AN INVESTIGATION OF THE RELATIONSHIP BETWEEN

SUPERVISION QUALITY, QUANTITY, AND TYPE

WITH CLIENT OUTCOMES IN THERAPY

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AN INVESTIGATION OF THE RELATIONSHIP BETWEEN SUPERVISION QUALITY, QUANTITY, AND TYPE WITH CLIENT OUTCOMES IN THERAPY

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Shockingly few studies have investigated the relationship between clinical supervision and client outcomes in therapy. This study attempted to better explain this relationship by tracking the type, amount, and quality of supervision provided and its correlation to client outcomes from a marriage and family therapy clinic. A significant, negative correlation was found between the average quality level of supervision provided on a case, and females' scores of avoidance in their romantic relationships. However, the quality of supervision was unable to predict unique variance in avoidance scores when therapeutic alliance was included in the regression. This study was distinctive in that it directly investigated the supervision-client outcome link: a longstanding recommendation in psychotherapy literature.

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INTRODUCTION

The possibilities for research topics in the field of psychotherapy are endless. Complications inevitably arise due to the practical and individualized nature of the field, but researchers strive to better understand exactly how and what makes this practice worth doing. Despite the vast array of research investigating certain themes such as common factors in therapy, treatment models, and the value of a strong therapeutic alliance (e.g. Hubble, Duncan, & Miller, 1996; Martin, Garske, & Davis, 2000; Reisner, 2005), there are still many areas in the field of psychotherapy that have been largely ignored. One such area is the specific relationship between supervision and client outcomes in therapy.

Most of the mental health professions have made supervision a featured and mandatory element of training; so much so that supervision could probably be deemed the cornerstone of preparing for a career in psychotherapy. However, the huge irony is that while supervision's importance is considered paramount, its direct effects are relatively unknown. Considering the strict requirements and minimum standards for supervision, the inadequacy of the state of the research is shocking. Furthermore, considering the stringent guidelines enforced to protect psychotherapy clients, the lack of information related to supervision's impact on client well-being (or more scary to think about: deterioration) seems unethical. For the protection of clients, miles of red tape are in place for researchers to weave through when conducting studies using human subjects,

even if the potential for harm/distress is negligible. Therefore, it is all the more interesting that research suggesting positive effects of clinical supervision on client outcomes has not been more adamantly demanded. Nonetheless, while adequate research linking clinical supervision and client outcomes is missing, each topic has been studied numerous times in isolation from one another, and valuable lessons have been learned.

Goodyear and Bernard (1998) have defined supervision, highlighting the importance of its distinction from the broader concept of clinical training. Thinking of it very generally, supervision is designed to enhance the training process of would be therapists, screening those admitted to practice psychotherapy, while simultaneously protecting the clients. Just as terminology is sometimes confused in the field of supervision (i.e. supervision versus training), research on this topic is notorious for being difficult due to methodological and practical constraints. However, several meta-analyses (Russell, Crimmings, & Lent, 1984; Ellis, Ladany, Krengel, & Schult, 1996) have outlined best practices/basic standards that should provide researchers with guidelines for conducting supervision research. Ellis et al.'s work suggests that some researchers are abiding by these suggested standards, while others seem to be ignoring them. Nonetheless, the trend in supervision research is loud and clear: there are ideals researchers should strive for, but quitting due to the impossibility of perfection is ill-advised.

Similar to that of Ellis et al., Milne and James (2000) conducted a review of recent supervision literature. However, instead of focusing on the methodology of the studies, they investigated the change process in the educational pyramid of supervision. Their results indicated that while clients appear to benefit from the process of supervision

(the authors did not elaborate beyond "beneficial effects;" p. 116), trainees and supervisors benefit to a larger degree. In other words, in their sample of the literature (N=28) supervision took place on many different levels, and while evidence supported the idea that clients may reap some gains, trainees and supervisors are more greatly benefited/show greater change by the supervisory process.

In looking at the relationship between the supervisor and supervisee, Ladany, Ellis, and Friedlander (1999) determined that this alliance does not predict a shift in the trainee's self-efficacy as originally hypothesized. Instead, they found that when the supervisory alliance is strong, trainees tend to have higher satisfaction rates with the supervision process (regardless of feelings of self-efficacy). Patton and Kivlighan (1997) also considered alliances in their research, and discovered significant relationships between trainees' perceptions of the supervisory alliance and the clients' perceptions of the therapeutic alliance. Because other research has consistently shown the value of a strong therapeutic alliance (e.g. Martin, Garske, & Davis, 2000) this study is quite noteworthy. If the therapeutic alliance is a known contributor to client outcomes, and these authors determined the supervisory alliance impacts the creation of the therapeutic alliance, then an indirect but important link between supervision and client outcomes can be inferred. A strong supervisory alliance may help promote a strong therapeutic alliance, which in turn positively affects client outcomes. In fact, a recent undertaking investigated the potential moderating effect of supervision on the alliance-client outcome link (Jindal, 2005). Though the results trended toward a possible effect suggesting such moderation, the results did not reach a level of statistical significance.

This indirect connection between supervision and client outcomes is unfortunately the only type of link present in the literature. Goodyear and Bernard (1998) have criticized the tendency for researchers to over-rely upon satisfaction scales as the outcome measure in their studies. While client satisfaction with services and the bond with their therapist is an important piece to improvement, it is not a direct, objective measure of gains—the exact piece missing from and needed in the literature. However, as previously stated it is no real surprise that such studies are lacking due to the difficulty in designing research that objectively measures both supervision and client outcomes.

