training settings were more closely associated with helpful supervision? And which aspects of the working alliance were more closely associated with helpful supervision experiences?

CHAPTER II

METHOD

Subjects. Two-hundred-ninety-four student-therapists from 25 different training settings were asked to complete a questionnaire designed to investigate their experiences in psychotherapy supervision. The criteria for inclusion in the study were kept to a minimum so that the pool of subjects would not be prematurely limited. The first criterion was that subjects currently be in training. The purpose of this was twofold: First, the issues of supervision would be ongoing and immediate for subjects; and second, it would impose some limit on the amount of time lapsed since the supervision experiences they were to describe.

The second criterion was that the student-therapists had at least one academic year of clinical training and had completed two supervision experiences prior to their current clinical experience. No further selection criteria were used.

The academic disciplines of the student-therapists were limited in that subjects were selected from training programs listed in The Directory of Approved Residencies and The Directory of Internship Programs in Professional Psychology.[1] Thus, subjects were psychiatrists or psychologists in training.

One final limitation on the selection of the subjects was geo-

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[1]The one exception was the Boston Institute of Psychotherapy.

graphical, i.e., they were located within a two-hour driving time from Stockbridge, Massachusetts, and no further than Boston or New Haven. A survey of training programs indicated there were approximately 500 student-therapists within this area.

Procedure. First, the investigator sent a query letter to the director of training explaining the research project and soliciting participation (Appendix A). This letter was followed up by a phone call to inquire about participation. When the director was willing, an appointment was made with the director or his designee to further explain the study and hopefully gain permission to conduct the research in the setting. When the permission was granted, a meeting with the trainees was arranged to explain the purpose of the research. Questionnaires together with cover letters and self-addressed, stamped envelopes were distributed at this meeting (Appendices B and C). In appreciation for their time, trainees were told they would be paid $5.00 upon completion of the questionnaire. Some trainees filled out the questionnaire at that time, but most completed it later and returned it by mail. In those instances where it was not possible to arrange a meeting with the staff and/or students, the students were contacted by phone. If the trainee expressed an interest, the questionnaire was mailed. When the completed questionnaire was received, $5.00 and a note of thanks were sent. All information was treated as completely confidential. After payment the students' names were not associated with responses.

The questionnaire asked students about their experiences as a supervisee in both helpful and unhelpful individual psychotherapy super-

visions. Students selected a "very helpful" and an "unhelpful or less helpful" supervision experience, which they had completed with two different supervisors. They rated their helpful supervision in Part A of the questionnaire, and then the same questions were repeated for rating unhelpful supervision in Part B. In each case students considered their supervision experiences in terms of the treatment of one specific patient.

The questionnaire was based on the literature reviewed in Chapter I and included sections covering the following elements: 1) the learning alliance developed between student and supervisor; 2) the topics discussed in supervision; 3) the organizational structure and atmosphere of the clinical setting in which the training took place; and 4) the working alliance developed between the student-therapist and the patient. Aside from questions asking for demographic information and a short section pertaining to contracting in the supervision relationship, the questionnaire was made up of statements which the subject rated on either a seven-point scale ("Very true" to "Not at all true") or a five-point scale ("Never discussed" to "A major focus in supervision").

CHAPTER III

RESULTS

The main purpose of this study was to determine whether each of four elements could discriminate between helpful and unhelpful supervision experiences. These elements included: 1) the learning alliance; 2) the topics discussed in supervision; 3) the setting; and 4) the working alliance.

First, I will present the demographic data vis-a-vis the respondents. This is not intended to test any hypotheses, but is a way to understand, as well as possible, who the respondents were. Second, as a preliminary step in the analysis of the differences between the helpful and unhelpful supervision experiences, t-tests and chi-squares were computed. (For those interested in the differences between the variables in the helpful and unhelpful supervision experiences, Appendix D presents the t-values.) Based on these results, background differences between the helpful and unhelpful supervision experiences will be presented. Third, the findings related to contracting, one aspect of the learning alliance, are presented. Fourth, a series of factor analyses on the items reflecting the four elements were carried out. This was done in order to reduce the number of variables for subsequent analyses and to determine the cognitive structure which students had about their supervision experiences. Each of these scales will be described. Fifth, using these derived factor scales a discriminant analysis was

performed to determine the relative contribution of the factor scales in differentiating between the helpful and unhelpful supervision experiences. The results of the discriminant analysis will be presented.

Characteristics of subjects: Demographic and professional. Of the 294 student-therapists given or sent questionnaires, 141 (48.0%) returned them. Of this group 135 were usable. The respondents came from twenty-five different training programs listed in Appendix E. The respondents were about equally divided according to sex: 52.6% men and 47.4% women. They ranged in age from 23 to 45 years old with a mean age of 29. Of the respondents 69.6% were studying psychology and 30.4% psychiatry. For their most advanced degree all psychiatry students had earned their M.D., 18.1% of the psychology students their Ph.D., 2.1% their Ed.D., 64.9% their M.S., 5.3% their M.Ed., and 8.5% their B.S. Of the subjects 31.1% described themselves as psychoanalytically oriented, and 60.0% as eclectic.[2] The students had a wide range of clinical experience--from 8 to 99+ months. The mean was 44.6 months. The number of supervisors they had worked with ranged from 2 to 8+; the mean was 7.8 and the mode was 8+. Of the respondents 80.7% had been or were in their own personal psychotherapy, and 94.7% reported that in the future they plan to practice psychotherapy professionally. In addition, 67.6% of the respond-

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[2]Subjects were asked to designate on a list of theoretical orientations including Psychoanalytic, Behavioral, Eclectic, Client-centered, Rational emotive, Family and Systems, and Other, what their theoretical orientation was. Responses were considered eclectic if Eclectic or any combination of one or more orientations were checked. (See Appendix F for a listing of the percentages of students representing each theoretical orientation.)

ents plan to teach, and 50.0% plan to do some kind of research as part of their professional plans.

In sum the respondents were an experienced group of trainees whose psychotherapy training was preparing them for careers in psychotherapy. One could, therefore, assume that the respondents were seriously committed to the work for which they were being trained and about which the questionnaire asked.

Background differences between the helpful and unhelpful supervision experiences. Some basic background information was gathered about the student, supervisor and patient in the helpful and unhelpful supervision. T-tests and chi-square tests were carried out to analyze the differences between these groups. On many of these variables it was expected and hoped that there would not be differences since the variables do not fit into the general formulations on which this study is based. Table 1 summarizes these findings.

The questionnaire included five demographic questions about the students' helpful and unhelpful supervision experiences. These were: "How many years of clinical experience had you had before this supervision?"; "How many supervisors had you worked with at the time of this supervision?"; "When did this supervision take place? (Give dates)"; "How many months did you work with this supervisor?"; and "Did this supervision end prematurely?" No differences between groups were revealed on the first three of these items, though significant differences were revealed on the fourth and fifth. On the average, students had three years of clinical work prior to both their helpful and unhelpful

Table 1

Background Differences between the Helpful and Unhelpful Supervision Experiences

Questions	Means by Group				Percentages by Group			
	Helpful	Unhelpful	N	t-value[1]	Helpful	Unhelpful	N	Chi-square[1]
About Student								
Years of prior clinical experience	3.01	2.91	134	.86				
Number of previous supervisors	5.13	4.80	133	1.35				
Months student and supervisor worked together	10.31	7.88	133	4.49***				
Supervision end prematurely?					2.4	9.4	254	4.53*
About Supervisor								
Age	41.75	41.03	132	.62				
Sex (male)					79.3	72.4	269	1.38
Theoretical orientation								
Psychoanalytic					54.8	50.8	267	
Eclectic					28.1	32.6	267	
Years of previous supervisory experience	11.27	9.33	118	1.88				
Supervisor supervised?					6.7	9.7	269	1.28
Supervisor in supervision seminar					36.9	26.7	269	1.58

*p < .05
**p < .01
***p < .001

[1]t-values were used to analyze ratio and interval data and Chi-square was used to analyze ordinal and nominal data.

Table 1 (continued)

Questions	Means by Group: Helpful	Unhelpful	N	t-value[1]	Percentages by Group: Helpful	Unhelpful	N	Chi-square[1]
About Patient								
Age	24.1	25.3	133	1.07				
Sex (male)					48.1	51.9	269	.24
Diagnosis								
Adjustment reaction					12.3	14.8	258	.13
Behavior disorder					5.4	3.9	258	.09
Neurotic depression					10.0	13.3	258	.34
Other neurosis					16.2	10.9	258	1.18
Character disorder					16.2	17.2	258	0
Borderline					10.0	10.2	258	0
Schizophrenia					20.0	22.7	258	.09
Other psychoses					3.8	2.3	258	.13
Other					6.2	4.7	258	.08
Months student and patient worked together	11.5	8.5	134	4.75***				

*p < .05
**p < .01
***p < .001

[1] t-values were used to analyze ratio and interval data and Chi-square was used to analyze ordinal and nominal data.

supervision experiences and had worked with five supervisors. While both helpful and unhelpful supervision experiences began about two years ago,[3] the helpful supervision experiences lasted on an average of 10.31 months while the unhelpful supervision experiences lasted 7.88 months.

Very few (5.9%) supervision experiences ended prematurely, which suggests that students generally worked with their supervisors for the predetermined length of time. As one might expect, though, unhelpful supervision experiences were more likely to be ended prematurely than helpful ones.

That the helpful supervision relationships lasted significantly longer than the unhelpful ones has some important implications. This may support the theory put forth by Hester et al. (1976) that supervision relationships develop in a number of stages, each of which requires a certain amount of time. In their view, longer supervision relationships allow students to develop more meaningful relationships with their supervisors. However, the more important point may be that unhelpful supervision experiences ended prematurely significantly more often than helpful supervision experiences. The premature endings might account for the differences in length of time student and supervisor worked with one another.

Demographic questions about the supervisors included questions pertaining to their age, sex, most advanced degree, theoretical orientation, amount of previous supervisory experience, and whether they were supervised on their supervisory work. Supervisors in the helpful and

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[3]How long ago the supervision experiences began was calculated from the reported dates of the supervision experiences.

unhelpful supervision experiences were similar in age or sex: The mean age was 41, and in both experiences the majority of supervisors were men (see Table 1).

As with the student-therapists, the majority of supervisors were psychologists (58.6%), and the second largest group was psychiatrists (39.1%). Of the psychologists in both the helpful and unhelpful experiences, 83.3% had earned a Ph.D., 3.8% an Ed.D., and 15.4% an M.S.

Unlike the student-therapists whose theoretical orientations were predominantly eclectic, most supervisors in both the helpful and unhelpful supervision experiences were described as psychoanalytically oriented. The next largest group was described as being eclectic (see Table 1).[4,5] The difference in amount of supervisory experience approached significance ($P = .06$), which indicated that students tended to perceive supervisors with more experience as more helpful. However, the supervisors as a group were experienced, having supervised on an average of 10.3 years. In approximately one-third of the cases a supervision seminar was provided in which supervisory issues could be discussed. Less often supervisors received supervision on the supervisory work that was being described by the students. Perhaps this might be explained by the fact that as a group the supervisors were experienced and did not

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[4]Subjects were asked to designate on a list of theoretical orientations including Psychoanalytic, Behavioral, Eclectic, Client-centered, Rational emotive, Family and Systems, and Other, what their supervisor's theoretical orientation was. Responses were considered eclectic if Eclectic or any combination of one or more orientations were checked.

[5]Because there were so few behaviorally oriented supervisors, the hypothesis regarding supervision approach as it related to the supervisor's theoretical orientation could not be tested.

need supervision on their work.

The demographic questions asked about the patient included "patient's sex, patient's age at the time of treatment, patient's diagnosis at the beginning of treatment, and length of time the student worked with the patient" (see Table 1). Patients were fairly closely matched on the first three variables and significantly differed on the fourth. Patients were about equally divided according to sex and were similar in age: the average age of the patients associated with helpful supervision experiences was 24.1 and of the patients associated with the unhelpful experiences, it was 25.3. The percentages of patients in each of the diagnostic categories were also quite similar. Table 1 summarizes the patient diagnoses at the beginning of treatment.

The patient groups differed according to how long they were in therapy with the student-therapists. The therapies associated with the helpful supervision experiences lasted on the average of 11.5 months, while those associated with the unhelpful supervision experiences lasted 8.5 months. Not surprisingly, this difference corresponds to the finding that students worked with their helpful supervisors significantly longer than with their unhelpful supervisors. The relationships as triadic systems lasted longer in the helpful cases.

Contracting in helpful and unhelpful supervision experiences. A group of questions were asked about how the students and supervisors began their relationships. Students were asked how they and their supervisors were matched, what they discussed in getting to know each other, and the nature of the working agreement developed in the first supervision meet-

ings. Data were again analyzed according to the differences between the helpful and unhelpful supervision experiences using t-tests and chi-squares (see Table 2 for a summary of these comparisons).

Although it is considered preferable for students and supervisors to request to work with each other (Hester et al., 1976; Langs, 1979), in the majority of cases in both helpful and unhelpful experiences matching was not accomplished as a result of student and supervisor requests. However, students in helpful supervision experiences requested or had been requested by their supervisors significantly more often than in the less helpful supervision experiences (Chi-square = 6.51, $p < .05$), lending support to the idea that it is helpful if students and supervisors request to work with each other. The high percentage of unrequested assignments may be accounted for by the fact that training sites frequently accept students for one-year placements and often assign students their supervisors on a random basis before students begin work. Apparently, students and supervisors were not generally matched according to sex. In 60% of the combined helpful and unhelpful instances, students were matched with the same sex supervisor and 89.2% were supervised by supervisors of the same discipline. And, in 71.6% of the instances student/supervisor pairs had different theoretical orientations.

What students and supervisors discussed in the process of getting to know one another differed significantly between the helpful and unhelpful supervision experiences. Students and supervisors in the helpful cases discussed their personal and professional backgrounds significantly more often than in the unhelpful cases (Chi-square = 4.66;

Table 2

Percentage of Time Each of Several Areas

Was Included in the Contract

(N = 190)

Area	Percent Helpful	Percent Unhelpful	Chi-square
Meeting hours	100.0	98.8	.00
Method of recording therapy sessions	67.0	48.4	6.01*
Method of presentation to supervisor	63.9	44.1	6.74**
Goals of therapy for patient	53.6	31.2	8.87**
How emergencies were to be handled	24.7	18.3	.82
Goals of supervision	47.4	14.0	23.27***

*$p < .05$

**$p < .01$

***$p < .001$

$p < .05$).

This may suggest a recognition of the relevance of both students' and supervisors' backgrounds to the work of clinical supervision. This finding supports Gardner (1953) who states that in the development of learning alliances student/supervisor relationships are enhanced by a discussion of personal backgrounds, and it supports Gardner (1963), Allen (1958) and Wolberg (1967) who have emphasized the importance of students and supervisors discussing their professional backgrounds. In 73.1% of the helpful experiences, students and supervisors discussed their expectations of the supervision, while only 48.5% did so in the unhelpful experiences (Chi-square = 16.03; $p < .001$). This highly significant difference supports Berger and Freeburg's (1973) idea that it is useful if expectations are discussed in the development of the supervision relationship.

In the establishment of a working relationship, students and supervisors in 69.4% of the helpful and 64.2% of the unhelpful supervision experiences formed explicit working agreements; this is not a significant difference. However, an examination of the incidence of the students and supervisors who established contracts reveals that in 79.6% of the combined cases, if students formed contracts with their supervisors, they formed them in both the helpful and unhelpful relationships (see Table 3). Similarly, in 70.7% of the cases, if students did not form a contract in a supervision relationship, they also did not in the other (Chi-square = 29.17, $p < .001$). Because the student served as his own control in the helpful and unhelpful supervision experiences, and because the supervisors were different in the helpful and unhelpful

Table 3

Incidence of Student-Supervisor Contracts

(N = 134)

		Percentages by Group	
		Unhelpful Supervision Experiences	
		Contract	No Contract
Helpful Supervision Experiences	Contract	79.6	20.4
	No Contract	29.3	70.7

Chi-square = 29.17***

*p < .05

**p < .01

***p < .001

experiences, it appears that contracting hinged on the student-therapists.

Students were asked to indicate whether six areas considered possible for inclusion in a supervision contract were indeed included in their contracts. In all cases, each of the six areas was more frequently discussed in the helpful experiences than in unhelpful experiences, and in four instances the differences between groups were significant (see Table 2). Meeting hours were universally discussed, while methods for handling emergencies were infrequently discussed in both types of experiences. Method of recording therapy sessions, method of presentation to supervisor, goals of therapy for patient, and goals of supervision each revealed significant differences between the helpful and unhelpful supervision experiences. That these differences were so great supports the theory put forth by Langs (1979), Wolberg (1967), and Greben, Markson and Sadavoy (1973), that it is helpful if some or all of these issues are discussed and made a part of a working agreement between student and supervisor at the beginning of supervision.

Most of the supervisors (76.8%) were seen as having an established method of supervision; however, the students were significantly more satisfied with these methods in the helpful experiences ($t = 18.53$; $p < .001$). In addition, students felt that in their helpful experiences approximately 50.0% of the working agreement was based on their own input, while in the unhelpful experiences, students' input was reported to be down to about 25% ($t = 2.31$; $p < .05$). This difference implies that students viewed helpful supervisors as those who took their views into greater consideration and were more willing to arrange working relation-

ships according to students' wishes. Finally, and not surprisingly, students reported significantly greater satisfaction with the final working arrangement with their helpful supervisors, whether the arrangement was explicit or not ($t = 17.36$; $p < .001$).