Returning to the findings related to client satisfaction with psychotherapy, Kivlighan, Angelone, and Swafford (1991) investigated the differences in client satisfaction with live versus videotaped supervision. They found that clients whose therapists received live supervision rated their satisfaction with the smoothness and depth of sessions as higher, as well as considered their therapeutic alliance to be stronger, on average, as compared to clients who received videotaped supervision. In a similar study, Locke and McCollum (2001) also investigated clients' opinions regarding experiencing live supervision. They too found that clients whose therapists received live supervision generally supported and liked the practice. However, their measures were slightly different, as they were based on the clients' satisfaction with the therapy process and overall comfort of having live supervision, not satisfaction with symptom outcomes or actual symptom relief.

Harkness and Hensley (1991) conducted a study that actually used client satisfaction *and* symptom reduction as outcome measures. They explored how client-focused versus a more administrative focused supervision would impact clients. While

they did find increased client satisfaction during client-focused supervision, there were no statistically significant findings related to the symptom reduction measure. Nonetheless, their efforts are certainly worth mentioning as they were unique in their attempt to directly link supervision with client outcomes.

As can be seen in this brief review of the literature, supervision is being studied in a variety of ways, but all fail to capture a direct connection between the supervisory process and potential impact on client outcomes. Nonetheless, there are ample findings related to client outcomes other than supervision. Some would argue the most important of all are what are known as the common factors in therapy (Stein & Lambert, 1995; Hubble, Duncan, & Miller, 1996; Martin, Garske, and Davis, 2000). While there are plenty of purists claiming their way is the only effective way of conducting psychotherapy, much research has suggested that several factors that "commonly" occur in most all situations, such as extra-therapeutic change, expectancy effects, and the therapeutic relationship play a much larger role than any specific style or technique (Hubble, Duncan, & Miller, 1996). With that said, the attempt to establish a very clear connection between supervision and outcomes is further complicated as the potential for confounding factors is great. Nonetheless, pure dependence on these common factors to promote healing in clients seems irresponsible, and therefore confirms the need to continue exploring, regardless of the likely challenges.

From a plethora of studies and multiple meta-analyses, one of the aforementioned common factors, the therapeutic alliance, has been studied in great detail, and subsequently deemed a critical contributor in the therapy process (e.g. Martin, Garske, and Davis, 2000). Johnson, Wright, and Ketring (2002) investigated the therapeutic

alliance in the field of marriage and family therapy. These authors used individuals' perceptions of the family's alliance, and how this perception was related to individual outcomes as measures. These researchers determined that the alliance can predict changes in symptom distress—a direct link to client outcomes.

From symptom severity to treatment regularity, therapist experience to motivation to change, other topics that relate to client outcomes are plentiful. Similarly, there is a vast array of topics other than definitions, alliances, focus, and mode related to supervision research. However, it is not only beyond the scope of this paper, but also beyond practical limits to comment on and/or control for each piece of the puzzle that makes up the bigger picture of "client outcomes" in psychotherapy. Nonetheless, the issue remains that the literature could be scoured from psychotherapy's beginnings to the present and results would still indicate a dearth of studies directly linking supervision and client outcomes.

As Patton & Kivlighan (1997) assert, the idea that direct supervision of trainees positively affects all aspects of the therapy process is a largely unchecked assumption, but, is still used to justify the use of supervision in the first place. For instance, The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) has minimum standards for clinical supervision in all accredited MFT training programs, requiring it take place despite the lack of empirical data supporting its usefulness. Of note, however, is the fact that just this year the COAMFTE revised its standards regarding supervision requirements, going from mandatory hours and ratios for each trainee in version 10.3 to a more subjective, "evidence-based" program in version 11.0.

This shift is yet another piece of evidence suggesting the uncertainty of exactly what role supervision plays in the training of hopeful therapists.

Needless to say, the value of supervision in MFT training programs is important, although seemingly less critical according to the new standards. This shift may or may not come as good news to many MFT training programs. While some may rejoice at the less stringent need for clocking every supervision hour and tracking each method of providing supervision, others may be disappointed to hear that supervision is being somewhat marginalized, possibly due to the lack of empirical support. Many of these training programs have invested thousands of dollars into equipment aimed at enhancing the supervisory experience. From advanced computers to digital microphones, two way mirrors to in-room intercoms, the technology abounds all in hopes of supporting the most up-to-date techniques of providing therapy supervision to therapists-in-training. However, despite all of the time, money, and energy invested in setting up state of the art training facilities, as stated, there is virtually no research that points to these bells and whistles making a positive contribution to a client's outcome in therapy. It should, then, come at no real surprise that the COAMFTE decided to change the requirements—at least until more concrete evidence regarding supervision's usefulness is produced.

If this literature review were to focus solely on available research linking supervision to client outcomes it could be summed up in a single sentence: while consistently recommended as a much-needed focus of research in the future (e.g. Ellis and Ladany, 1997; Goodyear & Bernard, 1998; Stein & Lambert, 1995), no empirical data is currently available that suggests a clear link in MFT training between supervision and client outcomes in therapy. However, all is not lost. As previously mentioned, the

literature does point toward a variety of benefits supervision provides, as well as a plethora of studies examining factors related to change/outcomes in clients. Both areas will be discussed in more detail below. Nonetheless, it is crucial that the assumption that clinical supervision is holistically beneficial is not left "unchecked" any longer. One of supervision's goals is to help in the education of a therapist-in-training. But one would think that not only practically, but also ethically, research should also be considering supervision's impact on the clients these very therapists are seeing. After all, the "Do No Harm" idea is not limited to the medical field. Despite the research being conducted separately on clinical supervision and outcomes in therapy, the literature seems to be missing a significant aspect of the bigger picture. It is in this vein the proposed study finds its home.

The proposed investigation is an attempt to discover a more direct link between supervision and client outcomes. Because the therapeutic alliance-client outcome link is so well established, this study will also include the alliance in the analyses. However, the primary focus will be tracking how the quality, quantity and type of supervision impacts clients' self-reported ratings of various outcome measures. These outcomes include relationship adjustment, experiences in close relationships, and symptom distress.

Research Questions:

1.) Is there an identifiable relationship between supervision and client outcomes?

2.) Is there an independent and/or additive relationship between the supervision variables (quality, quantity, and type) and the outcome variables (RDAS, OQ, and ECR), controlling for the therapeutic alliance?

LITERATURE REVIEW

As long as students have been training to become therapists, supervision in some form or fashion has occurred alongside their didactic studies. Similar to the apprenticeship system, students can watch and learn from supervisors, starting with observation and earning progressively more independence along the way. Not unlike learning to shape metal or fix watches, a hopeful therapist is learning an art that takes much time, practice, and patience. In the end, just as the customer expects their watch to be fixed, the client also expects to leave with something better than they came with—namely improved mental health or new solutions to old problems. Unfortunately, the available literature would make for a very difficult sales pitch for any supervisor trying to convince incoming clients that their work (i.e. the supervision of therapists-in-training) will lead to better outcomes and happier lives. The available literature that is relevant to both topics of supervision and client outcomes is discussed next.

Clinical Supervision

Clinical supervision has been defined as "an intervention provided by a more senior member of a profession to a more junior member or members of that same profession" (Bernard & Goodyear, 2004, p. 8). Bernard and Goodyear expand on the definition further claiming it to be "evaluative," that it "extends over time," and has multiple purposes of "enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients…, and

serving as a gatekeeper for those who are to enter the particular profession" (p. 8; 2004). Although it has been defined, one of the first obstacles in supervision research is the clumsy use of the word.

Goodyear and Bernard (1998) criticize the tendency for researchers to interchangeably use the words training and supervision. Training is typically referred to in two ways, neither of which fit the common definition of supervision. First, training is an intervention that is more limited in scope, without client contact; and second, a global meaning referring to all of what constitutes graduate education, including curriculum courses and supervised counseling experiences. The tendency for authors to interchange these terms has caused problems for those who turn to the literature to learn about the unique effects of supervision. Supervision is but one component of training, and the words should not be used interchangeably (Goodyear & Bernard, 1998).

Ellis, Ladany, Krengel, and Schult (1996) conducted an empirical review of supervision studies to see if the quality of methodology had improved since Russell, Crimmings, and Lent's (1984) review. After reviewing 144 studies the authors determined that despite previous recommendations there was still a general lack of conceptual and methodological rigor (Ellis et al., 1996). This review used specific exclusion and inclusion criteria, sorting through a potential sum of 2017 articles, to ultimately end up with the 144 studies that were included. Most studies were ex post facto in nature, and came from one book and 130 research articles. Each study was evaluated based on a) Cook and Campbell's (1979) 49 potential threats to validity of the results, b)Russell et al.'s (1984) 12 methodological threats for supervision research, and c) eight additional variables identified from the literature. Overall, very few studies came

close to passing the majority of the analyses testing for validity; several even went in the opposite direction of the suggestions made in Russell et al.'s (1984) review. However, critics of these studies should be careful: some of these tests may not have been entirely appropriate due to the pragmatic nature of the area of supervision (in other words, some threats to validity that may have been tested—and failed—might not have been relevant). In the end the authors make several baseline suggestions for future research in the area of supervision, admitting that the pragmatic nature of the activity complicates methodology, but standing firm in their purpose to improve the quality of supervision research. Several of the suggestions include: explicate a theory, define constructs, formulate unambiguous hypotheses, assess practical threats such as statistical power and confounds, perform only statistical tests that are directly tied to a research hypothesis, and whenever possible replicate the study (Ellis et al., 1996).

The results and subsequent recommendations from this study will appear daunting to most potential researchers. However, after evaluating their review readers should understand that although the nature of clinical supervision does not permit flawless studies, this fact should not deter potential researchers from appreciating the need to follow best-practices in research whenever possible. The authors conclude that much more methodologically sound research is needed to better understand the field of clinical supervision (Ellis et al., 1996).

Goodyear and Bernard (1998) present two additional challenges to studying supervision in their review: the absence of efficacy and effectiveness research, and the over-reliance on measures of trainee satisfaction. While psychotherapy literature is full of efficacy research (comparing a particular treatment to a control group to determine if

that treatment works better than no treatment at all), supervision research lags behind in this domain. The same phenomenon can also be said about effectiveness studies—those that compare a treatment to one or more others to evaluate outcomes across treatments. While some effectiveness studies have been conducted (e.g. Ellis, Ladany, Krengel, and Schult, 1996) more often than not the tendency is to rely on satisfaction measures, not objective measures of change. The authors also suggest three reasons for the lack of such studies: relatively little theory-driven supervision research has been undertaken, a lack of supervision manuals or protocols to follow, and the apparent difficulty of designing an efficacy study that protects clients. Any curious person can find a myriad of studies discussing supervision. However, these people will be hard-pressed to find studies that are more than theoretical debates or developmental model propositions. The state of the literature is sad, but simple: though many have talked about supervision, very few researchers have empirically investigated this complex process. Despite the aforementioned obstacles of conducing supervision research, several have tried, and as a result some interesting findings have surfaced.