In sum, the results indicate contracting hinged on the students. In helpful supervision experiences students and supervisors tended to develop more explicit contracts based on more of the students' own imput and with which students were significantly more satisfied.

Factor analysis of elements of supervision. Factor analyses of each of the four sets of questions pertaining to the learning alliance, content of supervision, setting, and working alliance were done. Items were factor analyzed using varimax rotations with the aim of reducing the data for ease of interpretation in subsequent analyses. Variables were considered for inclusion in the factor scales if the loading was .30 or higher, and/or if the item had its highest loading on that factor. Another consideration for inclusion was interpretability, i.e., how closely the item's face meaning was related to the concept underlying the other items in the scale. After deriving the factor scales, coefficients of reliability were calculated on the factor scales, and only those with at least .60 reliability were considered for inclusion in subsequent analyses (Table 4). All scales met this criterion. The derived factor scales reflect the students' reconstruction of their supervision experiences. For those who wish to know the relationships between the several scales, Appendices G, H, I and J present the inter-scale correlations.

Table 4

Internal Consistency Reliabilities for Supervision Scales

(N = 190)

Scale	Number of Items	Cronbach's Alpha
Regard for Supervisor	8	.92508
Supervisor's Behavior	11	.92103
New Ideas	3	.64127
Supervisor's Directiveness	3	.68884
Process	5	.76769
Student Focus	3	.68563
Supervisor's View	3	.61988
Patient Centered	3	.56452
Atmosphere	7	.81486
Training	7	.77346
Service	5	.69969
Esprit-de-corps	3	.75443
Student's Competence	7	.91175
Patient's Motivation	5	.87515
Regard for Patient	5	.83746
Student's Acceptance of Patient	6	.76303
Transference, Countertransference	3	.69840

The learning alliance. The 28 items pertaining to the learning alliance were factor analyzed and yielded a five-factor solution (see Table 5). Here and in subsequent presentations of factor analyses, descriptive titles will be provided which reflect the overall meaning of the factor.

The first factor, "Student's Regard for Supervisor," accounted for 71.3% of the variance and incorporates eight items which assess the student's feelings of regard for the supervisor. This scale also suggests a sense of mutuality between student and supervisor. Items include:

1) You respected your supervisor;
2) You liked your supervisor;
3) You identified with your supervisor;
4) You trusted your supervisor's judgment;
5) You felt free to discuss emotional subjects with your supervisor;
6) You and your supervisor established clear communication, e.g., clear language that both of you could understand;
7) You and your supervisor together assumed responsibility for your learning; and
8) You discovered how you could best learn from your supervisor.

These sentiments in large part are those considered by Wolberg (1967), Fleming and Benedek (1966), Gardner (1953), and Greben, Markson and Sadavoy (1973) as promoting and supporting the learning alliance. The high loadings on the several items suggesting a sense of mutuality between student and supervisor may indicate that a feeling of mutuality is highly associated with feelings of positive regard for the supervisor. The cornerstone of this scale is the students' positive regard for the supervisor whether that is expressed by liking, respecting, identi-

Table 5

Factor Loadings of 28 Learning Alliance Variables

on Five Factors after Varimax Rotation

(N = 255)

Variable	Factor I Student's Regard for Supervisor	Factor II Supervisor's Behavior	Factor III New Ideas	Factor IV Supervisor's Directive-ness	Factor V[1]
1. Supervisor was active in student learning	.11490	.23320	.11327	.75200	-.10319
2. Supervisor was decisive	.06446	-.02388	-.04034	.67313	-.08864
3. Supervisor was interested in patient change	.19601	.55634	.03198	.31672	.00922
4. Supervisor praised student	.19299	.72948	.22279	.21559	.09922
5. Supervisor accepted student dependence	.18183	.45233	-.03901	.43371	.11431
6. Supervisor was protective of student	.12690	.51433	-.05020	.23587	.10390
7. Supervisor was receptive to differences	.48849	.54554	.26761	-.01487	.17157
8. Supervisor respected student	.41674	.66685	.22118	.00994	.11824
9. Supervisor trusted student judgment	.33050	.60137	.24313	-.07239	.13307

[1]This factor was judged to be weak. It accounted for only a small amount of the variance and was not used in subsequent analyses.

Table 5 (continued)

Variable	Factor I Student's Regard for Supervisor	Factor II Supervisor's Behavior	Factor III New Ideas	Factor IV Supervisor's Directive-ness	Factor V[1]
10. Supervisor was supportive	.46113	.73082	.20519	.08029	.17263
11. Supervisor was punitive toward student[2]	.43142	.48476	.25602	-.15697	.36645
12. Supervisor was interested in student feelings	.42390	.52129	.09153	.08699	-.21199
13. Supervisor was empathic with student	.50662	.56645	.06967	.06565	.04565
14. Supervisor was available for more time	.24196	.47993	.05328	.13733	-.30759
15. Student was willing to try new approaches	.13020	.01760	.68718	.09868	.10915
16. Student felt free to try new ideas	.19170	.28436	.67769	-.05352	-.09381
17. Student was willing to examine own weaknesses	.48713	.14581	.28466	-.00408	.03330
18. Student respected supervisor	.88799	.13363	.07026	.12855	.12820
19. Student trusted supervisor judgment	.75218	.19494	.08235	.12355	.11092

[1]This factor was judged to be weak. It accounted for only a small amount of the variance and was not used in subsequent analyses.

[2]This item was recoded so that its positive loading would be consistent with the positive loadings on the other items.

Table 5 (continued)

Variable	Factor I Student's Regard for Supervisor	Factor II Supervisor's Behavior	Factor III New Ideas	Factor IV Supervisor's Directive-ness	Factor V[1]
20. Student felt free to discuss emotional subjects	.68714	.39136	.19521	-.00139	-.11407
21. Student was anxious	.16690	.41966	.33757	-.09919	.27122
22. Student liked supervisor	.76931	.41852	.12667	.05349	.07961
23. Student discovered how to best learn	.52432	.26462	.15082	.26197	.13192
24. Student identified with supervisor	.75880	.35049	.02104	.10764	.04276
25. Student and supervisor established communication	.55490	.36514	.33278	.16920	.23426
26. Student and supervisor responsible for learning	.54168	.37909	.14140	.29462	.01197
27. Supervisor liked student	.41465	.59579	.22904	.00352	.15031
28. Student and supervisor had disagreements[2]	.15064	.14462	.05288	-.08152	.60883

[1]This factor was judged to be weak. It accounted for only a small amount of the variance and was not used in subsequent analyses.

[2]This item was recoded so that its positive loading would be consistent with the positive loadings on the other items.

fying with or trusting the supervisor. Perhaps secondary to the feeling of positive regard is the sense of mutuality also encompassed by this factor.

The second factor, "Supervisor's Behavior Scale," was derived from ten items all of which express a range of supervisor behaviors including the expression of caring and a supportive attitude. This factor accounted for 10.6% of the variance and includes the variables:

1) Your supervisor was supportive of you;
2) Your supervisor praised you when you made an important gain;
3) Your supervisor respected you;
4) Your supervisor trusted your judgment;
5) Your supervisor liked you;
6) Your supervisor was empathic with you;
7) Your supervisor was receptive to your differences with him/her;
8) Your supervisor expressed an interest in your feelings;
9) Your supervisor was protective of you; and
10) Your supervisor was irritable or punitive toward you.[6]

This factor denotes the supervisor's positive regard as well as active and caring concern for the student. Wolberg (1967), Greben, Markson and Sadavoy (1973), Barnat (1973), and Searles (1962) have described some or all of these attitudes and behaviors as being conducive to the development of a learning alliance between student and supervisor.

"New Ideas," the third factor, explained 8.1% of the variance and is made up of three items, two of which have to do with a student's willingness and ability to experiment with new ideas. The three items included in this scale are:

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[6]This item was recoded so that its positive loading would be consistent with the other items' positive loadings.

1) You were willing to try new approaches to treatment;
2) You felt free to experiment with new ideas; and
3) You were anxious in supervision.

This particular student characteristic portrays an eagerness on the student's part to learn and has been detailed by Wolberg (1967) as being helpful in the development of the learning alliance. The third variable belonging to this scale has a somewhat higher loading on Factor II but is used here to stabilize this factor and establish its reliability. Its high loading here may have to do with the fact that experimenting with and learning new ideas is accompanied by a certain amount of anxiety (Chessick, 1971).

The fourth factor, "Supervisor's Directiveness," which accounted for 5.5% of the variance, consists of three items that reflect the supervisor's directiveness. Two of the variables convey the supervisor's directiveness. The items include:

1) Your supervisor took an active role in directing your learning;
2) Your supervisor was decisive; and
3) Your supervisor accepted your dependence on him/her.

The key concept underlying this scale is the active and directive stance taken by the supervisor in the supervision. It implies a supervisor who is actively involved in and feels a responsibility for teaching, in contrast to a supervisor who lets the supervision unfold. Wolberg (1967) feels that in good supervision supervisors take an active and directive stance. The third item, though it loaded higher on Factor II, is again included here to stabilize the factor and to establish reliability. The third item may be related to the other two items in the scale in that

supervisors who are perceived as directive and decisive in supervision may also be perceived by students as having encouraged their dependence.

The fifth factor which accounted for 4.4% of the variance consists of two items and as such was too small to create a scale. The items, "You and your supervisor had disagreements";[7] and "Your supervisor was available to you for extra time if you needed it," are related negatively to each other. Both items, as reflected in the t-values, relate positively to helpful supervision, that is to say, helpful supervisors were seen as more available to students for extra time and students had fewer disagreements with their helpful than unhelpful supervisors. The nature of the negative relationship of these variables cannot be explained right now. Because this scale was clearly marginal and statistically difficult to interpret, it was dropped from subsequent analyses.

The topics discussed in supervision. Fourteen items were included in the questionnaire because they represented topics from both didactic and process-oriented supervision. A factor analysis of these items yielded a four-factor solution (see Table 6).

The "Process Scale," Factor I, accounted for 46.2% of the variance in the factor analysis and incorporates five items which suggest process-oriented supervision as described by Ekstein and Wallerstein (1972), Wagner (1957), Bonn and Schiff (1963), Doehrman (1976), Searles (1955), and Mueller and Kell (1972). Items included are:

1) Authority issues with your supervisor;
2) Your relationship with your supervisor;

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[7]This item was recoded so that its positive loading was consistent with the positive loadings on the other items.

Table 6

Factor Loadings of 14 Topics Discussed in Supervision on Four Factors after Varimax Rotation

(N = 260)

Topic	Factor I Process	Factor II Student Focus	Factor III Supervisor's View	Factor IV Patient-Centered
1. What supervisor would have done	.00207	-.06889	.42647	.07148
2. Practical aspects of patient management	-.01176	-.09455	.14888	.44910
3. Supervisor's view of patient's problems	-.00184	.09138	.70078	.26705
4. Patient behavior	-.10201	.01726	.07364	.68163
5. Supervisor's formulation of patient's dynamics	.03624	.14427	.61935	.09058
6. Patient's therapeutic needs	.02058	.34427	.17547	.49653
7. Student feelings about patient	.10436	.66563	-.04092	.06889
8. Student errors relating to patient	.16713	.41185	.30986	-.07239
9. Self awareness issues	.25119	.82332	.05836	-.01109
10. Difficulties in learning	.80466	.01071	.13438	-.06923
11. Problems in acquiring therapeutic skills	.37393	.27349	.20289	-.17517
12. Student's personal problems not related to work	.37508	.23170	-.11113	.11526
13. Authority issues with supervisor	.75171	.08134	.10514	-.14433
14. Student's relationship with supervisor	.78608	.35823	-.10180	.04128

3) Your difficulties in learning from your supervisor;
4) Your problems in acquiring therapeutic skills;
5) Your personal problems not related to your work.

This scale reflects an interpersonal orientation in the supervision with an emphasis on discussing issues, such as problems that arise for a student in working with an authority figure. Student problems which interfere in acquiring psychotherapy skills, such as defensive patterns, as well as personal problems not related to work are also discussed.

The "Student Focus Scale," Factor II, made up of three items representing both didactic and process-oriented supervision, accounted for 26.6% of the variance. The variables are:

1) Your feelings about the patient;
2) Your errors in relating to the patient; and
3) Self-awareness issues.

The emphasis is similar to that of the Process Scale in that student feelings and self-awareness issues are emphasized, but different in that the main focus of supervision is on the student rather than the student/supervisor relationship. In this kind of supervision, the supervisor primarily concerns himself with the student's transference feelings about the patient and the errors the student makes as a result of those feelings. The goal is to heighten self-awareness in students so that their transference and countertransference feelings will not interfere with their work with patients. Items in this scale portray the corrective approach to supervision, one of several didactic approaches, as described by Fleming (1953). Rioch et al. (1976) use this approach almost exclusively in group supervision of internship students.

The third factor, "Supervisor's View Scale," accounted for 15.8% of the variance and consists of three items each of which describes the supervisor's perspective on the clinical work:

1) What your supervisor would have done in the therapeutic situation you described;
2) Your supervisor's view of what your patient's problems were; and
3) Your supervisor's formulation of the patient's dynamics.

This factor largely embodies aspects of the imitative approach, one of the three didactic approaches described by Fleming (1953). The basic assumption underlying this kind of supervision is that the teaching of psychotherapy is, for the most part, a matter of demonstrating techniques and thereby enabling students to learn by imitating what the supervisor would have done.

The fourth factor, "Patient-Centered Scale," is again a didactic factor that accounted for 11.4% of the variance. The scale points to a focus on the patient in the supervision and consists of three items:

1) The practical aspects of your patient's management;
2) The patient's behavior; and
3) The patient's therapeutic needs.

In this kind of supervision, which closely resembles what Tarachow (1963) describes as patient-centered supervision, attention is exclusively on the patient and students are instructed strictly according to the needs of the patient.

The setting. The factor analysis of the twenty-three questions pertaining to the training setting yielded a four-factor solution (see Table 7). Three of the four factors reflect the educational climate,

Table 7

Factor Loadings of 23 Setting Variables

on Four Factors after Varimax Rotation

(N = 255)

Variable	Factor I Atmosphere	Factor II Training	Factor III Service	Factor IV Esprit-de-corps
1. Rules and expicit guidelines	-.06729	.66619	.15283	.11540
2. Goals of training program clear	.14377	.59569	.40923	.27781
3. Number of cases students to carry clear	.10674	.53135	.22385	.06835
4. Rules of patient assignment clear	.09374	.44366	.18411	.16058
5. Length of time student and supervisor work clear	-.09941	.29108	.03047	.06281
6. Process of evaluations clear	.17133	.56084	.05715	-.01738
7. Rules for transfer to another supervisor clear	.04451	.42787	.08914	-.01821
8. Program integrated with clinical services	.21183	.40936	.35506	.05403
9. Regulations applied flexibly[1]	.43125[1]	-.22808	.04888	.04773
10. Setting structure stable	.25661	.30342	.37955	.04630
11. Rules safeguarded treatment	.23630	.14456	.56602	.09583
12. How to handle patient crises clear	.11604	.15820	.54416	.07616
13. Patients receive good treatment	.30284	.12986	.65971	.26763
14. Organized system of record keeping	-.02172	.11362	.37507	.00841
15. Communication open among staff	.49987	.09150	.13020	.45643

[1]There was evidence for curvilinearity on this item. To avoid distortion in this scale this item was removed from further consideration for subsequent analyses.

Table 7 (continued)

Variable	Factor I Atmosphere	Factor II Training	Factor III Service	Factor IV Esprit-de-corps
16. Staff had frequent social contacts	.30217	.02605	.02146	.48917
17. Staff had unifying treatment philosophy	-.03867	.03001	.16405	.58969
18. Staff shared training philosophy	.09813	.36285	.05421	.87953
19. Atmosphere was one of sharing	.57580	.06156	.15766	.49457
20. Staff was supportive of students	.67041	.17438	.28747	.16164
21. Supervisors were available to students	.33586	.29187	.26273	.12437
22. Defensiveness characterized setting[2]	.72190	.17481	.12645	.16144
23. Supervisors were critical of students[2]	.65506	.07613	.12703	-.06207

[2]This item was recoded so that its positive loading would be consistent with the positive loadings on the other items.

the regulations and expectations, and the quality of patient care that Ekstein and Wallerstein (1972) have set forth as characteristics of a good psychotherapy training setting. The fourth factor suggests the internal philosophical and social atmosphere which Chessick (1971) terms "esprit de corps."

The first factor, "Atmosphere Scale," which explained 61.1% of the variance, consists of six variables suggesting the general work atmosphere of the training setting. The items included were:

1) Defensiveness characterized your setting;[8]
2) The staff was supportive of its students;
3) Supervisors were critical of students;[9]
4) The atmosphere was one of sharing;
5) Communication was open among staff in your setting; and
6) Supervisors were generally available to student-therapists.

This scale characterizes a setting as accepting and supportive of its students and as one where there is sharing and open communication.

The second factor, "Training Scale," is made up of seven items reflecting the clarity of the organizational and structural aspects of the training program. This factor accounted for 19.6% of the variance and is comprised of:

1) The goals of your training program were clear;
2) There were rules which guided the clinical training program;
3) The process of student evaluations was clear;
4) The number of cases students were to carry was clear;

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[8]This item was recoded so that its positive loading would be consistent with the positive loadings on the other items.

[9]This item was recoded so that its positive loading would be consistent with the positive loadings on the other items.

5) The rules of patient assignment were clear;
6) The rules for transfer to another supervisor were clear; and
7) The training program was integrated with the rest of the clinical services the setting offered.

The key concept underlying this scale is that the organizational and structural aspects of the training setting are clear. In this kind of setting students know what is expected of them and what to expect from their program. There are clear rules for student functioning within the setting.