Through a quasi-experimental design, Kivlighan, Angelone, and Swafford (1991) compared live and videotaped individual psychotherapy supervision in the training of new therapists. The therapists were master's level counseling students who were supervised by a doctoral level counseling psychologist and eight counseling-psychology doctoral students. Undergraduates served as clients who were recruited and seen for four sessions. Participating clients completed the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984) at the end of each of the four therapy sessions. All sessions were videotaped, and

within 24 hours of each session the therapist was to watch and code their use of intentions (Intentions List; Hill & O'Grady, 1985). The "how" of therapist behaviors (i.e. what the therapist does in session) can be operationalized as intentions use (Hill & O'Grady, 1985). Some examples include support, relationship, assessment, educate, and restructure intentions. Results indicated that clients seen by therapists with live supervision reported stronger working alliances than clients seen by therapists with videotaped supervision, as the authors hypothesized. Implications about the differences in intention use suggest that live supervision also influenced therapists' intention use. The authors tested for the directionality of these findings and discovered that live supervision primarily affects how the therapists behave in session (intention use), which in turn effects clients' session evaluation and working alliance. The results taken as a whole suggest that live supervision enhances or accelerates the performance of a dynamic-interpersonal approach to psychotherapy, and also impacts clients' perception of the working alliance. This study is not without its limitations (e.g. lack of random assignment, use of supervisors with little experience, etc.), but has the major strengths of empirically examining live supervision in the context of individual psychotherapy and using client perspective as an outcome variable. It may have been indirect, but live supervision contributed to the clients' perception of the smoothness and depth of the sessions, as well as their alliance with the therapist: a finding not to be ignored.

In another study linking supervision with clients, Locke and McCollum (2001) examined clients' perceptions of live supervision and their satisfaction with therapy. Though this study did not directly measure improvements in clients' mental health, it is important to the proposed study in two ways. First, this study was conducted in a

similarly equipped university-based marriage and family therapy clinic, and second, it captures the client's perspective (self-report) on how supervision affects their therapy experience.

Clients in this study completed the Client Satisfaction Questionnaire (CSQ-8; Attkinsson et al., 1989) and the Purdue Live Observation Satisfaction Scale (PLOSS; Sprenkle, Constantine, and Piercy, 1982), as well as answered two short answer questions investigating how having a therapy team was and was not helpful. Results indicated that in general, the clients surveyed were very satisfied with their experience in therapy (mean CSQ-8 score was 28.4; possible range from 8-32 with higher scores indicating greater satisfaction). Furthermore, results from the PLOSS subscales indicated that clients felt a high degree of comfort with live supervision, endorsed the helpfulness of live supervision, and did not find live supervision overly intrusive. The participants seemed to adhere to the theme of two heads are better than one, and were therefore generally positive about the idea of having multiple therapists involved on their case. Nonetheless, as some participants mentioned, the need for a balance between a helpful versus intrusive team can be a fine line. On this note, the authors highlight the need for more research including clients' views about the supervisory process, namely to maximize the chances of success for outcomes. This study was a replication of Piercy, Sprenkle, and Constantine's (1986) study which also questioned clients about their experience with live supervision, and found that they were generally satisfied with live supervision. These studies provide strong support that the supervisory process has the ability to both enhance (if collaborative) and hinder (if intrusive) client outcomes, but does not extend into the realm of the proposed study to investigate exactly how outcomes are affected.

As an extension of Ellis et al.'s work (1996), Milne and James (2000) conducted a systematic review of the literature investigating the effectiveness of cognitive-behavioral supervision. While the effect of supervision on the supervisee was examined, more remarkably, so was the relationship between supervision and the patient. Milne and James reviewed 28 empirical studies of the change processes between participants of the educational pyramid: consultant and supervisor, supervisor and supervisee, and supervisee and patient. In the end, Milne and James concluded that while the pyramid approach does appear to benefit patients, the impact of supervision decreased steadily from supervisors to patients. In other words, most studies were able to more strongly support the idea that supervisors and supervisees benefit from supervision than do patients. This link to patient benefits is an important one, but as the authors caution, should be carefully applied to other fields due to the fact that the majority of included studies came from the field of learning disabilities, and utilized relatively simple interventions. Whether or not such clear findings for the effectiveness of supervision could be found for the field of marriage and family therapy is unknown, but unlikely due to the more complex nature of problems and interventions.

Many theorists agree that the supervisory working alliance is potentially one of the most important common factors in the change process of supervision (Bordin, 1983; Efstation, Patton, & Kardash, 1990; Mueller & Kell, 1972). Ladany, Ellis, and Friedlander (1999) tested Bordin's (1983) proposition that changes in trainees' perceptions of the quality of the supervisory alliance would predict supervisory outcomes. These outcomes included changes in their self-efficacy expectations and

changes in their reported satisfaction with supervision. (Once again, note the emphasis on things other than client outcomes in relation to supervision research.)

In this study, the supervisory working alliance was measured with the Working Alliance Inventory-Trainee version (WAI-T; Bahrick, 1990) which assesses trainees' perceptions of three factors (agreement on the goals of supervision, agreement on the tasks of supervision, and the supervisor-trainee emotional bond). Trainee self-efficacy was measured with the Self Efficacy Inventory (SEI; Friedlander & Snyder, 1983) which assesses trainees' confidence in their ability to perform counseling activities. Finally, trainee satisfaction with supervision was measured with the Trainee Personal Reaction Scale-Revised (TPRS-R; Holloway & Wampold, 1984) which assesses perceived satisfaction of supervision on 5 point scale. The trainees were graduate students from multiple states, and completed packets of these assessments twice during their supervision (between the 3rd and 5th week, and then again between the 11th and 16th). In the end, the researchers were interested in how the supervisory alliance impacted trainees' self-efficacy and overall satisfaction with supervision.

Results indicated that though changes in trainees' self-efficacy were evidenced, changes in the supervisory alliance did not predict these shifts in perceived self-efficacy. In other words, the supervisory alliance did not have a unique contribution to impacting trainees' feelings of efficacy. On the other hand, the emotional bond in supervision was significantly related to supervision satisfaction. When this bond became stronger over time trainees perceived their supervisor's personal qualities and performance more positively, judged their own behavior more positively, and were more comfortable in supervision on the whole. The opposite could also be said about a weakening emotional

bond. So, the overall results show that trainees are more satisfied when they have a strong emotional bond with their supervisor. Something the authors did not test for was directionality of this finding, meaning that it is unclear whether the strong bond leads to increased satisfaction, or if it is the sense of satisfaction that allows for the bonding. Once again this study is not without limitations, but it does help iterate the importance of the trainee-supervisor relationship.