The third factor, "Service Scale," reveals the service aspects of the training setting and accounted for 11.4% of the variance. It incorporates five items related to patient care:

1) Patients receive good treatment at the training setting;
2) There were rules which safeguarded the treatment process;
3) Arrangements for handling patient crisis were clear;
4) The setting's organizational structure was stable; and
5) Your setting had an organized system of record keeping.

The important feature of this scale is the high quality of care given patients at the training site.

The fourth factor, "Esprit-de-corps Scale," describes a construct similar to Factor I yet reliably distinct. The scale is made up of five variables and it accounted for 7.8% of the variance. The variables are:

1) Staff shared a training philosophy;
2) There was a unifying treatment philosophy among the staff;
3) The staff had frequent social contacts outside the training setting;
4) The atmosphere was one of sharing; and
5) Communication was open among staff in your setting.

The sum and substance of this scale seems to be "esprit-de-corps" among

the staff both at work and socially which has been noted to be characteristic of effective training sites (Chessick, 1971).

The working alliance. The 27 items pertaining to the working alliance at first yielded a seven-factor solution. Solutions involving seven, six, and five factors were examined, and the five-factor solution was selected as the most meaningful and compelling (see Table 8).

"Student's Competence Scale," the first factor, which is comprised of seven items, explained 69.1% of the variance. Variables included are:

1) You felt able to help your patient;
2) Your patient seemed to like you;
3) Your patient trusted you;
4) Your patient responded well in your relationship;
5) Your patient respected you;
6) You were able to make genuine contact with your patient; and
7) Your patient felt the goals of treatment could be attained.[10]

This scale depicts a student's view of his or her ability to establish a working relationship with his/her patient which elicits such feelings as respect, trust, and hope on the part of the patient. A working alliance characterized by these qualities serves as the basis for treatment and is a prerequisite of positive outcome in treatment (Friedman, 1969).

Five items make up the second factor, "Patient's Motivation Scale," which accounted for 12.6% of the variance. These include:

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[10]On face value this item would seem to belong in Factor II. However it loaded slightly higher on Factor I, and one could understand that a patient might feel the goals of treatment could be attained with a therapist he felt was competent.

Table 8

Factor Loadings of 27 Working Alliance Variables

on Five Factors after Varimax Rotation

(N = 254)

Variable	Factor I Student's Competence	Factor II Patient's Motivation	Factor III Student's Regard for Patient	Factor IV Student's Acceptance of Patient	Factor V Transference and Counter-transference
1. Patient aware of his emotional problem	.07300	.55928	.16692	.15769	.04180
2. Patient motivated for help	.22928	.79790	.12294	.15266	-.00517
3. Student confident therapy goals attainable	.32543	.42843	.14244	.05662	.26438
4. Patient felt therapy goals attainable	.43404	.41989	-.05521	.06868	.11450
5. Student accepted patient's dependency needs	.13478	.10857	.15813	.48304	.14331
6. Student was understanding with patient	.08485	.17283	.47326	.57935	.13599
7. Student was accepting of patient	.13433	.08289	.36365	.46799	.04943
8. Student withstood patient's painful feelings	.14598	.16989	.15519	.42101	.26163
9. Patient partially identified with student	.22819	.18843	.19927	.52031	.14209
10. Student dealt with patient's resistances to working alliance	.02488	.08958	-.07309	.47315	.41641
11. Student understood patient's feelings for student	.24805	.11287	.09825	.33941	.56493

Table 8 (continued)

Variable	Factor I Student's Competence	Factor II Patient's Motivation	Factor III Student's Regard for Patient	Factor IV Student's Acceptance of Patient	Factor V Transference and Counter-transference
12. Student aware of own feelings for patient	.01924	.03464	.13490	.10604	.56627
13. Student could manage own feelings for patient	.21052	.19944	.34020	.12160	.60245
14. Student had warm feelings for patient	.33428	.10067	.77144	.21509	.15086
15. Student respected patient	.26098	.12853	.48997	.28093	.27507
16. Student liked patient	.25964	.14171	.79911	.18963	.12010
17. Student empathized with patient	.10230	.32571	.48182	.36188	.17438
18. Student was interested in patient	.00646	.11557	.37885	.28091	.24975
19. Patient respected student	.56226	.22534	.19855	.48937	.11803
20. Patient seemed to like student	.63974	.08354	.27589	.42870	-.02662
21. Patient trusted student	.61055	.26064	.30907	.29000	.03409
22. Therapy relationship was free of anxiety	-.43069	-.12543	-.29003	.10062	-.02440
23. Student developed collaborative relationship with patient	.55448	.58387	.12362	.16260	.21348
24. Student made genuine contact with patient	.49532	.36139	.24655	.30230	.24665
25. Patient responded well in therapy relationship	.59930	.47440	.13993	.21119	.28473
26. Student felt able to help patient	.64044	.36847	.16016	.21180	.26454
27. Patient wanted to master his problems	.23612	.76663	.12049	.15135	.12742

1) Your patient was motivated for help;
2) Your patient wanted to master his/her problems;
3) You developed a collaborative relationship with your patient;
4) Your patient was aware that he had an emotional problem; and
5) You felt confident the goals of treatment could be attained.[11]

This scale's main concept denotes a patient aware of his/her problem and actively seeking help from the therapist of his/her own accord. S/He willingly engages in therapy and is able to develop a collaborative relationship with his/her therapist. This kind of patient stands in contrast to the patient who, for example, is ordered by the courts to seek treatment as a condition of parole.

The third factor, "Student's Regard for Patient Scale," consists of five items and taps the student's feelings for the patient, e.g., warmth, interest, and liking. Variables making up this scale include:

1) You liked your patient;
2) You had warm feelings toward your patient;
3) You respected your patient;
4) You empathized with your patient; and
5) You were interested in your patient.

This factor, which accounted for 7.6% of the variance, reflects a student's positive regard for his/her patient. The feelings described by this scale are those that therapists often experience for their patients

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[11]On face value it might seem that this item belongs with Factor I. However it did load higher on this factor and one could conceive that a student-therapist might feel confident the goals of therapy could be attained if the patient was motivated for help. Likewise, a therapist might not feel the goals of therapy could be attained if the patient was not motivated for treatment.

in the development of the working alliance (Friedman, 1969; Wolberg, 1967).

"Student's Acceptance of Patient Scale," the fourth factor, is made up of six variables and it accounted for 5.6% of the variance. Items with high loadings on this factor include:

1) You were understanding with your patient;
2) Your patient at least partially identified with you;
3) You accepted your patient's legitimate need to be dependent;
4) You dealt with your patient's resistances to the development of your working relationship;
5) You were accepting of your patient; and
6) You were able to withstand your patient's expressions of painful feelings.

Items on this scale define a construct having to do with the students' acceptance of their patients. They accept and work with their patients' resistances and they accept and work with their patients' painful feelings. In addition, therapists meet certain patient needs, e.g., dependency needs, in order to establish and maintain a working alliance (Wolberg, 1967).

"Transference and Countertransference Scale," the fifth factor, accounted for 5.1% of the variance and is made up of three items:

1) You were able to manage or work out your feelings toward your patient;
2) You were aware of your feelings toward your patient; and
3) You understood your patient's feelings toward you.

This factor, which might be called a transference-countertransference factor, points to the student's understanding of and ability to cope with the strong feelings aroused in the therapeutic relationship.

Crucial in the development of the working alliance is a therapist's ability to manage these feelings (Langs, 1979; Wolberg, 1967). This factor suggests the student's ability to do this.

Discriminant analysis. The primary aim of this study, as outlined in the Introduction, was to test the hypothesis that each of four elements would influence students' evaluations of helpful supervision experiences. Secondarily, this study sought to determine the relative impact that each element had on students' views of helpful and unhelpful psychotherapy supervision. These elements were: 1) the learning alliance; 2) the topics in supervision; 3) the setting; and 4) the working alliance. Toward these ends, discriminating variables (items on the questionnaire) were selected on which helpful and unhelpful supervision experiences were expected to differ. Then, using the factor scales derived from the factor analyses described earlier, a discriminant analysis was performed. The aim of discriminant analysis is to statistically distinguish between two or more groups by means of a combination of variables. Mathematically, discriminant analysis weights and linearly combines discriminating variables (in this case factor scales) so that the groups are forced to be as statistically distinct as possible. The point is that no single variable can completely discriminate between groups so that several variables are combined which will maximally distinguish the groups. Thus, discriminant analysis is a procedure whereby differences are maximized between groups and minimized within groups. Usually discriminate analysis is used to distinguish groups of respondents, but here it is used to distinguish two groups of supervision

experiences both of which have been reported on by the respondents. In this analysis a stepwise method was used by which the various factor scales were chosen for entry into the analysis according to their ability to improve the combined discriminating power. In each step of the analysis the "next best" discriminator was selected. The result was a reduced group of variables which discriminated as well as, or better than the complete set.

The results of the stepwise discriminant for the helpful and unhelpful supervision experiences are presented in Tables 9 and 10 and Figure 1. In the first and second columns, Table 9 presents the means and standard deviations of the scales included in the discriminant. In the third column the univariate F-ratios are presented together with significance levels. These F-ratios indicate whether the variable alone significantly differentiated between helpful and unhelpful supervision experiences. Table 10 presents the results of the stepwise discriminant analysis. The measures are named in the first column; the Wilks-Lambda[12] and its significance in the second; the RAO'S V[13] and its significance in the third; and the change in RAO'S V and its significance in the fourth. Of the original 17 scales 10 were selected before their con-

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[12]"A. . .criterion for eliminating discriminant functions is to test for the statistical significance of discriminating information not already accounted for by the earlier functions. As each function is derived, starting with no (zero) functions, Wilks-Lambda is computed. Lambda is an inverse measure of the discriminating power in the original variables which has not yet been removed by the discriminant functions" (Nie et al., p. 442). The smaler lambda is, the closer one is to a best solution for the discriminant.

[13]RAO'S V is a generalized distance measure. The larger RAO'S V, the further apart the combined variables have pushed the groups.

Table 9

Scale Means, Standard Deviations and Univariate F Ratios

(N = 235)

	Helpful		Unhelpful		
Scale	M	SD	M	SD	Univariate F
Student's Regard for Supervisor	46.23	6.22	27.39	8.34	384.10***
Supervisor's Behavior	57.20	7.68	39.07	10.66	223.00***
New Ideas	15.36	3.01	12.86	3.75	31.59***
Supervisor's Directiveness	14.84	3.18	11.61	4.56	39.22***
Process	10.06	3.15	9.31	3.64	2.84
Student Focus	10.19	2.13	8.56	2.59	27.58***
Supervisor's View	11.10	1.73	10.42	2.68	5.35*
Patient-Centered	11.47	1.73	10.43	2.14	16.92***
Atmosphere	29.94	5.57	26.40	6.82	18.91***
Training	32.19	8.39	29.61	8.75	5.30*
Service	27.74	4.42	26.15	5.11	6.50*
Esprit-de-corps	12.10	4.18	11.21	3.94	2.84
Student's Competence	36.60	6.76	32.50	7.91	18.25***
Patient's Motivation	25.82	5.55	21.82	5.89	28.59***
Student's Regard for Patient	28.72	4.41	26.13	4.85	18.29***
Student's Acceptance of Patient	34.08	4.54	31.32	5.25	18.53***
Transference and Countertransference	16.62	2.46	15.17	3.17	15.31***

*p < .05
**p < .01
***p < .001

Table 10

Summary Table for Stepwise Discriminant Analysis

(N = 235)

Scale	Wilks Lamda	Sig.	RAO'S V	Sig.	Change in V	Sig.
Student's Regard for Supervisor	.377581	0	384.0868	0	384.0868	0
Supervisor's Behavior	.360568	.0000	413.2026	0	29.1158	.0000
Supervisor's Directiveness	.348420	0	435.7335	0	22.5309	.0000
Process	.341868	.0000	448.5489	0	12.8155	.0003
Training	.335468	0	461.5526	0	13.0037	.0003
Student's Acceptance of Patient	.329522	.0000	474.0838	0	12.5312	.0004
Student Focus	.327513	0	478.4211	0	4.3372	.0373
Esprit-de-corps	.325549	.0000	482.7151	0	4.2941	.0382
Patient's Motivation	.323694	0	486.8167	0	4.1016	.0428
Student's Competence	.320331	.0000	494.3728	0	7.5561	.0060
Service	.319489	0	497.2897	0	1.9169	.1667
Supervisor's View	.318949	.0000	497.5248	0	1.2351	.2664
New Ideas	.318558	0	498.4212	0	.8964	.3437
Student's Regard for Patient	.318423	.0000	498.7320	0	.3108	.5772
Transference and Countertransference	.318354	0	498.8888	0	.1568	.6921
Atmosphere	.318327	.0000	498.9520	0	.0632	.0815
Patient-Centered	.318302	0	499.0083	0	.0563	.8124

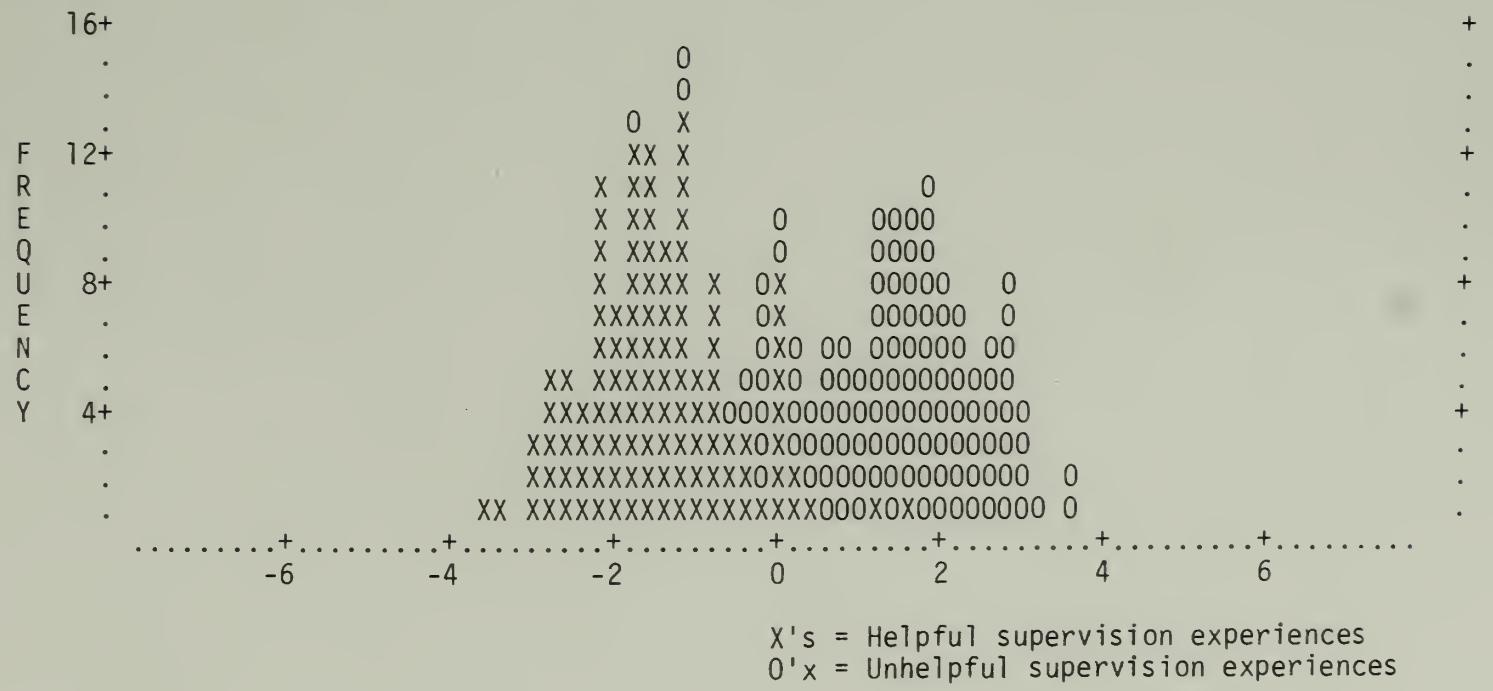

Figure 1. Canonical discriminant function all-groups stacked histogram (N = 235).

tribution to the change in RAO'S V became nonsignificant, i.e., $p < .05$. A great degree of separation resulted from these 10 factor scales as revealed by the final Wilks-Lambda (.318) and the cannonical correlation of .826. The cannonical correlation is a measure of the discriminant function's ability to discriminate the groups. Figure 1 presents the stacked histogram representing the classification and frequency of the helpful and unhelpful supervision experiences.

The results of the discriminant analysis supported the original hypothesis that each of the four elements would influence students' views of helpful supervision experiences. At least two factor scales derived from each of the four elements are represented among the reduced group of variables which differentiated the helpful from unhelpful supervision experiences. That is to say, some aspects of the learning alliance, the topics discussed in supervision, the setting, and the working alliance did indeed influence students' evaluations of their supervision experiences. These included three Learning Alliance scales, two Topics in Supervision scales, two Setting scales, and three Working Alliance scales.

The Learning Alliance scales. Three Learning Alliance scales--1) the Student's Regard for Supervisor Scale; 2) the Supervisor's Behavior Scale; and 3) the Supervisor's Directiveness Scale--contributed significantly to the discriminant function. Of these three scales, the Regard for Supervisor Scale accounted for the bulk of the discrimination. This suggests that from the students' perspective what was most important in discriminating helpful from less helpful supervision experiences were the students' own positive feelings of regard for their supervisors and

a sense of mutuality in their work as developed in the early phase of the supervision work.[14] These feelings were reflected in some of the students' comments at the end of the questionnaire:

> "Very important to me was that the supervisor was open, honest, direct. I knew he would be straight with me, and therefore I trusted him, felt safe and could be open and honest with him."
>
> "This supervisor was a very pleasant, firm, knowledgeable senior analyst at -- University."
>
> "I greatly respected this supervisor. His opinion of me was very important which caused me to work harder in preparing for supervision."

In contrast, some students commented on their inability to trust or respect their supervisors or to establish a sense of mutuality about their work:

> "I did not trust him. I caught him once talking about me in a private communication to the clinic director. . . . I could not respect him."
>
> "This supervisor made hostile comments about patients and used sarcasm frequently toward me and toward my patients. I never felt safe in supervision and tended to be quite constricted. . . . This supervisor tended to discuss diagnosis and formulation by fishing--asking leading questions to get me to say what he was thinking. I found this annoying and often wished he would just say what he thought instead of trying to have me say it. I found this supervisor condescending and annoying though I really needed his help."
>
> "I did not respect this supervisor who operated on a psychoanalytic, T-group model that I felt was inappropriate with many of the clients in that setting. He did not seem able to

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[14]The reader is reminded that the students were asked to answer these questions with reference to the initial phase of their supervision, i.e., the first third of the supervision, or one to three months.

teach me much, and so I tended not to expect much, and it turned out to be useless supervision."

The second Learning Alliance scale which differentiated helpful from unhelpful supervision experiences was the Supervisor's Behavior Scale. This suggests the importance of supervisors reciprocating students' feelings of positive regard. In addition, it reflects the significance of the supervisor's active caring for, support of, and interest in their students. Many students' comments addressed these issues:

"I knew this supervisor really cared about me as an individual and was concerned about me as a person and my personal growth and well-being in addition to my professional growth. He was very concerned about supervision and seeing clients being a good experience."

"This supervisor was remarkably accepting of me, had a sense of humor but also tremendous consistency and a work attitude. He seemed quite committed to our task. He did not speak of himself much but mostly we spoke of the patient. I presented process material in great detail and looked forward to our meetings. I was more consistent in keeping detailed process notes for this supervisor, and I think it related to his non-critical, interested, committed approach."

". . .very careful listening by supervisor both to case material and to my perceptions. Supervisor's presence--undistracted, quiet, and calm."

On the other hand, some unhelpful supervisors were seen as unsupportive, disrespectful, uninterested, argumentative, and unreceptive to ideas different from their own.

"The major source of unhelpfulness in this supervision I think was that the supervisor seemed argumentative and as if he wanted me to act like he did. I thought he was neither attentive to nor respectful of my personal style. So I found I wasn't able to integrate the things we talked about in supervision with what I was already doing. And I quit trying."

"This supervisor was very reluctant to share his negative feelings about me or my work early in the relationship. Late in the relationship I felt he partly had been defensive himself and unwilling to take emotional risks. Perhaps he did not respect me early in the supervisory relationship. Also, he was covertly dogmatic in his psychoanalytic stance, i.e., seemed to tolerate more diverse approaches but in fact had no patience for them."

"The most unsatisfactory part of the supervision resulted from my growing sense that the patient had a thought disorder radically different from the original diagnosis of neurosis, which, when I shared it with the supervisor, was not paid attention to. As often as I raised this, each time it was discussed or explained away. I felt that showed communication with the supervisor about the patient and how she made me feel was impossible. Thus, the supervision was extremely unsatisfactory."

"This supervisor became more supportive, trusting of my judgment, interested in my ideas at the close of supervision, but this came very late."

The third Learning Alliance scale which contributed to the discriminant function was the Supervisor's Directiveness Scale which stresses the importance of supervisors' taking an active and directive stance in the supervision and their willingness to accept students' dependence. This was reflected in two of the students' statements:

"The first third of supervision was pretty awful now that I remember. I was very anxious and felt incompetent. My supervisor stuck with me through this experience and seemed to like me. . . . Initially we talked about my anxiety and about literally what words I should say, how I should respond to her (the patient's) questions, etc."

"This supervisor is not in any way oriented toward a collaborative relationship between supervisor and student. He believes in his authority and expertise and my role as a student. Within this framework he is qutie supportive, warm and genuine. It must be noted that I underwent a tremendous amount of resistance to his methods but having succumbed feel I've received more benefits than in any other supervisory experiences. His sheer brilliance allows me in some respects to have this degree of respect for him."

And some less helpful supervisors were viewed as laissez-faire and non-directive.

> "This supervision was very chaotic. . . . His style of supervision was non-directive and it was often difficult to focus on my agenda. However, I liked him and never confronted him."
>
> "My supervisor was seen as somewhat of a Guru. She supervised in a style similar to how she probably did therapy, very little or no direct guidance. I found her not terribly supportive or consistent."
>
> "This supervisor was pleasant but insufficiently assertive. Much to my detriment he communicated less of his considerable knowledge than he might have."
>
> "My supervisor reacted poorly to an active student. He felt threatened by my knowledge and reacted poorly to my attempts to relate to him as a colleague. In part the degree to which I became active was a function of his lack of leadership, indecisiveness and excessive direction over our relationship. I also had no opportunity to observe his clinical work, had no clear idea of how he wanted me to behave either with him or the patient, e.g., a lack of supervision--student communication. Even dogmatic directive communication is more useful than lay-back and let the student do his thing. You can't learn anything from a vacuum."

In sum, three of the five scales derived from the learning alliance variables contributed significantly to the discriminant with the majority of the discrimination being accounted for by the Regard for Supervisor Scale. The student's regard for the supervisor, an established sense of mutuality, the supervisor's caring and respect for the student and the supervisor's active and directive stance in the supervision each influenced the students' views of helpful supervision.

The Topics in Supervision scales. Two of the four scales derived from the Topics in Supervision added significantly to the discriminant. These included the Process Scale and the Student Focus Scale. Though

process issues and student focus issues were reportedly discussed infrequently in both the helpful and unhelpful supervision experiences, the student-therapist felt that these issues were important to deal with when necessary. Thus, a focus on the relationship between student and supervisor, the student's problems in acquiring therapy skills, together with a focus on student feelings and errors vis-a-vis the patient were important to helpful supervision experiences. Some students commented on the importance of being able to discuss process issues in their supervision:

> "The only problem of any significance in the supervisory relationship was that my supervisor was overly protective and paternalistic with female supervisees. However, he was very receptive to feedback and we were able to talk about this. And he was able to give me more room for growth than he probably would have otherwise."

> "This supervisor was exquisitely sensitive to and accepting of the way in which feelings would float through the patient-therapist-supervisor 'system' and tactful in clarifying these issues while maintaining with me a sustaining working alliance."

> "What I felt to be the most important aspect of this supervision at the beginning was my supervisor's ability to help me deal with my anxieties as a beginning therapist. I remember him saying that if I never made mistakes, I didn't belong in the training program. This helped me accept the fact that I would make mistakes and that I needed to do so in order to learn more about the therapeutic process. This has remained with me above and beyond the more specific workings of the supervision."

Problems arose when students and supervisors could not talk about problems in their relationship:

> "In this supervision the first three months went fine, partly because I was very busy complying with what I thought my supervisor wanted from me. However, the supervision as a

whole was not helpful due to the fact that the approval seeking I was manifesting was not confronted and explored."

Students also found it useful when supervisors focused on students' feelings toward their patients and the resultant therapy errors.

"Most of all in my supervision I learned how my own affective response to the patient is to be used therapeutically."

"All the problems I had (my own feelings, patient's dependence on me, my inability to make contact with the patient) did not begin to be resolved until I began working with the helpful supervisor. At that point the therapy began to move, primarily because supervision enabled me to understand my responses to the patient and use them."

"The style of this supervision was to elicit a great amount of data regarding my personal feelings toward my client and my life in general."

Thus, students found it helpful to discuss their anxieties with their supervisors and they also valued a focus on their feelings and thoughts vis-a-vis their patients.

The Setting scales. In addition to the influences of the elements which are parts of the student-supervisor dyad, elements outside the supervisory dyad also influenced students' perceptions of the helpfulness of supervision. These included the setting and working alliance elements. Of the Setting scales, the Training Scale and the Esprit-de-corps Scale added significantly to the discriminant. From students' perspectives it was important that their roles in the clinical settings be clearly outlined, that expectations of them were set forth, and that there was a sense of esprit-de-corps among the staff. One student commented:

> "The expectation of supervisor and program and mine, as well, was that I would adopt the analytic approach in my therapy rather than utilize other techniques. Although at times I found these assumptions difficult to accept, I was willing to do this for the internship year and indeed found it a valuable experience although at times frustrating. My understanding of process was greatly increased as a result of this experience (which included process notes and examination of detailed process of the hour). At times I found the supervisor rigid, but by the end of the year I had learned a great deal and our relationship had become much more relaxed and I felt more respect and acceptance from him."

And another student commented on the lack of integration of their training program with the other clinical services.

> "The setting where I worked was a VA hospital which was fully functional without trainees. And the trainees had a poorly defined role."

The Working Alliance scales. Three of the five Working Alliance scales contributed significantly to the discrimination between the helpful and unhelpful supervision experiences. These included: 1) the Student's Acceptance of Patient Scale; 2) the Patient's Motivation Scale; and 3) the Student's Competence Scale. Thus, from the students' perspectives the quality of the working alliances they developed with their patients influenced their evaluations of their supervision experiences.

Students included fewer comments about their patients than they did about the other elements affecting their supervision experiences and no student stated that the relationship developed between him/herself and the patient affected the supervision relationship. However, from the following comments one can see the supervision's influence on the treatment of the patient.

The first comment expresses the student's ability to accept the patient:

> "As described above, the patient was very difficult to work with in the first few months and my supervisor helped me tolerate my anger, frustration and dislike. At the current time I am still working with the patient and she is a delightful young woman who has benefitted a great deal from the therapy and whom I like a great deal and vice versa, a big change from the initial stages. My supervisor was largely responsible for helping me to stay with the patient through the initial difficult phase of treatment."

Students also wrote about the impact their supervision had on their abilities to help their patients.

> "This patient made two suicide attempts while I was seeing him and supervision was only minimally helpful to me in foreseeing them, managing the aftermath or in getting me to understand the patient's behavior and my reaction to it. At times I had to resort to a second supervisor for management advice on this case."

> "All the problems I had (my own feelings, patient's dependence on me, my inability to make contact with the patient, etc.) did not begin to be resolved until I began working with the helpful supervisor. At that point the therapy began to move, primarily because supervision enabled me to understand my responses to the patient and use them."

Thus, though the working alliances developed between student and patient were found to influence students' evaluations of the helpfulness of their supervision experiences, they made no comments directly to this effect.

Students also made no comment about their patients' motivation for treatment, though the Patient's Motivation Scale contributed significantly to the discriminant function. Patients associated with helpful supervision experiences were seen as more aware that they had problems,

more motivated for help and more able to develop a collaborative relationship with their student-therapists than were the patients associated with the unhelpful supervision experiences.

The remaining seven scales which included one Learning Alliance scale, two Topics in Supervision scales, two Setting scales, and two Working Alliance scales, did not significantly contribute to the differentiation between the helpful and unhelpful supervision experiences. This might be explained by the moderately high correlations between some of these remaining seven scales and those which did contribute significantly to the discriminant. Scales which contribute significantly to a discriminant function can, in their contribution, account for the variance of others which do not. This can occur when scales are moderately to highly correlated. This could have been the case for five of the seven remaining scales (see Appendices H, I, J and K).

In sum, the results of the discriminant analysis supported the hypothesis put forth in this study. Some dimensions of each of the four elements did indeed influence students' evaluations of their supervision experiences. That is, 10 of the 17 factor scales derived in the factor analysis and representing each of the four elements were combined mathematically so that the helpful and unhelpful supervision experiences were made as statistically distinct as possible. It is noteworthy that the discriminant function achieved a high degree of differentiation between the helpful and unhelpful experiences. Thus, in thinking about supervision experiences from the viewpoint of the student, one has to take into account the several elements that have been identified in this study: 1) the learning alliance; 2) topics discussed in supervision; 3) the

setting; and 4) the working alliance.

CHAPTER IV

DISCUSSION

This study examined psychotherapy supervision from students' perspectives. Data were gathered from student-therapists participating in a variety of programs in Massachusetts and Connecticut. The results, analyzed primarily by t-tests, chi-square, factor analysis, and discriminant analysis, supported the original hypothesis that some aspects of each of four elements would influence students' evaluations of their supervision experiences: 1) the learning alliance; 2) the topics discussed in supervision; 3) the setting; and 4) the working alliance. These findings indicate that at least from the students' point of view, these four elements should be considered when attempting to understand the reported helpfulness of supervision.

The learning alliance. The primary importance of the development of the learning alliance in psychotherapy supervision was clearly supported by the results of this study. This results corresponds with the previous theory and research of Berger and Freebury (1973); Bury, Labrie, and Pomerleau (1973); Chessick (1971); Ekstein and Wallerstein (1972); Fleming and Benedek (1966); Greben, Markson and Sadavoy (1973); Mueller and Kell (1972); Muslin et al. (1967); Marshall and Confer (1980); and Hester et al. (1976). The nature of the working agreements (contracts) and several dimensions of the learning alliance including the Student's Regard for Supervisor Scale, the Supervisor's Behavior Scale, and the

Supervisor's Directiveness Scale, influenced students' evaluations of their supervision experiences. Though students and supervisors sometimes disagree about what is helpful in supervision (Worthington and Roehlke, 1980), both supervisors (Berger and Freebury, 1973; Bury, Labrie, and Pomerleau, 1973; Chessick, 1971; Ekstein and Wallerstein, 1972; Fleming and Benedek, 1966; Greben, Markson and Sadavoy, 1973; Mueller and Kell, 1972; Muslin et al., 1967), and students (based on the results of this study) believed that the development of a learning alliance was the cornerstone of helpful supervision.

Contracting. This study supported the idea suggested by Langs (1979), Greben, Markson and Sadavoy (1973), and Wolberg (1967), that contracting is an important aspect in the development of the learning alliance. In particular, the way students and supervisors were matched, the amount of student input into the contract, and the nature of the contract, made a significant difference in how students eventually evaluated their supervision experiences.

The findings suggested that helpful supervision was encouraged if students and supervisors requested to work with each other. Although the majority of the students and supervisors in the study were randomly assigned to one another, helpful supervision experiences had a significantly greater percentage of requested assignments. The high frequency of random assignments may be accounted for by the time constraints on training programs which assign supervisor to students before students begin their placements, in order to ensure the smooth running treatment facilities. Hester et al. (1976) feel that the element of choice is important to the student-supervisor relationship because it increases the

probability of successful supervision. In addition, Langs (1979) has written that random matching increases the risk of antagonism and anxiety-provoking interactions between student and supervisor.

The nature of the contract between student and supervisor was also indicative of a helpful supervision experience. Contracting generally hinged on the student, a phenomenon addressed by Greenberg (1980), who suggests that students see their skills in a broader perspective than their supervisors, and therefore feel responsible for determining their needs. Also, supervisors are usually unfamiliar with a student's entire clinical experience and, therefore, may not be completely informed as to the student needs.

Helpful contracts in this study were reported to be more explicit than unhelpful contracts. This supports Greenberg (1980) who states that a totally explicit contract is an ideal which is seldom attained. An explicit contract makes the expectations of both student and supervisor clear and provides a framework for the completion of those aims. Hence, roles are less likely to be vague. To this point Langs (1979) has commented that students will ". . .function best when participants' roles are clearly defined and ground rules are well established" (p. 15).

Helpful contracts were reported to have contained approximately 50% student input, a significantly greater student input than in the unhelpful supervision experiences. As suggested by Greenberg (1980), the importance of a balanced contribution from both the student and the supervisor might be attributed to: 1) students probably learn more by being open and willing to learn from a supervisor's area of expertise; and 2)

students can relate their previous experiences to the present supervision and are conscious of what helps them to learn effectively.

In sum, contracting hinged on students; and students were more satisfied with contracts which were explicit and based on equal input. It appears that contracting created a framework for helpful supervision experiences. It is possible that without an explicit contract there could be confusion as to what is expected; students and supervisors might be more likely, without such a contract, to be working at cross purposes based on false assumptions of what the other person wants or can benefit from. In this vein Langs (1979) concludes: "I think it is evident that the manner in which the supervisory situation is structured significantly influences the supervisory technique and the supervisory experience for both participants" (p. 15).

Learning alliance scales. Several qualities of the learning alliance were found to be crucial to students' evaluations of their supervision experiences. These included: 1) the students' positive regard for their supervisors; 2) the supervisors' active caring for their students; and 3) the supervisors' directive role in the supervision.

The supervision relationship is a special and often intense relationship involving many of the students' fears and anxieties. Specifically, students often feel threatened because they are supposed to reveal their weaknesses to a person who will ultimately evaluate them and their work. Furthermore, students are required to establish an open relationship with an authority figure who may be critical of them and whose evaluation may determine the course of their professional careers (Greenberg, 1980). Given this context for supervision, it is natural

that students' regard for their supervisors and the degree of mutuality in their relationships with them were of primary importance.

The results of this study confirmed the necessity of establishing the emotional climate described by Wolberg (1967) where the student feels respect and trust for his supervisor and an ability to discuss emotional subjects. The sense of mutuality described by Bury, Labrie and Pomerleau (1973) and Wolberg (1967) was also key to the students' developing a sense that they could work effectively with their supervisors. Thus, from the students' perspective supervision was not a one-sided process in which the supervisor took responsibility for the work. In their view, it required a joint effort by student and supervisor for the potential benefits to be realized.