Patton and Kivlighan (1997) also considered alliances in their research, and investigated how the trainee's perception of the supervisory alliance is related to the strength of the therapeutic alliance. Their participants included 75 undergraduate student volunteers as clients, 75 graduate students as counselors, and 25 counseling psychology students as supervisors. Each client was randomly assigned to a counselor, and had four 50-minute counseling sessions. Each session was supervised live, and each supervisor provided in-session feedback, as well as an additional 50-minutes of post-session feedback immediately after the session.

After each session clients filled out the Working Alliance Inventory (WAI; Horvath and Greenberg, 1989), and supervisees completed the Supervisor Working Alliance Inventory (SWAI; Efstation et al., 1990). Using hierarchical linear modeling the authors determined that the clients considered the working alliance to increase linearly across the four sessions. Furthermore, the unbiased correlation (i.e. not simply due to time) between this alliance and the supervisory alliance was .66. In other words, trainees' perceptions of the supervisory alliance were significantly related to the client's perception of the counseling alliance. Yet again, an indirect link can be inferred: stronger

supervisory alliances may be correlated with stronger therapeutic alliances, which are known to enhance client outcomes

Harkness and Hensley (1991) conducted a rare study where client outcomes were actually used as a component of their research question regarding supervision. The primary purpose of the study was to examine differences in client outcomes produced by changing the focus of social work supervision. Two methods of focus were contrasted: a) mixed focus—administration, training, and clinical consultation versus b) client focused—client problems and staff interventions in context of client outcomes. Client outcomes were measured based on two separate domains. First, depression was measured by the Generalized Contentment Scale (Hudson, 1982). Second, satisfaction with services based on worker helpfulness, goal attainment, and worker-client partnership was measured by Client Satisfaction Scales (Poertner, 1986). Both measures were deemed to be psychometrically sound instruments (Harkness & Hensley, 1991).

The authors hypothesized that changing from a mixed to client-focused style of supervision would change the focus of therapy, increasing the focus on client problems, goals, and outcomes, leading clients to better/higher generalized contentment and satisfaction with services. The study utilized four community mental health workers as the experimental staff, along with each of their caseloads as potential subjects. Only those subjects that completed the questionnaire were used (161 total). These four clinicians were assigned to an eight-week baseline period consisting of mixed-focus supervision two hours per week, followed by eight weeks where one of those hours was replaced with client-focused supervision. Additionally, two psychologists and their

caseloads served as control staff/subjects. These two psychologists received 16 weeks of mixed-focus supervision only.

A visual inspection of individual caseload outcome trends were conducted to compare the effects of the mixed versus client-focused supervision. Results for the first domain (generalized contentment) were mixed, with depression decreasing in some clients and increasing in others during the client-focused supervision. Results for the second domain (client satisfaction) indicated that as compared to the mixed-focus style, the client-focused supervision produced 10, 20, and 30% improvements in satisfaction with goal attainment, worker helpfulness, and the partnership between client and worker respectively. A statistically significant difference was found between the control (those who only received mixed-focus supervision) and experimental (received mixed and client-focused supervision) groups, with superior gains for clients in the experimental group. More specifically, results indicated that the clients of therapists with client-focused supervision improved on 14 of the 16 (87%) comparisons (4 outcomes times 4 therapists). However, clients of those therapists receiving mixed-only supervision showed improvements on only 8 (50%) of the comparisons during the same time-frame. Because this difference was deemed statistically significant, the authors consider any concern about order effects (time) accounting for the improvements in the experimental group to be reduced.

Of the results reported from this study, the one most directly linked with the proposed study was dubious (no clear increase or decrease in the client outcome measure—depression—for the experimental condition). However, the 10% improvement in goal attainment for clients whose cases did receive client-focused supervision does

establish a possible, albeit small link between supervision and client outcomes. Once again, though, it must be noted that increased satisfaction with goal attainment (not an objective measure of goal attainment) was the outcome. This study is different from the proposed study in several possibly meaningful ways: it was conducted within the field of social work, in a mental health setting, with professionals, not trainees, and it compared two different supervision methods. Nonetheless, it is a valuable starting place in the attempt to delineate the supervision, client outcome link.

One additional study that tried to connect supervision with client outcomes comes from an unpublished master's thesis (Jindal, 2005). The purpose of her study was not to directly link supervision with client outcomes, but instead to investigate the moderating effect of supervision on the relationship between therapeutic alliance and outcomes. The participants included were adult therapy clients who were currently involved in a committed relationship. Further inclusion criteria were that clients must attend at least 4 sessions of therapy, and complete all necessary paperwork. Supervision was tracked using a weekly supervision form that both therapists supervisors completed. On it they recorded the quality, quantity, and type of supervision received/given on each case. Therapeutic alliance was measured with the Couple Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986), and client outcomes were assessed using the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995). The results from this study further supported the idea that therapeutic alliance impacts the change process in therapy, but were unable to reach a level of statistical significance attesting to a possible moderating effect of supervision on the alliance-outcome link. The author noted that a trend towards significance was evidenced, and due to the small sample size is

noteworthy, but nonetheless was unable to establish a significant link with the data available.

Aside from these studies, others only *suggest* investigating supervision's impact on client outcomes, but have not actually carried out the investigation.