In addition to respecting, trusting and liking the student, students found it helpful if their supervisors actively cared for them. Students described their helpful supervisors as supportive, a quality both Searles (1962) and Langs (1979) have emphasized as important. In line with Wolberg's (1967) views students perceived their helpful supervisors as being interested in their feelings, welcoming different opinions, and praising them when achieving important gains. Helpful supervisors were also viewed as being neither irritable nor punitive, characteristics which Searles (1962), Greben, Markson and Sadavoy (1973), and Barnat (1973) have suggested hinder the learning alliance. Otto Will's (1962) summation of some of the important supervisor qualities seems to reflect students' views:

> Growth and wisdom is encouraged by the teacher who feels affection for his students, has a desire to reveal to them that

> which he genuinely values and also finds pleasures in their discovery of values and purposes which may differ from his (p. 85).

Within this atmosphere of mutual respect, caring and trust, supervisors were seen as helpful if they took an active, directive, and decisive stance in the supervision and accepted the student's dependency needs. Supervision experiences were seen as less helpful if supervisors adopted a laissez-faire attitude, allowing the supervision to flounder within direction. These findings are in accordance with supervisor attitudes which Wolberg (1967) has described as helpful in the development of the learning alliance.

Three studies of psychotherapy supervision relationships have found that student-therapists valued supervisor qualities similar to those identified as important in this study. Worthington and Roehlke (1980) in a study of thirty-one beginning counseling students found that student satisfaction with their supervision was predicted by two criteria: 1) a good relationship with the supervisor; and 2) direct help with learning counseling skills. They found that students wanted supervisor relationships that were "somewhat structured, pleasant, personal and informative" (p. 71). In another study Balsam and Garber (1970) investigated the supervision of forty-five residents in training at Yale. They found two factors important in the supervisor's personal style with his student: being warm and being active in the supervision.

In another study of Yale psychiatry residents, Nash (1975) found that students tended to evaluate the quality of their supervision on the basis of their relationships with their supervisors. She concluded that,

although students and supervisors see themselves as sophisticated and trained professionals engaged in a professional task, what determines the helpfulness of the relationship as perceived by the student is primarily the quality of that relationship.

The topics discussed in supervision. The topics discussed in supervision make up the second element of the student-supervisor relationship. Two of the four scales derived in the factor analysis, the Process Scale and the Student Focus Scale, contributed to the differentiation between the helpful and unhelpful supervision. Though process and student-focused issues were not discussed frequently, that they were discussed when necessary distinguished the helpful and unhelpful supervision experiences. The importance of these two scales might be accounted for by the fact that the students studied were primarily an experienced group and, therefore, might have been less concerned with didactic issues which are often seen as more important to beginning students (Nash, 1975; Worthington and Roehlke, 1980; Fleming and Benedek, 1966).

Theoreticians and researchers have tended to hold that either a process orientation or a didactic orientation to supervision was superior (Mueller and Kell, 1972; Tarachow, 1963; Wagner, 1957; Ekstein and Wallerstein, 1972). The results of this study challenged the validity of this controversy so widely discussed in the literature. The findings suggested it may be more useful to conceive of helpful supervision as a combination of these approaches, as Fleming and Benedek (1966) and Nash (1975) described. It seems likely that didactic and process-oriented issues should be discussed according to the needs of

the student; neither should claim an exclusive focus.

The setting. The importance and impact of the clinical training setting has been for the most part ignored in its effects on the supervision relationship. This study found that training settings which had clearly defined expectations for students and incorporated both a unified treatment and training philosophy, and an esprit-de-corps, more often lent themselves to helpful supervision experiences. Though supervision is often discussed in the literature as if it occurs in a vacuum (Balsam and Garber, 1970), this study found that the setting has an impact on students' evaluations of their supervision experiences. Administrators have been described as largely controlling the quality of training settings (Ekstein and Wallerstein, 1972; Moldawsky, 1980; Langs, 1979). And indeed, though the setting in this study was more broadly conceptualized to include aspects beyond the administration, the two scales which provided discriminatory power were determined, to a greater degree, by the administrator of the setting, than were the two setting scales which did not contribute significantly to the discriminant. One could reasonably speculate that there is less administrative influence on the overall quality of treatment or an accepting atmosphere, than on the structure of the training program or esprit-de-corps within a setting. Thus, students seemed to be influenced more by the administrative atmosphere of their settings than by other dimensions.

The working alliance. The results of this study suggest that the quality of the students' working alliances with their patients had a bearing on their evaluations of their supervision experiences. These findings

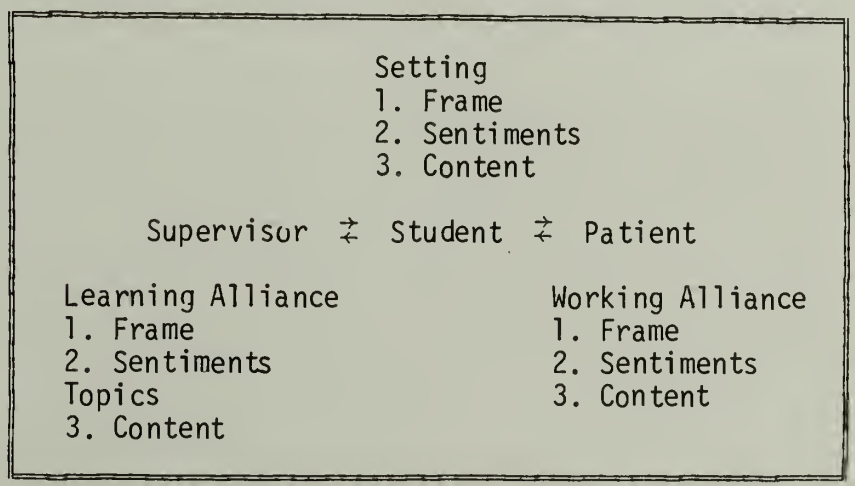
support those theorists who have suggested that the therapy relationship is reflected in the supervision relationship (Searles, 1955; Ekstein and Wallerstein, 1972; Doehrman, 1976). The effect of the working alliance on the students' evaluations of their supervision experiences remains a matter of speculation. The variables making up the Student's Acceptance of Patient Scale have their counterparts in the Learning Alliance scales. Student-therapists reported being able to create relationships in which their patients regarded them as they regarded their helpful supervisors. Students also accepted, trusted, and respected their patients while also developing collaborative relationships with them. As suggested by Greben, Markson and Sadavoy (1973), it is possible supervisors modelled these behaviors, helping students maintain a similar stance in the therapy.

These findings also supported the notion that the supervisory relationship is reflected in the student-patient relationship, indicating one possible reason why the relationship between student and supervisor is so crucial. Lanning (1971) has found that trainees expect to achieve a relationship with their clients similar to the one they establish with their supervisors:

> Practicum supervisors might also be aware of the impact that their behavior with the trainee is likely to have on the behavior of the trainee with his clients. Supervisors might focus more on the working relationship they establish with their trainees and in that way foster better working relationships between trainee and client (p. 405).

Essential threads in psychotherapy supervision. The results of this study suggest that psychotherapy supervision cannot be understood by

studying isolated aspects of the supervision relationship. Indeed, the results suggest that it is important to consider psychotherapy supervision in terms of the four elements identified in this study and found to influence students' evaluations of psychotherapy supervision. A close examination of these elements reveals that they have several common threads or dimensions. These include: 1) the frame, which is the structure of each element (this is a term used by Langs (1979) in reference to ground rules established in psychotherapy and supervision); 2) the sentiments, which are the feelings characterizing each element; and 3) the content, which represents the issues focused on within each element. The four elements and their common dimensions have been diagrammed below. The learning alliance and topics in supervision, two aspects of the student-supervisor dyad, have been combined and between them they possess the three common dimensions described.



The results of this study have led the investigator to speculate that for psychotherapy supervision to be helpful, at least from the student's perspective, these threads need to be present throughout the context of

psychotherapy supervision experiences.

Frame. The three elements--the learning alliance, setting, and working alliance--were described by students as having clear frames in helpful supervision experiences. Helpful supervision experiences were characterized by more explicit contracts than those in unhelpful supervision experiences. Settings which had clearly outlined the expectations of the students, and which had established clear rules and regulations in the training programs, were also rated as more helpful by student-therapists. Finally, the results pointed to some greater clarity in the psychotherapy relationships associated with the helpful supervision relationships. Students and patients significantly more often discussed the objectives of the treatment in helpful than in unhelpful supervision experiences. Explicit roles and expectations in each of these three elements provide clear and secure frames for the work to be carried out. For instance, students know what their programs expect of them and what they can expect from their training programs. Students and supervisors agree on explicit expectations of their supervision work, and similarly, therapists establish and maintain clear and secure boundaries with their patients in psychotherapy. Langs (1979) has written at length about the importance of the frame to the psychotherapy relationship, and he has also emphasized this, though to a lesser extent, in the supervision relationship. When problems arise in any of these three contexts, they can be thought about and worked through within their respective frames. Supervision experiences are characterized to greater and lesser degrees by structure in each of these elements. Establishing a clear framework for a training program,

a supervision relationship, and a therapy relationship requires care and effort, implying a commitment on the parts of those involved. This commitment is necessary for the effective carrying out of the clinical work. Two practical suggestions emerge from this study with regard to these structural dimensions. Students and supervisors could be encouraged to formulate explicit contracts and administrators might be encouraged to make training program expectations as clear as possible.

Sentiments. It is suggested that established frames may pave the way for the second common thread to emerge, the presence of certain sentiments within the elements. These include mutual feelings of positive regard in both the therapy and supervision relationships and a sense of esprit-de-corps among the setting staff. The presence of these feelings as they were described by students in the learning alliance was the primary determinant in the discrimination between helpful from unhelpful supervision experiences. These sentiments included "liking," "caring for," "respecting," and "trusting" the supervisor. In addition, there was a sense of mutuality developed between student and supervisor which might in part have emerged from the contracting and the supervisor's commitment to the work. Similarly, the therapy relationships associated with helpful supervision were described by students as characterized by sentiments similar to those which student-therapists held for their supervisors. Patients were described as "liking," "respecting," and "trusting" the student-therapists. Although the Student's Regard for Patient scale did not contribute significantly to the discriminant, it also reflected feelings of regard. These feelings, as they exist on the parts of the student, supervisor, and patient are essential to the work-

ing alliance and the learning alliance which, in turn, form the bases for the therapy and the supervision. For these reasons the emergence of these feelings is crucial. It is suggested here that the frame is the first essential ingredient, and that it is within the secure frames that the sentiments can develop. This process is also suggested when one considers the setting. That is to say, a clear structure may promote a caring and supportive atmosphere and a sense of esprit-de-corps within a staff. The setting element and the learning alliance element may interact on this dimension. For example, the staff might model respect and caring for one another which might facilitate the development of these sentiments within the supervision. This study points to two suggestions for clinical training. First, administrators might consider the importance of a staff which is unified in both treatment and training philosophies, for it seems that this determines in large part a feeling of esprit-de-corps among the staff. Second, because students' regard for their supervisors appears to be so crucial, perhaps when possible students and supervisors could be given the opportunity to request to work with each other.

Content. Content issues on the whole were minimally explored in this study and perhaps no conclusions along these lines should be made. Within the student-supervisor dyad content issues were studied through the topics in supervision; however, the content in the working alliance and setting elements were not studied. With regard to the topics discussed in supervision, the results of this study suggest that the traditional controversy of didactic content vs. process-oriented content is not a useful way of viewing what is most productive in supervision.

Helpful supervisors were seen as using a combination of approaches. Further, it seems that the issues dealt with in the supervision were less important to students than their feelings about their supervisors. The content of the working alliance refers to the sorts of issues discussed in the psychotherapy. This study did not address this aspect of the treatment. However, one might think of patient diagnosis at the beginning of the treatment as being "content" in the sense that the patient presented certain kinds of problems in the therapy. To the extent that these reflect content of the student-patient dyad, there were no significant differences between the problems presented in the helpful and unhelpful supervision experiences. How the content thread might be expressed in the setting is not possible to determine at this time. In line with the above, one might find that what is important to students is not the particular expectations that their training programs hold for them, but rather that the program holds expectations for them at all.

The results of this study suggest that it is crucial to consider psychotherapy supervision within the context of the four elements identified in this study. Further, it is suggested that these elements share some common threads, dimensions or characteristics which may be necessary to helpful supervision--at least from the students' perspective.

Limitations of this study and future research. A major limitation of this study is the problem of definition of positive outcome or positive process of psychotherapy supervision. This study focused on the student's view of that outcome; that is, the measure was the experience of

the student. It is difficult to know where to look for a validating measure. One could look at the outcome of the therapy, which would presumably reflect the quality of the supervision, or, assuming that helpful supervision improves a student's performance, one could measure the student's performance at some later date. However, this would be a major undertaking for a small gain. First, the student's work would have to be measured and then a follow-up measure would be necessary. The research would require outside raters and the reliability of their judgments would need to be established.

A second limitation involved the distribution of questionnaires: They were completed by student-therapists who were located within a limited geographical region and who were participating in traditional programs. Of all the programs contacted in this study, approximately 72.0% were primarily psychoanalytically oriented.

Third, the students' responses to the questionnaire were based on their own memories of those experiences which may be subject to distortion by the passage of time--a helpful supervision experience may come to seem exaggeratedly positive in recollection. Students' memories for the fine details may not be as accurate as they might have been had the questions been answered shortly after each supervision experience. In addition, the direction of causality is impossible to determine. Students' ratings of their supervision experiences were undoubtedly influenced by dimensions other than the qualities of the four elements studied. For example, a student may have felt that the outcome of the therapy was positive and this view may have influenced the student to rate his helpful experience more positively in comparison to his un-

helpful experience.

Future research. It would be valuable to investigate the same elements explored in this study from the supervisor's perspective. Areas of differences could be identified; furthermore, the reasons for their different emphases could be explored. Mutuality in purpose is important to learning; if students' and supervisors' views of supervision could be reconciled, training programs based on the overall needs and wants of both parties could be evolved.

Second, using the derived factor scale, students from less traditional training programs could be studied to test for the generalizability of these results.

Finally, one could study supervision experiences in light of their common threads, the frame, sentiments and content, to see if this is a meaningful way of conceptualizing the supervision experiences of students.

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APPENDIX A

Dear--Director of Training--:

I am writing to you about my dissertation project because I would like to ask the psychiatry residents/psychology interns at the--Program--to participate in my study.

I am a graduate student in clinical psychology at the University of Massachusetts/Amherst. A large part of my training has occurred in psychotherapy supervision. Having had many very different supervision experiences, I developed an interest in what makes psychotherapy supervision helpful. My dissertation project has evolved from this interest.

My research focuses on some determinants of helpful supervision experiences. In particular I am interested in the impact of three factors on supervision. These include the learning alliance formed between student and supervisor, the method of the supervision, e.g., didactic or process oriented, and the organizational structure of the clinical setting where the training took place. I am also interested in the nature of the working alliance developed between the student-therapist and the patient. I would like to find out more about how these factors affect students' perceptions of psychotherapy supervision. To do this I have developed a self-report questionnaire to be completed by student therapists.

I will call in a few days to ask you about soliciting the participation of the psychiatry residents/psychology interns at the--Program--. I would also like to make an appointment to speak with you. At that time I will be glad to answer any questions you may have.

Thank you for your time.

Sincerely,

Sally Kinder, M.S.
Box 327
Stockbridge, MA 01262

APPENDIX B

Dear Colleague:

I am seeking your help with my dissertation research project which is in partial fulfillment of the requirements for my degree in clinical psychology at the University of Massachusetts/Amherst. Your experience as a student-therapist in individual psychotherapy supervision is the subject of my study. From your and other student-therapists' experiences, I will identify and analyze helpful aspects of individual psychotherapy supervision.

My research focuses on some determinants of helpful supervision experiences. In particular I am interested in the impact of three factors on supervision: the learning alliance formed between student and supervisor, the topics discussed in supervision sessions, and the organizational structure of the clinical setting where the training took place. I will also be studying the nature of the working alliance developed between the student-therapist and the patient.

Enclosed is a self-report questionnaire which I developed to study the above aspects of supervision. It is lengthy but can be filled out rather quickly. Pilot samples have averaged one hour. If you have completed at least two individual supervision experiences with two different supervisors, you qualify to be a respondent for this study. Upon receipt of your completed questionnaire, I will send you $5.00 in appreciation for your time.

All data will be treated as completely confidential. After I have received your questionnaire and paid you, your name will not be associated with your responses.

If you choose to participate in this study, please read the instructions carefully, sign the consent form, and return the questionnaire to me in the addressed postage paid envelope provided. Also, be sure to include your return address so that I can send you $5.00. If you choose not to participate in this study, kindly return the blank questionnaire to me. If you have any questions, please feel free to call me collect at 413-298-3580.

Thank you for your help.

Sincerely,

Sally Kinder, M.S.
Box 327
Stockbridge, MA 01262

APPENDIX C

A STUDY OF PSYCHOTHERAPY SUPERVISION

INSTRUCTIONS

PURPOSE OF THE STUDY. This questionnaire is part of a study of supervision experiences of therapists in training. The results will be used to systematically identify helpful aspects of supervision and point the way toward improved training based on your experience.

PROCEDURE. This study will ask you about your experience as a supervisee in both helpful and unhelpful individual psychotherapy supervisions. Please select a very helpful and an unhelpful, or less helpful, supervision experience which you have completed with two different supervisors. "Completed" supervision experiences refer to supervision experiences with supervisors with whom you are no longer working. After filling in the General Information section (page 1), rate your helpful supervision in Part A. Then the same questions will be repeated for you to rate your unhelpful supervision in Part B. In each case consider your supervision in terms of the treatment of one specific patient whom you presented to your supervisor at least during the initial phase of treatment. "Initial phase" refers to approximately the first third of the treatment, or one to three months.