Client Outcomes

As discussed, several things are known about supervision, but very few relate to client outcomes. Similarly, many things have been studied and determined to impact client outcomes; they just happen to be things other than supervision. As the possibilities are endless, a thorough overview of factors that significantly affect client outcomes is beyond the scope of this paper. One example related to factors affecting client outcomes includes the idea that therapists who possess more training see greater improvement in clients than those with less training/experience (Stein & Lambert, 1995). Another client outcome assertion is that psychotherapy in general appears to have more positive effects on outcomes as compared to control samples—with certain types being better indicated in special circumstances than others (Matt & Navarro, 1997). Other examples affecting outcomes include clients' readiness for change (Prochaska & Norcross, 2001) and length of time spent in treatment (e.g. Ward & McCollum, 2005). Once again, an extensive overview of these and other contributors to client outcomes will not be undertaken. However, due to both its confirmed link to client outcomes in the literature, and use in the proposed study, there is one area that warrants additional attention: the therapeutic alliance.

As mentioned, the literature points toward a variety of contributors to client outcomes. However, some would argue that it is common factors (including the

therapeutic alliance)--not specific techniques or styles—that primarily affect outcomes in therapy (Stein & Lambert, 1995; Hubble, Duncan, & Miller, 1996; Martin, Garske, & Davis, 2000). The common therapeutic factors can be broken down into four broad areas: therapeutic relationship, extratherapeutic change, expectancy effects, and techniques (Hubble, Duncan, & Miller, 1996). Most pertinent to the proposed study is the therapeutic relationship or alliance.

The therapeutic alliance has been defined both as a single construct (e.g. Zetzel, 1956) and as multi-dimensional (e.g. Bordin, 1979), but nonetheless has three common themes in its theoretical definition: (a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks (Martin, Garske, & Davis, 2000). Martin, Garske, and Davis (2000) conducted a meta-analysis investigating the effect of the therapeutic alliance on client outcomes. They aggregated data from 79 studies and concluded that the overall relation of the therapeutic alliance with outcome is moderate (r =.22), but consistent, regardless of potential influential variables. This result was similar to the previous meta-analysis conducted by Horvath and Symonds (1991) which found an average effect size of .26 between quality of alliance and outcome.

In a MFT-specific investigation of the relationship between the therapeutic alliance and client outcomes, Johnson, Wright, and Ketring (2002) also found a significant link. In their study, home-based therapy was provided to 43 families by a team consisting of both a therapist (doctoral level student therapist) and case manager (master's level student therapist). The measures used were all self-report measures and included The Family Therapy Alliance Scale (Pinsof & Catherall, 1986), the Outcome

Questionnaire (OQ-45.2; Lambert et al., 1996), and the Family Crisis Oriented Personal Evaluation Scales (F-COPES; McCubbin, Olson, and Larsen, 1981).

The researchers found that the therapeutic alliance accounts for a significant portion of variation in symptom distress for clients (19% for mothers, 55% for fathers, and 39% for adolescents). Returning to Bordin's (1979) idea that the therapeutic alliance is multifaceted and can be accounted for with three constructs (development of bonds, assignment of tasks, and agreement on goals) the researchers found differing results for certain family members. More specifically, they found that the task domain was more predictive of symptom distress for mothers and adolescents while the goal domain was more influential for fathers. This study investigated only one aspect of the therapeutic alliance: the individuals' perceptions of the family's alliance, and how this perception was related to individual outcomes. The overall results are consistent with the findings from the previously discussed meta-analyses that the therapeutic alliance is predictive of changes in symptom distress, and add support for this trend in marriage and family literature.

METHODS

This study aims to establish a relationship between clinical supervision and client outcomes in psychotherapy.

Participants

The participants in this study included clients who sought treatment at the university MFT clinic between January 2003 and December 2006, the therapists that provided services to these clients, and the AAMFT approved supervisors who provided supervision on each of the cases. This was a nonrepresentative, convenience sample.

Clients. The initial inclusion criterion for clients required that their case receive supervision at least once during the first four sessions of therapy. There were 271 client cases that met this requirement. Participants also needed to attend a minimum of four sessions and complete the standard battery of both first and fourth session paperwork. Of the original 271 supervised cases, 180 were eliminated because the clients either dropped out/terminated prior to their fourth session, or the fourth session paperwork was not completed. Therefore, 91 cases fulfilled all the requirements: an overall retention rate of about 33.6%.

The age of the participants in this study ranged from 18 to 56 years old, with the majority of the study subjects being Caucasian (82%). The demographic categories considered were age, race, household income, and level of education. A more specific breakdown of the available demographical information is presented in Table 1 below.

Table 1. Available demographics of male and female clients

Demographics	Males		Females	
	N	Percent	N	Percent
Age Group				
18-29	29	42.6	40	53.3
30-39	24	35.3	21	28
40-49	11	16.2	11	14.7
50 or above	4	5.9	3	4
Racial Group				
Caucasian	53	82.8	58	80.6
African American	10	15.6	10	13.8
Hispanic/Non-White	0	0	1	1.4
Asian	1	1.6	3	4.2
Household Income				
Less than $10,000	11	16.9	18	26.5
$10,001 to $20,000	19	29.4	19	27.9
$20,001 to $30,000	11	16.9	5	7.4
$30,001 to $40,000	12	18.4	12	17.6
Over $40,000	12	18.4	14	20.6
Client Education				
Jr. High School	1	1.5	1	1.4
GED/High School	24	35.9	29	40.2
Vocational/Technical	3	4.5	1	1.4
Associate's Degree	10	14.9	11	15.3
Bachelor's Degree	18	26.9	13	18.1
Master's Degree	5	7.5	11	15.3
Other	6	9.0	6	8.3

Inclusion of cases. It is important to examine possible differences between included and excluded cases because significant variations could create a threat to the study's validity. Because supervision was the primary focus of the study, differences in supervised versus unsupervised cases were analyzed. More specifically, t-tests were

used to test for differences on each first session outcome score as well as on demographical information. There were no significant differences between supervised and unsupervised cases for any variable or category, and therefore no exclusion bias exists in the study. The t-scores are reported in table 2 below.