CONTENT OF THE QUESTIONNAIRE. The questionnaire asks about the learning alliance developed between you and your supervisor, the topics discussed in your supervision sessions, the organizational structure of the setting where you were working when your supervision took place, as well as the working alliance you developed with your patient.

PERSONAL INFORMATION. All information will be treated as completely confidential. This questionnaire is expected to take about one hour of your time. Upon receipt of your questionnaire, I will give or send you $5.00 in appreciation for your time. After I have received your questionnaire and paid you, your name will not be associated with your responses.

INFORMED CONSENT

I understand the purpose of this study is to investigate students' views of what contributes to making supervision experiences helpful. I agree to complete the questionnaire about two supervision experiences I have had--one which was helpful and one which was not helpful. I understand that I may decline to answer any question and that I can withdraw

at any point I wish. I understand that everything I say will be kept completely confidential.

I agree to participate in this study.

_____ _____

Name Date

If you would like to receive a report of the results of the study, please check here._____

Thank you very much for your help.

For purposes of payment only:

Name_____

Address_____

_____

DO NOT WRITE IN THIS SPACE

Card #1

GENERAL INFORMATION

1. Age (current)_____ 3,4,5_____

2. Sex_____ 8, 9_____

3. Discipline Psychology_____ 10_____
Medicine_____
Social work_____
Other (specify)_____ 11_____

4. What is your most advanced degree?

B.S._____
M.S._____
Ph.D._____
M.D._____
Other (specify)_____ 12_____

5. What is the total amount of time you have spent in prior clinical experience? (months)
_____ 13,14_____

6. How many supervisors have you worked with?
_____ 15_____

7. What is your theoretical orientation?

Psychoanalytic_____
Behavioral_____
Eclectic_____
Client centered_____
Rational emotive_____
Family and systems_____
Other (specify)_____ 16_____

8. What are your future career plans?

Psychotherapy_____
Teaching_____
Research_____
Some combination of the above (specify)_____
Other (specify)_____ 17_____

DO NOT WRITE IN THIS SPACE

9. Are you currently, or have you ever been in your own personal psychotherapy? Yes_____ No_____ If so, please give the dates.

_____ 18_____

19,20_____

21_____ X___

PART A HELPFUL

SUPERVISION EXPERIENCE

(Remember to select a helpful supervision experience which you have completed, i.e. a supervision experience with a supervisor with whom you are no longer working.)

10. When did this supervision experience take place? Give dates. _____/_____ to _____/_____
mo yr mo yr

22,23_____

11. How old was your supervisor at the time of this supervision?_____ 24,25_____

12. Sex of supervisor_____ 26_____

13. Approximately how many years of supervisory experience had your supervisor had at the time of this supervision?_____ 27,28_____

14. How many years of clinical experience had you had before this supervision?_____ 29_____

15. How many supervisors had you worked with at the time of this supervision?_____ 30_____

16. How were you and your supervisor matched?

a. By your request_____
b. By his/her request_____
c. By mutual request_____
d. By random assignment_____
e. Other (specify)_____ 31_____

DO NOT WRITE IN THIS SPACE

17. How long did you work with this supervisor?
Months_____ 32,33_____

34_____X_____

THE NEXT SET OF QUESTIONS REFER TO THE INITIAL PHASE OF YOUR SUPERVISION. "INITIAL PHASE" REFERS TO APPROXIMATELY THE FIRST THIRD OF YOUR SUPERVISION, OR ONE TO THREE MONTHS.

18. Did you and your supervisor discuss each other's personal and professional backgrounds --e.g. academic experience, clinical experience, theoretical orientation, research, family background, extracurricular interests?

a. Discussed personal backgrounds_____
b. Discussed professional backgrounds _____
c. Discussed both a. and b._____
d. Discussed neither a. nor b._____ 35_____

19. What was your supervisor's theoretical orientation?

a. Psychoanalytic_____
b. Behavioral_____
c. Eclectic_____
d. Client-centered_____
e. Rational emotive_____
f. Family and systems_____
g. Other (specify)_____ 36_____

20. Did your supervisor have an established or preferred way of doing supervision?

Yes_____ No_____ 37_____

If so, how satisfied were you with his/her method? (Please place check in appropriate space.)

_____/_____/_____/_____/_____/_____
Very satisfied Not at all satisfied 38_____

DO NOT WRITE IN THIS SPACE

21. Did you and your supervisor discuss each other's expectations of supervision?

a. Discussed supervisor's expectations _____
b. Discussed your expectations _____
c. Discussed both a. and b. _____
d. Discussed neither a. nor b. _____ 39 _____

22. When you first began work with your supervisor did you and your supervisor formulate an explicit contract or agreement as to how you would work together?

Yes _____ No _____ 40 _____

If so, what did this agreement include?

	Yes	No	
a. Arrangement of meeting hours for supervision			41 _____
b. Methods of recording your therapy sessions			42 _____
c. Methods of presentation to your supervisor			43 _____
d. Goals of treatment for your patient			44 _____
e. How emergencies were to be handled			45 _____
f. Goals of your supervision			46 _____

23. If you answered "Yes" to #22, what percent of your working agreement was based on <u>your</u> input? <u>Circle one</u>.

0% 25% 50% 75% 100% 47 _____

24. Rate your overall satisfaction with your working agreement. (<u>WHETHER EXPLICIT OR NOT</u>) (Place check in appropriate space.)

_____/_____/_____/_____/_____/_____
Very satisfied Not at all satisfied 48 _____

DO NOT WRITE IN THIS SPACE

25. Rate your satisfaction with the following aspects of your work.
In filling in the rating scales please place a check in the appropriate space.

EXAMPLE

/ / / ✓ / / /
Very often ——— Never

a. The frequency of your supervision meetings.

/ / / / / /
Not at all satisfied ——— Very satisfied

49 _____

b. The method of recording your therapy sessions.

/ / / / / /
Very satisfied ——— Not at all satisfied

50 _____

c. The method of presentation to your supervisor.

/ / / / / /
Not at all satisfied ——— Very satisfied

51 _____

d. The goals of your supervision.

/ / / / / /
Very satisfied ——— Not at all satisfied

52 _____

e. The goals of your patient's treatment.

/ / / / / /
Not at all satisfied ——— Very satisfied

53 _____

f. The therapeutic orientation of treatment.

/ / / / / /
Very satisfied ——— Not at all satisfied

54 _____

55 X

RATE THE FOLLOWING DESCRIPTIVE CHARACTERISTICS AS THEY APPY TO THIS SUPERVISOR IN THE INITIAL PHASE OF THIS SUPERVISION, I.E. WITHIN APPROXIMATELY THE FIRST 1/3 OF YOUR SUPERVISION OR 1-3 MONTHS.

DO NOT WRITE IN THIS SPACE

26. Your supervisor took an active role in directing your learning.

Not at all / / / / / / Very often

56_____

27. Your supervisor was decisive.

Very decisive / / / / / / Not at all decisive

57_____

28. Your supervisor was interested in your patient's change.

Not at all interested / / / / / / Very interested

58_____

29. Your supervisor praised you when you made an important gain.

Very often / / / / / / Not at all

59_____

30. Your supervisor accepted your dependence on him/her.

Not at all / / / / / / Very much

60_____

31. Your supervisor was protective of you.

Very much / / / / / / Not at all

61_____

32. Your supervisor was receptive to your differences with him/her.

Not at all / / / / / / Very much

62_____

33. Your supervisor respected you.

Very much / / / / / / Not at all

63_____

DO NOT WRITE IN THIS SPACE

34. Your supervisor trusted your judgement.

/ / / / / /
Not at all — Very much

64 _____

35. Your supervisor was supportive of you.

/ / / / / /
Very supportive — Not at all supportive

65 _____

36. Your supervisor was irritable or punitive toward you.

/ / / / / /
Not at all — Very often

66 _____

37. Your supervisor expressed an interest in your feelings.

/ / / / / /
Very often — Not at all

67 _____

38. Your supervisor was empathic with you.

/ / / / / /
Not at all empathic — Very empathic

68 _____

39. Your supervisor was available to you for extra time if you needed it.

/ / / / / /
Very available — Not at all available

69 _____

70 X _____

PLEASE RATE THESE STATEMENTS AS DESCRIPTIVE STATEMENTS OF YOURSELF IN THE INITIAL PHASE OF THIS SUPERVISION RELATIONSHIP, I.E. WITHIN APPROXIMATELY THE FIRST 1/3 OF YOUR SUPERVISION, OR 1-3 MONTHS.

Card 2

40. You were willing to try new approaches to treatment.

/ / / / / /
Not at all willing — Very willing

8 _____

DO NOT WRITE IN THIS SPACE

41. You felt free to experiment with new ideas.

Very often / / / / / / Not at all 9_____

42. You were willing to examine your weaknesses with your supervisor.

Not at all willing / / / / / / Very willing 10_____

43. You respected your supervisor.

Very much / / / / / / Not at all 11_____

44. You trusted your supervisor's judgement.

Not at all / / / / / / Very much 12_____

45. You felt free to discuss emotional subjects with your supervisor.

Very much Not at all 13_____

46. You were anxious in supervision.

Not at all / / / / / / Very much 14_____

47. You liked your supervisor.

Very much / / / / / / Not at all 15_____

48. You discovered how you could best learn from your supervisor.

Not at all true / / / / / / Very true 16_____

DO NOT WRITE IN THIS SPACE

49. You identified with your supervisor.

/ / / / / /
Very much Not at all 17_____

50. You and your supervisor established clear communication, e.g. clear language that both of you could understand.

/ / / / / /
Not at all Very much 18_____

51. You and your supervisor together assumed responsibility for your learning.

/ / / / / /
Very true Not at all true 19_____

52. Your supervisor liked you.

/ / / / / /
Not at all Very much 20_____

53. You and your supervisor had disagreements.

/ / / / / /
Very often Not at all 21_____

54. Did you end this supervision prematurely?

Yes_____ No_____ 22_____

If so, briefly describe the circumstances.

_____

_____ 23_____

55. Was your supervisor supervised on his work with you?

Yes_____ No_____ Don't know_____ 24_____

INDICATE THE FREQUENCY WITH WHICH EACH OF THE FOLLOWING TOPICS WAS A SUBJECT IN THE SUPERVISION EXPERIENCE YOU ARE DESCRIBING. USE THE FOLLOWING SCALE, AND CIRCLE THE APPROPRIATE NUMBER. 25_____X_____

DO NOT WRITE IN THIS SPACE

1--never discussed
2--rarely discussed
3--occasionally discussed, but not a primary focus of supervision
4--frequently discussed
5--a major focus of supervision

56. What your supervisor would have done in the therapeutic situation you described, e.g. what your supervisor would have said.

1 2 3 4 5 26_____

57. The practical aspects of your patient's management, e.g. medications, crisis management

1 2 3 4 5 27_____

58. Your supervisor's view of what your patient's problems were

1 2 3 4 5 28_____

59. The patient's behavior

1 2 3 4 5 29_____

60. Your supervisor's formulation of the patient's dynamics

1 2 3 4 5 30_____

61. The patient's therapeutic needs

1 2 3 4 5 31_____

62. Your feelings about the patient

1 2 3 4 5 32_____

63. Your errors in relating to the patient

1 2 3 4 5 33_____

64. Self awareness issues

1 2 3 4 5 34_____

DO NOT WRITE IN THIS SPACE

65. Your difficulties in learning from your supervisor

1 2 3 4 5 35_____

66. Your problems in acquiring therapeutic skills

1 2 3 4 5 36_____

67. Your personal problems not related to your work

1 2 3 4 5 37_____

68. Authority issues with your supervisor

1 2 3 4 5 38_____

69. Your relationship with your supervisor

1 2 3 4 5 39_____

THE NEXT GROUP OF QUESTIONS PERTAINS TO THE TRAINING SETTING IN WHICH YOU DID THIS CLINICAL WORK. BY TRAINING SETTING I AM REFERRING TO THE ORGANIZATIONAL STRUCTURE, RULES AND REGULATIONS, ATTITUDES AND ATMOSPHERE OF THE SETTING. 40 X

70. In what kind of setting were you working when this supervision took place?

Hospital in-patient_____
Hospital out-patient_____
Community mental health center_____
Student mental health center_____
Other (specify)_____ 41_____

RATE THE FOLLOWING STATEMENTS AS TO HOW WELL THEY DESCRIBE THE TRAINING SETTING

71. There were rules which guided the clinical training program, e.g. explicit guidelines as to what should be taught, how students and supervisors were to be matched, etc.

_____/_____/_____/_____/_____/_____
Very true Not at all true 42_____

DO NOT WRITE IN THIS SPACE

72. The goals of your training program were clear.

Not at all clear / / / / / / Very clear

43_____

73. The number of cases students were to carry was clear.

Very clear / / / / / / Not at all clear

44_____

74. The rules of patient assignment were clear.

Not at all clear / / / / / / Very clear

45_____

75. The length of time student and supervisor worked together was clear.

Very clear / / / / / / Not at all clear

46_____

76. The process of student evaluations was clear.

Not at all clear / / / / / / Very clear

47_____

77. The rules for transfer to another supervisor were clear.

Very clear / / / / / / Not at all clear

48_____

78. The training program was integrated with the rest of the clinical services the setting offered.

Not at all integrated / / / / / / Very integrated

49_____

DO NOT WRITE IN THIS SPACE

79. Regulations were applied flexibly.

Very flexibly / / / / / / Not at all flexibly

50_____

80. The setting's organizational structure was stable.

Not at all stable / / / / / / Very stable

51_____

81. There were rules which safeguarded the treatment process, e.g. confidentiality.

Very true / / / / / / Not at all true

52_____

82. Arrangements for handling patient crises were clear.

Not at all clear / / / / / / Very clear

53_____

83. Patients receive good treatment at the training setting.

Very often / / / / / / Never

54_____

84. Your setting had an organized system of record keeping.

Not at all organized / / / / / / Very organized

55_____

85. A seminar was provided for supervisors in which supervisory techniques were discussed.

Yes_____ No_____ Don't know_____

56_____

DO NOT WRITE IN THIS SPACE

86. Communication was open among staff in your setting.

/ / / / / /
Very open — Not at all open

57_____

87. The staff had frequent social contacts outside the training setting.

/ / / / / /
Not at all true — Very true

58_____

88. There was a unifying treatment philosophy among the staff.

/ / / / / /
Very true — Not at all true

59_____

89. The staff shared a training philosophy.

/ / / / / /
Not at all true — Very true

60_____

90. The atmosphere was one of sharing.

/ / / / / /
Very sharing — Not at all sharing

61_____

91. The staff was supportive of its students.

/ / / / / /
Not at all supportive — Very supportive

62_____

92. Supervisors were generally available to student therapists.

/ / / / / /
Very available — Not at all available

63_____

DO NOT WRITE IN THIS SPACE

93. Defensiveness characterized your setting.

____/____/____/____/____/____/____
Not at all Very much

64_____

94. Supervisors were critical of students.

____/____/____/____/____/____/____
Very much Not at all

65_____

95. How many supervision hours were provided for each therapy hour?_____

66_____

THE FOLLOWING SET OF STATEMENTS REFER TO THE INITIAL PHASE (I.E. APPROXIMATELY THE FIRST 1/3 OF THE THERAPY, OR 1-3 MONTHS) OF YOUR WORK WITH THE PATIENT YOU WERE PRESENTING IN SUPERVISION.

Card 3

96. Patient's sex_____

8_____

97. Patient's age at the time of treatment_____

9,10_____

98. Patient's diagnosis at the beginning of treatment_____

11_____

99. How many months did you work with this patient?_____

12,13_____

100. Your patient was aware that he had an emotional problem.

____/____/____/____/____/____/____
Not at all aware Very aware

14_____

101. Your patient was motivated for help.

____/____/____/____/____/____/____
Very motivated Not at all motivated

15_____

102. You discussed with your patient how emergencies were to be handled.

Yes_____ No_____

16_____

DO NOT WRITE IN THIS SPACE

103. The objectives of the therapy were initially defined by:

a. You_____
b. The patient_____
c. Both a. and b._____
d. Neither a. nor b._____ 17_____

104. You and your patient discussed the approximate length of the therapy.

Yes_____ No_____ 18_____

105. You felt confident the goals of treatment could be attained.

_____/_____/_____/_____/_____/_____
Not at all confident — Very confident 19_____

106. Your patient felt the goals of treatment could be attained.

_____/_____/_____/_____/_____/_____
Very true — Not at all true 20_____

107. You accepted your patient's legitimate need to be dependent on you.

_____/_____/_____/_____/_____/_____
Not at all — Very much 21_____

108. You were understanding with your patient.

_____/_____/_____/_____/_____/_____
Very much — Not at all 22_____

109. You were accepting of your patient.

_____/_____/_____/_____/_____/_____
Not at all — Very much 23_____

110. You were able to withstand your patient's expressions of painful feelings.

_____/_____/_____/_____/_____/_____
Very much — Not at all 24_____

DO NOT WRITE IN THIS SPACE

111. Your patient at least partially identified with you.

Not at all / / / / / / Very true 25_____

112. You dealt with your patient's resistances to the development of your working relationship, e.g. irrational expectations, sexual desires, intense hostility, etc.

Very much / / / / / / Not at all 26_____

113. You understood your patient's feelings toward you.

Not at all / / / / / / Very much 27_____

114. You were aware of your feelings toward your patient.

Very aware / / / / / / Not at all aware 28_____

115. You were able to manage or work out your feelings toward your patient.

Not at all / / / / / / Very much 29_____

116. You had warm feelings toward your patient.

Very much / / / / / / Not at all 30_____

117. You respected your patient.

Not at all / / / / / / Very much 31_____

118. You liked your patient.

Very much / / / / / / Not at all 32_____

DO NOT WRITE IN THIS SPACE

119. You empathized with your patient.

Not at all / / / / / / Very much

33_____

120. You were interested in your patient.

Very much / / / / / / Not at all

34_____

121. Your patient respected you.

Not at all / / / / / / Very much

35_____

122. Your patient seemed to like you.

Very much / / / / / / Not at all

36_____

123. Your patient trusted you.

Not at all / / / / / / Very much

37_____

124. The therapeutic relationship was free of anxiety.

Very true / / / / / / Not at all true

38_____

125. There was a feeling of hope and expectation in the therapy.

a. On your part_____
b. On your patient's part_____
c. On both yours and your patient's parts _____
d. There was not a feeling of hope and expectation in the therapy._____

39_____

126. You developed a collaborative relationship with your patient.

Not at all / / / / / / Very much

40_____

DO NOT WRITE IN THIS SPACE

127. You were able to make genuine contact with your patient.

Very much / / / / / / Not at all

41_____

128. Your patient responded well in your relationship.

Not at all well / / / / / / Very well

42_____

129. You felt able to help your patient.

Very much / / / / / / Not at all

43_____

130. Your patient wanted to master his problems.

Not at all / / / / / / Very much

44_____

131. Did your work with this patient end prematurely?

Yes_____ No_____

45_____

If so, briefly describe the circumstances.

_____

_____

46_____

132. Are there other important aspects of your supervision experience not touched on by this questionnaire which you would like to comment on?

_____

47_____

_____

_____

_____

_____

DO NOT WRITE IN THIS SPACE

GO ON TO PART B

PART B UNHELPFUL

SUPERVISION RELATIONSHIP

(Remember to select an unhelpful supervision experience which you have completed, i.e. a supervision experience with a supervisor with whom you are no longer working.)

Card 4

133. When did this supervision experience take place? Give dates. ____/____ to ____/____
mo yr mo yr

10,11_____

DO NOT WRITE IN THIS SPACE

134. How old was your supervisor at the time of this supervision?_____ 12,13_____

135. Sex of supervisor_____ 14_____

136. Approximately how many years of supervisory experience had your supervisor had at the time of this supervision?_____ 15,16_____

137. How many years of clinical experience had you had before this supervision?_____ 17_____

138. How many supervisors had you worked with at the time of this supervision?_____ 18_____

139. How were you and your supervisor matched?

a. By your request_____
b. By his/her request_____
c. By mutual request_____
d. By random assignment_____
e. Other (specify)_____ 19_____

140. How long did you work with this supervisor? Months_____ 20,21_____

THE NEXT SET OF QUESTIONS REFER TO THE INITIAL PHASE OF YOUR SUPERVISION. "INITIAL PHASE" REFERS TO APPROXIMATELY THE FIRST THIRD OF YOUR SUPERVISION, OR ONE TO THREE MONTHS. 22 X

141. Did you and your supervisor discuss each other's personal and professional backgrounds--e.g. academic experience, clinical experience, theoretical orientation, research, family background, extracurricular interests?

a. Discussed personal backgrounds_____
b. Discussed professional backgrounds _____
c. Discussed both a. and b._____
d. Discussed neither a. nor b._____ 23_____

DO NOT WRITE IN THIS SPACE

142. What was your supervisor's theoretical orientation?

a. Psychoanalytic_____
b. Behavioral_____
c. Eclectic_____
d. Client-centered_____
e. Rational emotive_____
f. Family and systems_____
g. Other (specify)_____ 24_____

143. Did your supervisor have an established or preferred way of doing supervision?

Yes_____ No_____ 25_____

If so, how satisfied were you with his/her method? (Please place check in appropriate space.)

_____/_____/_____/_____/_____/_____
Very satisfied Not at all satisfied 26_____

144. Did you and your supervisor discuss each other's expectations of supervision?

a. Discussed supervisor's expectations _____
b. Discussed your expectations_____
c. Discussed both a. and b._____
d. Discussed neither a. nor b._____ 27_____

145. When you first began work with this supervisor did you and your supervisor formulate an explicit contract or agreement as to how you would work together?

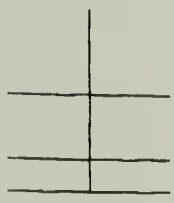
Yes_____ No_____ 28_____

If so, what did this agreement include?

	Yes	No	
a. Arrangement of meeting hours for supervision			29_____
b. Methods of recording your therapy sessions			30_____
c. Methods of presentation to your supervisor			31_____

DO NOT WRITE IN THIS SPACE

d. Goals of treatment for your patient — 32
e. How emergencies were to be handled — 33
f. Goals of your supervision — 34



146. If you answered "Yes" to #145, what percent of your working agreement was based on your input? Circle one.

0% 25% 50% 75% 100% — 35

147. Rate your overall satisfaction with your working agreement. (WHETHER EXPLICIT OR NOT) (Place check in appropriate space.)

/ / / / / /
Very satisfied — Not at all satisfied — 36

148. Rate your satisfaction with the following aspects of your work.
In filling in the rating sacles please place a check in the appropriate space.
EXAMPLE
/ / ✓ / / / /
Very often — Never

a. The frequency of your supervision meetings.
/ / / / / / .
Not at all satisfied — Very satisfied — 37

b. The method of recording your therapy sessions.
/ / / / / /
Very satisfied — Not at all satisfied — 38

c. The method of presentation to your supervisor.
/ / / / / /
Not at all satisfied — Very satisfied — 39

DO NOT WRITE IN THIS SPACE

d. The goals of your supervision.

Very satisfied / / / / / / Not at all satisfied

40 _____

e. The goals of your patient's treatment.

Not at all satisfied / / / / / / Very satisfied

41 _____

f. The therapeutic orientation of treatment.

Very satisfied / / / / / / Not at all satisfied

42 _____

RATE THE FOLLOWING DESCRIPTIVE CHARACTERISTICS AS THEY APPLY TO THIS SUPERVISOR IN THE INITIAL PHASE OF THIS SUPERVISION, I.E. WITHIN APPROXIMATELY THE FIRST 1/3 OF YOUR SUPERVISION, OR 1-3 MONTHS.

43 X

149. Your supervisor took an active role in directing your learning.

Not at all / / / / / / Very often

44 _____

150. Your supervisor was decisive.

Very decisive / / / / / / Not at all decisive

45 _____

151. Your supervisor was interested in your patient's change.

Not at all interested / / / / / / Very interested

46 _____

152. Your supervisor praised you when you made an important gain.

Very often / / / / / / Not at all

47 _____

DO NOT WRITE IN THIS SPACE

153. Your supervisor accepted your dependence in him/her.

Not at all / / / / / / Very much

48 _____

154. Your supervisor was protective of you.

Very much / / / / / / Not at all

49 _____

155. Your supervisor was receptive to your differences with him/her.

Not at all / / / / / / Very much

50 _____

156. Your supervisor respected you.

Very much / / / / / / Not at all

51 _____

157. Your supervisor trusted your judgement.

Not at all / / / / / / Very much

52 _____

158. Your supervisor was supportive of you.

Very supportive / / / / / / Not at all supportive

53 _____

159. Your supervisor was irritable or punitive toward you.

Not at all / / / / / / Very often

54 _____

160. Your supervisor expressed an interest in your feelings.

Very often / / / / / / Not at all

55 _____

DO NOT WRITE IN THIS SPACE

161. Your supervisor was empathic with you.

Not at all empathic / / / / / / Very empathic

56 _____

162. Your supervisor was available to you for extra time if you needed it.

Very available / / / / / / Not at all available

57 _____

PLEASE RATE THESE STATEMENTS AS DESCRIPTIVE STATEMENTS OF YOURSELF IN THE INITIAL PHASE OF THIS SUPERVISION RELATIONSHIP, I.E. WITHIN APPROXIMATELY THE FIRST 1/3 OF YOUR SUPERVISION, OR 1-3 MONTHS.

58 X

Card 5

163. You were willing to try new approaches to treatment.

Not at all willing / / / / / / Very willing

20 _____

164. You felt free to experiment with new ideas.

Very often / / / / / / Not at all

21 _____

165. You were willing to examine your weaknesses with your supervisor.

Not at all willing / / / / / / Very willing

22 _____

166. You respected your supervisor.

Very much / / / / / / Not at all

23 _____

167. You trusted your supervisor's judgement.

Not at all / / / / / / Very much

24 _____

DO NOT WRITE IN THIS SPACE

168. You felt free to discuss emotional subjects with your supervisor.

/ / / / / /
Very much — Not at all 25_____

169. You were anxious in supervision.

/ / / / / /
Not at all — Very much 26_____

170. You liked your supervisor.

/ / / / / /
Very much — Not at all 27_____

171. You discovered how you could best learn from your supervisor.

/ / / / / /
Not at all true — Very true 28_____

172. You identified with your supervisor.

/ / / / / /
Very much — Not at all 29_____

173. You and your supervisor established clear communication, e.g. clear language that both of you could understand.

/ / / / / /
Not at all — Very much 30_____

174. You and your supervisor together assumed responsibility for your learning.

/ / / / / /
Very true — Not at all true 31_____

175. Your supervisor liked you.

/ / / / / /
Not at all — Very much 32_____

DO NOT WRITE IN THIS SPACE

176. You and your supervisor had disagreements.

____/____/____/____/____/____/____

Very often Not at all

33_____

177. Did you end this supervision prematurely?

Yes_____ No_____

34_____

If so, briefly describe the circumstances.

_____

_____

35_____

178. Was your supervisor supervised on his work with you?

Yes_____ No_____ Don't know_____

36_____

INDICATE THE FREQUENCY WITH WHICH EACH OF THE FOLLOWING TOPICS WAS A SUBJECT IN THE SUPERVISION EXPERIENCE YOU ARE DESCRIBING. USE THE FOLLOWING SCALE AND CIRCLE THE APPROPRIATE NUMBER.

37____X_____

1--never discussed
2--rarely discussed
3--occasionally discussed, but not a primary focus of supervision
4--frequently discussed
5--a major focus of supervision

179. What you supervisor would have done in the therapeutic situation you described, e.g. what your supervisor would have said.

1 2 3 4 5

38_____

180. The practical aspects of your patient's management, e.g. medications, crisis management

1 2 3 4 5

39_____

181. Your supervisor's view of what your patient's problems were

1 2 3 4 5

40_____

DO NOT WRITE IN THIS SPACE

182. The patient's behavior

1 2 3 4 5 41_____

183. Your supervisor's formulation of the patient's dynamics

1 2 3 4 5 42_____

184. The patient's therapeutic needs

1 2 3 4 5 43_____

185. Your feelings about the patient

1 2 3 4 5 44_____

186. Your errors in relating to the patient

1 2 3 4 5 45_____

187. Self awareness issues

1 2 3 4 5 46_____

188. Your difficulties in learning from your supervisor

1 2 3 4 5 47_____

189. Your problems in acquiring therapeutic skills

1 2 3 4 5 48_____

190. Your personal problems not related to your work

1 2 3 4 5 49_____

191. Authority issues with your supervisor

1 2 3 4 5 50_____

192. Your relationship with your supervisor

1 2 3 4 5 51_____

DO NOT WRITE IN THIS SPACE

THE NEXT GROUP OF QUESTIONS PERTAINS TO THE TRAINING SETTING IN WHICH YOU DID THIS CLINICAL WORK. BY TRAINING SETTING I AM REFERRING TO THE ORGANIZATIONAL STRUCTURE, RULES AND REGULATIONS, ATTITUDES AND ATMOSPHERE OF THE SETTING. IF YOU RECEIVED THIS CLINICAL TRAINING IN THE SAME SETTING AS THE ONE YOU DESCRIBED IN PART A, DO NOT FILL IN THIS SECTION AGAIN. GO ON TO PAGE , QUESTION #219.

52 X

193. In what kind of setting were you working when this supervision took place?

Hospital in-patient_____
Hospital out-patient_____
Community mental health center_____
Student mental health center_____
Other (specify)_____

53_____

RATE THE FOLLOWING STATEMENTS AS TO HOW WELL THEY DESCRIBE THE TRAINING SETTING

194. There were rules which guided the clinical training program, e.g. explicit guidelines as to what should be taught, how students and supervisors were to be matched, etc.

_____/_____/_____/_____/_____/_____
Very true Not at all true

54_____

195. The goals of your training program were clear.

_____/_____/_____/_____/_____/_____
Not at all clear Very clear

55_____

196. The number of cases students were to carry was clear.

_____/_____/_____/_____/_____/_____
Very clear Not at all clear

56_____

197. The rules of patient assignment were clear.

_____/_____/_____/_____/_____/_____
Not at all clear Very clear

57_____

DO NOT WRITE IN THIS SPACE

198. The length of time student and supervisor worked together was clear.

/ / / / / /
Very clear — Not at all clear

58_____

199. The process of student evaluations was clear.

/ / / / / /
Not at all clear — Very clear

59_____

200. The rules for transfer to another supervisor were clear.

/ / / / / /
Very clear — Not at all clear

60_____

201. The training program was integrated with the rest of the clinical services the setting offered.

/ / / / / /
Not at all integrated — Very integrated

61_____

202. Regulations were applied flexibly.

/ / / / / /
Very flexibly — Not at all flexibly

62_____

203. The setting's organizational structure was stable.

/ / / / / /
Not at all stable — Very stable

63_____

204. There were rules which safeguarded the treatment process, e.g. confidentiality.

/ / / / / /
Very true — Not at all true

64_____

DO NOT WRITE IN THIS SPACE

205. Arrangements for handling patient crises were clear.

Not at all clear / / / / / / Very clear

65_____

206. Patients receive good treatment at the training setting.

Very often / / / / / / Never

66_____

67 X

207. Your setting had an organized system of record keeping.

Not at all organized / / / / / / Very organized

Card 6

8_____

208. A seminar was provided for supervisors in which supervisory techniques were discussed.

Yes_____ No_____ Don't know_____

9_____

209. Communication was open among staff in your setting.

Very open / / / / / / Not at all open

10_____

210. The staff had frequent social contacts outside the training setting.

Not at all true / / / / / / Very true

11_____

211. There was a unifying treatment philosophy among the staff.

Very true / / / / / / Not at all true

12_____

DO NOT WRITE IN THIS SPACE

212. The staff shared a training philosophy.

Not at all true / / / / / / Very true

13_____

213. The atmosphere was one of sharing.

Very sharing / / / / / / Not at all sharing

14_____

214. The staff was supportive of its students.

Not at all supportive / / / / / / Very supportive

15_____

215. Supervisors were generally available to student therapists.

Very available / / / / / / Not at all available

16_____

216. Defensiveness characterized your training setting.

Not at all / / / / / / Very much

17_____

217. Supervisors were critical of students.

Very much / / / / / / Not at all

18_____

218. How many supervision hours were provided for each therapy hour?_____

19_____

THE FOLLOWING SET OF STATEMENTS REFER TO THE INITIAL PHASE (I.E. APPROXIMATELY THE FIRST 1/3 OF THE THERAPY, OR 1-3 MONTHS) OF YOUR WORK WITH THE PATIENT YOU WERE PRESENTING IN SUPERVISION.

219. Patient's sex_____

20_____

220. Patient's age at the time of treatment_____

21_____

DO NOT WRITE IN THIS SPACE

221. Patient's diagnosis at the beginning of treatment_____ 23_____

222. How many months did you work with this patient?_____ 24,25_____

223. Your patient was aware that he had an emotional problem.

_____/_____/_____/_____/_____/_____
Not at all aware — Very aware

26_____

224. Your patient was motivated for help.

_____/_____/_____/_____/_____/_____
Very motivated — Not at all motivated

27_____

225. You discussed with your patient how emergencies were to be handled.

Yes_____ No_____ 28_____

226. The objectives of the therapy were initially defined by:

a. You_____
b. The patient_____
c. Both a. and b._____
d. Neither a. nor b._____ 29_____

227. You and your patient discussed the approximate length of the therapy.

Yes_____ No_____ 30_____

228. You felt confident the goals of treatment could be attained.

_____/_____/_____/_____/_____/_____
Not at all confident — Very confident

31_____

DO NOT WRITE IN THIS SPACE

229. Your patient felt the goals of treatment could be attained.

Very true / / / / / / Not at all true

32_____

230. You accepted your patient's legitimate need to be dependent on you.

Not at all / / / / / / Very much

33_____

231. You were understanding with your patient.

Very much / / / / / / Not at all

34_____

232. You were accepting of your patient.

Not at all / / / / / / Very much

35_____

233. You were able to withstand your patient's expressions of painful feelings.

Very much / / / / / / Not at all

36_____

234. Your patient at least partially identified with you.

Not at all / / / / / / Very much

37_____

235. You dealt with your patient's resistances to the development of your working relationship, e.g. irrational expectations, sexual desires, intense hostility, etc.