Table 2: Comparing means of supervised and unsupervised cases

	Males		Females	
	t-score	Sig. (2-tailed)	t-score	Sig. (2-tailed)
Age	-.309	.758	.290	.772
Race	1.41	.159	.998	.319
Income	-.274	.784	-.449	.654
Education	-1.49	.137	-.989	.323
Relationship Satisfaction	.005	.996	-.803	.423
Symptom Distress	-1.41	.160	1.38	.168
Avoidance	-1.18	.240	.320	.749
Anxiety	-.072	.942	-.746	.445

Therapists and Supervisors. The therapists included are students who since January of 2003 have completed or are currently enrolled in the two-year marriage and family therapy master's program at the local university. The supervisors are licensed marriage and family therapists from this same time period (N=4). Each are AAMFT

approved supervisors with an average of 24 years of experience as therapists and an average of 21 years of experience as clinical supervisors.

Procedure

This study utilized data from an on-campus training facility of a COAMFTE accredited Master's program in Marriage and Family Therapy; the center is staffed by student therapists. The data has been collected from the files of adult clients who received individual or couples therapy services from January 2003 through December 2006. Information obtained is from the self-report questionnaires completed by clients before the intake and after the fourth session of therapy. Clients were informed of the purposes of questionnaire completion at the beginning of treatment, and signed agreements to release information for clinical, administrative, and research purposes.

Therapy is supervised by the MFT faculty in the form of case consultation, live, or video-assisted supervision. Any supervision that occurs is recorded on a Weekly Supervision Record; the time, quality, and type of supervision provided on each case is logged. These logs were tracked and collected through the first four sessions.

Measures

Therapeutic Alliance (Appendix A). This study will utilize the revised versions of the Individual Therapy Alliance Scale and The Couple Therapy Alliance Scale (ITAS-R and CTAS-R; Pinsof & Catherall, 1994). Both are self report instruments that are designed to measure clients' perceptions of their relationship with their therapist, in other words, the therapy alliance. Each consists of 40 statements which the client evaluates using a 7-point Likert type scale, rating the extent to which they completely disagree (1) to completely agree (7) about the various features of the alliance (Pinsof & Catherall,

1994). The 40 statements encompass three subscales: bonds, tasks, and goals, and have questions that are both positively and negatively phrased. Internal consistency for this sample was $\alpha = .96$ and .94 for males and females respectively.

Weekly Supervision Record (See Appendix B). Every time a case is supervised, supervisors and students keep track of the type, quality, and quantity of supervision. They independently log their perceptions of each category into the Weekly Supervision Record which was developed by faculty of the Marriage and Family Therapy program.

The type of supervision refers to both setting and style. Settings include planned or unplanned individual supervision, as well as meeting as a group in-class or just after a therapy session. Styles are logged if supervision is live or supplemented through the use of video footage of the session. The type variable in this study was measured by tracking when supervision is live and/or video assisted.

Quality of supervision is logged as either limited, moderate, or extensive. Limited supervision is seen as supervision which focuses on the details of providing services and the therapeutic techniques used in the therapy. Supervisors often check in with therapists concerning decision making. Moderate supervision is characterized by a more in-depth focus on how the therapist is managing the case issues, client relationships, and the flow of therapy. This supervision moves from evaluating therapeutic techniques towards enhancing management skills in therapy concerning session flow, therapeutic ruptures, and case management within session and across sessions. Extensive supervision focuses not only on the client relationship and functioning, but on how the therapist works with the clients. Here, the supervisor ensures that the therapy is more

process oriented rather than content based. The therapist/client characteristics are evaluated in connection with session flow and case progress.

In attempt to establish inter-rater reliability in the "quality" aspect of the log, three of the supervisors provided independent evaluations of the supervision offered on 10 separate cases presented in supervision. These cases were selected as a convenience sample. Two of the supervisors watched the supervision from remote location as one supervisor discussed cases with a student. Each supervisor independently rated the quality of supervision offered while conducting case consultation and video observation. There was complete agreement on 9 of the 10 cases. For the remaining case, the supervisors reviewed their decision processes and came to a consensus. The quality of supervision variable was measured by determining the average level of supervision on each case.

Quantity of supervision is tracked on a 15 minute incremental basis, with the exception of the first two categories which are 1) less than 5 minutes, or 2) from 5 to 15 minutes. Again, both the therapist and supervisor independently log the amount of supervision time devoted to a case. The quantity supervision variable was measured by totaling the number of supervision minutes provided on a given case, using the upper end of the category from the form (e.g. 5, 15, 30, etc.).

Because supervision is such a complex event, the quality and quantity variables were also combined to create a more complete variable: the quantity of supervision at each quality level. Finally, because the supervisors had more extensive practice and training on how to best rate the quality aspect of supervision, only their records were used.

Revised Dyadic Adjustment Scale-RDAS (See Appendix C). The RDAS is a 14 item scale that can be used to evaluate dyadic adjustment in distressed and nondistressed relationships (Busby, Christensen, Crane, & Larson, 1995). As it is measuring adjustment in relationships, this will be used to measure client outcomes only for clients in committed relationships.

The RDAS was developed by shortening the 32-item Dyadic Adjustment Scale created in 1976 by Spanier (1976) and maintains the original scales' strength of multidimensionality (Crane, Bean, & Middleton, 1998). The RDAS consists of the following three subscales: Dyadic Consensus, Dyadic Satisfaction, and Dyadic Cohesion. Couples' combined scores can range from 0 to 69 with higher scores suggesting better adjustment.

In terms of internal consistency and reliability, Busby et al. (1995) report Chronbach's alpha at .90 for the total score, and .81, .85, and .80 for the Consensus, Satisfaction, and Cohesion scales respectively. The Spearman-Brown split half reliability coefficient is reported at .95 for the aggregate, and .89, .88, and .80 for the respective subscales (Busby et al., 1995). Internal consistency for this sample was $\alpha = .87$ and .86 for males and females respectively.