Very much / / / / / / Not at all

38_____

236. You understood your patient's feelings toward you.

Not at all / / / / / / Very much

39_____

DO NOT WRITE IN THIS SPACE

237. You were aware of your feelings toward your patient.

Very aware / / / / / / Not at all aware

40_____

238. You were able to manage or work out your feelings toward your patient.

Not at all / / / / / / Very much

41_____

239. You had warm feelings toward your patient.

Very much / / / / / / Not at all

42_____

240. You respected your patient.

Not at all / / / / / / Very much

43_____

241. You liked your patient.

Very much / / / / / / Not at all

44_____

242. You empathized with your patient.

Not at all / / / / / / Very much

45_____

243. You were interested in your patient.

Very much / / / / / / Not at all

46_____

244. Your patient respected you.

Not at all / / / / / / Very much

47_____

245. Your patient seemed to like you.

Very much / / / / / / Not at all

48_____

DO NOT WRITE IN THIS SPACE

246. Your patient trusted you.

Not at all / / / / / / Very much

49_____

247. The therapeutic relationship was free of anxiety.

Very true / / / / / / Not at all true

50_____

248. There was a feeling of hope and expectation in the therapy.

a. On your part_____
b. On your patient's part_____
c. On both yours and your patient's parts _____
d. There was not a feeling of hope and expectation in the therapy_____

51_____

249. You developed a collaborative relationship with your patient.

Not at all / / / / / / Very much

52_____

250. You were able to make genuine contact with your patient.

Very much / / / / / / Not at all

53_____

251. Your patient responded well in your relationship.

Not at all / / / / / / Very well

54_____

252. You felt able to help your patient.

Very much / / / / / / Not at all

55_____

DO NOT WRITE IN THIS SPACE

253. Your patient wanted to master his problems.

_____/_____/_____/_____/_____/_____

Not at all Very much

56_____

254. Did your work with this patient end prematurely?

Yes_____ No_____

57_____

If so, briefly describe the circumstances.

_____

_____

58_____

255. Are there other important aspects of your supervision experience not touched on by this questionnaire which you would like to comment on?

_____

59_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DO NOT WRITE
IN THIS SPACE

Thank you very much, and good luck
in your clinical training!

Sally Kinder
Box 327
Stockbridge
MA 01262

APPENDIX D

Table 11

Table of Means, Standard Deviations and t-values

of Helpful and Unhelpful Supervision Experiences

Variable		Helpful	Not Helpful	t	2-Tail Probability	N
Months ago supervision began	M	23.08	24.96	-1.43	.156	134
	SD	13.14	13.91			
Supervisor age	M	41.75	41.03	.62	.534	132
	SD	9.53	9.21			
Supervisor's previous years of supervisory experience	M	11.27	9.33	1.88	.063	118
	SD	7.95	7.55			
Student previous years of clinical experience	M	3.01	2.91	.86	.390	134
	SD	1.70	1.83			
Number of previous supervisors	M	5.13	4.80	1.35	.179	133
	SD	2.66	2.77			
Months student worked with supervisor	M	10.31	7.88	4.49	.001	133
	SD	5.13	4.41			
Student satisfaction with supervisor's method	M	5.95	2.72	18.53	.001	96
	SD	1.06	1.46			
Percent of student input to agreement	M	2.71	2.40	2.31	.024	76
	SD	.96	1.06			
Student overall satisfaction with agreement	M	5.93	3.24	17.36	.001	127
	SD	.97	1.54			
Student satisfaction with frequency of supervision meetings	M	6.04	5.13	5.06	.001	134
	SD	1.28	1.78			

Table 11 (continued)

Variable		Helpful	Not Helpful	t	2-Tail Probability	N
Student satisfaction with method of recording therapy	M SD	5.55 1.41	4.65 1.70	5.43	.001	134
Student satisfaction with method of presentation to supervisor	M SD	5.69 1.17	4.13 1.68	9.52	.001	134
Student satisfaction with goals of supervision	M SD	5.74 1.33	3.04 1.54	14.46	.001	133
Student satisfaction with goals of patient's therapy	M SD	5.55 1.43	3.84 1.72	9.32	.001	134
Student satisfaction with therapy orientation	M SD	5.87 1.33	4.11 1.71	10.77	.001	133
Supervisor was active in directing student learning	M SD	5.16 1.44	3.86 1.97	6.00	.001	134
Supervisor was decisive	M SD	4.77 1.47	4.12 1.99	2.87	.005	134
Supervisor was interested in patient change	M SD	5.90 1.22	4.55 1.66	7.51	.001	134
Supervisor praised student for important gain	M SD	5.58 1.45	3.97 1.69	8.39	.001	134
Supervisor accepted student dependence	M SD	5.06 1.42	3.69 1.70	6.96	.001	131
Supervisor was protective of student	M SD	4.37 1.56	3.24 1.67	5.96	.001	131
Supervisor was receptive to student differences with supervisor	M SD	5.47 1.26	3.24 1.61	12.93	.001	133

Table 11 (continued)

		Helpful	Not Helpful	t	2-Tail Probability	N
Supervisor respected student	M	6.13	4.34	11.40	.001	134
	SD	1.05	1.58			
Supervisor trusted student judgment	M	5.78	4.25	9.83	.001	133
	SD	1.23	1.54			
Supervisor was supportive of student	M	6.13	3.77	14.15	.001	134
	SD	1.06	1.60			
Supervisor was irritable or punitive toward student	M	6.54	4.75	11.69	.001	134
	SD	.78	1.76			
Supervisor expressed interest in student feelings	M	5.75	3.91	9.95	.001	134
	SD	1.38	1.75			
Supervisor was empathic with student	M	5.58	3.45	11.20	.001	134
	SD	1.56	1.48			
Supervisor was available to student for more time	M	5.12	3.69	7.00	.001	131
	SD	1.65	2.00			
Student was willing to try new approaches	M	5.81	5.22	4.33	.001	134
	SD	1.13	1.47			
Student felt free to experiment with ideas	M	5.41	4.32	6.29	.001	134
	SD	1.33	1.78			
Student was willing to examine student weaknesses with supervisor	M	5.76	4.35	8.22	.001	134
	SD	1.14	1.73			
Student respected supervisor	M	6.43	3.81	17.17	.001	134
	SD	.87	1.59			
Student trusted supervisor judgment	M	6.12	3.97	12.18	.001	134
	SD	1.19	1.64			
Student felt free to discuss emotional subjects in supervision	M	5.34	2.96	12.25	.001	134
	SD	1.57	1.72			

Table 11 (continued)

		Helpful	Not Helpful	t	2-Tail Probability	N
Student was anxious in supervision	M	4.27	3.41	4.37	.001	134
	SD	1.63	1.75			
Student liked supervisor	M	6.12	3.56	14.94	.001	134
	SD	1.02	1.67			
Student discovered how best to learn from supervisor	M	5.71	3.31	15.15	.001	133
	SD	1.38	1.57			
Student identified with supervisor	M	5.02	2.59	14.44	.001	133
	SD	1.38	1.57			
Student and supervisor established communication	M	6.04	3.91	13.78	.001	134
	SD	.95	1.62			
Student and supervisor responsible for student learning	M	5.49	3.34	13.89	.001	134
	SD	1.41	1.40			
Supervisor liked student	M	5.79	4.38	9.68	.001	133
	SD	1.07	1.44			
Student and supervisor had disagreements	M	4.78	4.22	3.60	.001	134
	SD	1.33	1.62			
What supervisor would have done	M	3.40	3.40	.06	.949	134
	SD	.80	1.09			
Practical aspects of patient management	M	3.19	3.10	.74	.459	134
	SD	1.02	1.07			
Supervisor view of patient problems	M	3.91	3.73	1.58	.117	133
	SD	.73	1.02			
Patient's behavior	M	4.08	3.87	2.43	.017	134
	SD	.76	.89			
Supervisor's formulation of patient dynamics	M	3.73	3.31	3.25	.001	133
	SD	.90	1.24			
Patient's therapeutic needs	M	4.18	3.40	8.25	.001	134
	SD	.77	.82			

Table 11 (continued)

		Helpful	Not Helpful	t	2-Tail Probability	N
Student's feelings about patients	M	3.63	2.92	6.48	.001	134
	SD	.96	1.06			
Student errors in relating to patient	M	3.22	3.05	1.55	.124	134
	SD	.84	1.07			
Self-awareness issues	M	3.17	2.44	5.26	.001	128
	SD	1.10	1.16			
Difficulties in learning	M	1.86	1.87	-.28	.776	134
	SD	.86	.99			
Problems in acquiring therapeutic skills	M	2.44	2.23	2.10	.037	133
	SD	.96	1.01			
Student personal problems not related to work	M	1.75	1.52	2.21	.029	134
	SD	.88	.88			
Authority issues with supervisor	M	1.61	1.68	-.64	.525	134
	SD	.83	.99			
Student relationship with supervisor	M	2.26	1.87	3.53	.001	134
	SD	.95	1.05			
Rules and guidelines for training	M	3.97	3.86	.69	.491	133
	SD	1.95	1.97			
Goals of training program clear	M	4.46	4.02	2.95	.004	134
	SD	1.74	1.82			
Number of cases student to carry clear	M	5.12	4.85	1.66	.100	133
	SD	1.93	2.09			
Rules of patient assignment clear	M	4.75	4.46	1.63	.106	134
	SD	2.01	2.00			
Length of time student and supervisor work clear	M	6.18	6.04	1.17	.243	134
	SD	1.41	1.54			
Process of student evaluations clear	M	4.68	4.02	3.88	.001	132
	SD	1.93	2.08			

Table 11 (continued)

		Helpful	Not Helpful	t	2-Tail Probability	N
Rules for transfer to another supervisor clear	M	3.79	3.47	1.68	.096	131
	SD	2.16	2.21			
Training program integrated with clinical services	M	5.68	5.22	3.31	.001	132
	SD	1.63	1.81			
Regulations were applied flexibly	M	4.95	4.72	1.74	.084	134
	SD	1.35	1.52			
Setting structure was stable	M	5.04	4.75	2.33	.021	134
	SD	1.77	1.85			
Rules safeguarded treatment	M	6.29	5.92	3.39	.001	134
	SD	1.02	1.37			
How handle patient crises clear	M	4.90	4.52	2.73	.007	134
	SD	1.60	1.84			
Patients receive good treatment at setting	M	5.91	5.38	4.53	.001	133
	SD	1.01	1.37			
Organized system of record keeping	M	5.65	5.46	1.51	.134	134
	SD	1.43	1.62			
Communication open among staff	M	4.81	4.25	4.25	.001	134
	SD	1.48	1.68			
Staff had frequent social contacts	M	3.99	3.76	1.77	.080	132
	SD	1.70	1.67			
Staff had a unifying treatment philosophy	M	3.64	3.52	.81	.419	132
	SD	1.93	1.94			
Staff shared a training philosophy	M	4.23	3.90	2.25	.026	132
	SD	1.70	1.72			
Atmosphere was one of sharing	M	4.47	3.83	4.92	.001	133
	SD	1.41	1.61			
Staff was supportive of students	M	5.27	4.66	4.88	.001	134
	SD	1.39	1.61			
Supervisors were available to students	M	5.79	5.20	4.99	.001	134
	SD	1.15	1.50			

Table 11 (continued)

		Helpful	Not Helpful	t	2-Tail Probability	N
Defensiveness characterized setting	M	4.61	4.01	4.02	.001	134
	SD	1.46	1.72			
Supervisors were critical of students	M	5.03	4.53	4.80	.001	134
	SD	1.18	1.39			
Patient's age	M	24.08	25.28	-1.07	.288	133
	SD	9.87	10.88			
Months worked with patient	M	11.51	8.50	4.75	.001	134
	SD	7.93	6.34			
Patient aware he had an emotional problem	M	5.75	4.95	4.64	.001	133
	SD	1.48	1.65			
Patient was motivated for help	M	5.26	4.45	4.65	.001	133
	SD	1.42	1.59			
Student confident goals of therapy attainable	M	4.25	3.78	2.58	.011	134
	SD	1.59	1.46			
Patient felt goals of therapy attainable	M	3.89	3.68	1.38	.171	130
	SD	1.47	1.41			
Student accepted patient need to be dependent	M	5.58	5.34	2.31	.022	130
	SD	1.15	1.18			
Student was understanding with patient	M	6.02	5.57	4.68	.001	134
	SD	.87	1.10			
Student was accepting of patient	M	5.90	5.50	2.91	.004	134
	SD	1.19	1.24			
Student withstood patient's painful feelings	M	5.94	5.66	2.59	.011	134
	SD	1.13	1.13			
Patient at least partially identified with student	M	5.34	4.70	3.99	.001	130
	SD	1.32	1.51			

Table 11 (continued)

		Helpful	Not Helpful	t	2-Tail Probability	N
Student dealt with patient resistance to working alliance	M SD	5.34 1.39	4.72 1.61	4.10	.001	131
Student understood patient feelings toward patient	M SD	5.22 1.18	4.65 1.42	4.03	.001	133
Student could manage own feelings toward patient	M SD	5.63 1.02	5.08 1.35	4.46	.001	131
Student had warm feelings toward patient	M SD	5.62 1.19	5.14 1.28	3.46	.001	134
Student respected patient	M SD	5.67 1.19	5.06 1.24	4.80	.001	134
Student liked patient	M SD	5.63 1.32	5.00 1.40	3.94	.001	134
Student empathized with patient	M SD	5.76 1.03	5.20 1.25	4.40	.001	134
Student was interested in patient	M SD	6.19 .97	5.86 1.00	3.58	.001	134
Patient respected student	M SD	5.80 1.09	5.19 1.32	4.64	.001	131
Patient seemed to like student	M SD	5.66 1.26	5.28 1.37	2.71	.008	134
Patient trusted student	M SD	5.39 1.28	4.94 1.50	2.87	.005	132
Therapy relationship was free of anxiety	M SD	4.73 1.54	4.78 1.46	-.36	.717	134
Student developed collaborative relationship with patient	M SD	5.12 1.36	4.52 1.48	3.84	.001	133
Student made genuine contact with patient	M SD	5.47 1.27	4.77 1.44	4.21	.001	134

Table 11 (continued)

		Helpful	Not Helpful	t	2-Tail Probability	N
Patient responded well in therapy relationship	M	5.38	4.58	5.03	.001	134
	SD	1.32	1.40			
Student felt able to help patient	M	5.24	4.52	4.79	.001	134
	SD	1.23	1.40			
Patient wanted to master his problems	M	5.36	4.58	4.69	.001	130
	SD	1.45	1.55			

APPENDIX E

Table 12

Table of Institutions and Number of Respondents from Each Institution

Institution	Number of Respondents
Austen Riggs Center (Postdoctoral program)	6
Beaverbrook Guidance Center (Internship program)	1
Beth Israel Hospital (Internship program)	7
Boston City Hospital (Residency program)	5
Boston City Hospital (Internship program)	3
Boston Institute of Psychotherapy (Professional School of Psychology)	4
Boston Veterans Administration Medical Center (Internship program)	6
Boston Veterans Administration Outpatient Clinic (Internship program)	3
Children's Hospital and Medical Center (Internship program)	6
Framingham Youth Guidance Clinic (Internship program)	1
Institute of Living (Internship program)	3
Judge Baker Guidance Center (Internship program)	3
Kennedy Memorial Hospital (Internship program)	5
Massachusetts Mental Health Center (Residency program)	5
Psychological Services Center (University of Massachusetts/Amherst, Graduate training program)	10
Psychological Services (Boston University internship program)	2
University Health Services (University of Massachusetts/Amherst, Internship program)	2
Veterans Administration Medical Center, Brockton, MA (Internship program)	3
Veterans Administration Medical Center, Northampton, MA (Internship program)	2
Veterans Administration Medical Center, West Haven, CT (Internship program)	3
Worcester State Hospital (Internship program)	7
Worcester Youth Guidance Center (Internship program)	4
Yale University School of Medicine (Residency program)	27
Yale University School of Medicine (Internship program)	7
Personal Contacts*	4

*These respondents completed the questionnaire independently of their association with their training program.

APPENDIX F

Table 13

Percent of Respondents Representing

Each of the Theoretical Orientations

(N = 135)

Orientation	Percent of Respondents
Psychoanalytic	31.1
Behavioral	3.0
Eclectic	60.0
Client-centered	.7
Rational-emotive	1.5
Family and Systems	1.5
Other	2.2
	100.0

APPENDIX G

Table 14

Table of Correlations of Learning Alliance Scales[1]

Scale	I	II	III	IV
I. Student's Regard for Supervisor	1.000	.784***	.371***	.448***
II. Supervisor's Behavior		1.000	.328***	.540***
III. Supervisor's Directiveness			1.000	.107*
IV. New Ideas				1.000

*p < .05

**p < .01

***p < .001

[1]The N's for these correlations ranged from N = 259 to N = 266.

APPENDIX H

Table 15

Table of Correlations of Topics in Supervision Scales[1]

Scale	I	II	III	IV
I. Process	1.000	.402***	.072	-.050
II. Student Focus		1.000	.159**	.103*
III. Supervisor's View			1.000	.271***
IV. Patient-centered				1.000

*p < .05

**p < .01

***p < .001

[1]The N's for these correlations ranged from N = 261 to N = 268.

APPENDIX I

Table 16

Table of Correlations of Setting Scales[1]

Scale	I	II	III	IV
I. Atmosphere	1.000	.393***	.481***	.431***
II. Training		1.000	.503***	.292***
III. Service			1.000	.274***
IV. Esprit-de-corps				1.000

*p < .05

**p < .01

***p < .001

[1]The N's for these correlations ranged from N = 255 to N = 267.

APPENDIX J

Table 17

Table of Correlations of Working Alliance Scales[1]

Scale	I	II	III	IV	V
I. Student's Competence	1.000	.730***	.614***	.599***	.494***
II. Patient's Motivation		1.000	.476***	.450***	.394***
III. Student's Regard for Patient			1.000	.621***	.523***
IV. Student's Acceptance of Patient				1.000	.542***
V. Transference and Countertransference					1.000

*p < .05

**p < .01

***p < .001

[1]The N's for these correlations ranged from N = 257 to N = 264.