Outcome Questionnaire-OQ (See Appendix D). Because the OQ can be completed in a short amount of time and is designed for repeated measurement of client status throughout the course of therapy, it is particularly well suited for the proposed study. This measure will be used as a dependent variable for all participants: individual clients, and those in committed relationships.

The OQ is a 45 item questionnaire designed to evaluate self-reported psychological functioning and symptomatic distress (Lambert et al., 1996). The questionnaire has 3 subscales relevant to mental health: Symptom Distress, Interpersonal Relations, and Social Role Performance, each aiming to assess a different domain of client functioning (Lambert et al., 1996). Possible total scores from these subscales range from 0 to 180 and are continuum based with higher scores suggesting greater distress/pathology.

Relevant to the proposed study, the OQ has been established as sensitive to change in counseling center clients by detecting significantly more improvements in clients receiving psychotherapy than in untreated individuals (Vermeersch et al., 2004). Additional studies also support the soundness of the OQ, with high total score estimates for test-retest reliability (.84) and internal consistency (.93). Validity estimates range from .60 to .86, suggesting the strong correlation of findings between the OQ and other measures of client distress (Lambert et al., 1996). Internal consistency for this sample was $\alpha = .94$ for males and females.

Experiences in Close Relationships-ECR (See Appendix E). This scale was created by Brennan, Clark, and Shaver (1998) to measure attachment in adult relationships; because of this, it will be used to measure outcomes only for clients in committed relationships. The authors took all the known assessments that measure attachment and using factor analysis derived two 18-item sub-scales: avoidance and anxiety. Both subscales are reliable in internal-consistency, and have high construct, predictive, and discriminant validity (Crowell, Fraley, & Shaver, 1999). The avoidance subscale measures discomfort with closeness, the avoidance of intimacy, and

self-reliance. The anxiety subscale measures jealousy/fear of abandonment, fear of rejection, and preoccupation. Both subscales are rated on a 7-point scale, with reverse scoring required for certain items. Scores can be translated into attachment styles, with secure clients scoring low on both subscales, preoccupied clients scoring low on avoidance but high on anxiety, dismissing clients scoring high on avoidance but low on anxiety, and fearful clients scoring high on both. Internal consistency for the avoidance scale in this sample was $\alpha = .90$ for males and females; $\alpha = .93$ and .91 for males and females respectively for the anxiety scale.

RESULTS

This study investigated the relationship between supervision and client outcomes in therapy. Supervision was measured by the Weekly Supervision Record developed by the Marriage and Family Therapy faculty at Auburn University. Client outcomes were measured by residualized change scores on the OQ (Lambert et al., 1996), the RDAS (Busby, et al., 1995), and the ECR (Brennan et al., 1998). Therapeutic Alliance Scales (Pinsof, 1994) measured the alliance between each client and the therapist, and were used as controls in the final stage of the analysis.

Research Findings

The means and standard deviations for all continuous variables have been reported in tables 3-5 below. Table 3 outlines the supervision (predictor) variables, excluding the live and video-assisted supervision variables as they were discrete. Table 4 reports descriptive statistics for males and females on all four assessment scales at both points of data collection (intake and fourth session). Table 5 reports the residualized change scores for each of the outcome variables. These were calculated for each measure by regressing the fourth session score into the first session score for each case. Because the study is interested in investigating how supervision is related to client outcomes, a change score that took into account each time point was most appropriate. Therefore, these residualized scores were calculated and are the variables that will be used and referred to in all subsequent data analysis and discussion.

Table 3: Sample Descriptive Statistics—Continuous Predictor Variables

Predictor Variable	N	Mean	Std. Deviation
Avg. Supervision Frequency	82	2.90	1.53
Avg. Supervision Level	82	1.97	0.46
Total Supervision Time (minutes)	82	103.91	68.80
Time at Level 1	82	14.70	24.45
Time at Level 2	82	55.85	42.85
Time at Level 3	82	34.02	51.16

Table 4: Sample Descriptive Statistics—Outcome Measures

Outcome Measures	N	Mean	Std. Deviation
Female RDAS Intake	50	52.16	9.81
Female OQ Intake	66	68.55	22.13
Female Avoidance Intake	63	53.19	21.51
Female Anxiety Intake	64	75.72	22.77
Male RDAS Intake	46	55.46	7.71
Male OQ Intake	59	64.31	25.62
Male Avoidance Intake	59	49.64	19.68
Male Anxiety Intake	59	67.90	25.06
Female RDAS Fourth	46	57.65	9.22
Female OQ Fourth	65	60.69	25.14
Female Avoidance Fourth	45	52.40	18.47
Female Anxiety Fourth	45	70.27	19.46
Male RDAS Fourth	64	212.53	31.64
Male OQ Fourth	40	57.77	7.85
Male Avoidance Fourth	51	57.49	24.67
Male Anxiety Fourth	39	48.13	19.14
Female RDAS Fourth	39	62.92	18.67

Table 5: Sample Descriptive Statistics—Outcome Variables (Residualized)

Residualized Variables	N	Mean	Std. Deviation (Unstandardized)	Std. Deviation (Standardized)
Female RDAS	46	.00	6.55	.989
Female OQ	64	.00	17.42	.992
Female Avoidance	45	.00	11.44	.989
Female Anxiety	45	.00	10.36	.989
Male RDAS	39	.00	5.02	.987
Male OQ	51	.00	13.80	.990
Male Avoidance	39	.00	10.11	.987
Male Anxiety	39	.00	8.77	.987

The data analysis began by examining the data for outliers and for normality. An outlier was defined as any case that is more than two standard deviations away from the sample mean. This was an important first step because due to the small sample size, the potential for outliers to greatly affect the results was high. It was determined that a total of nine cases were outlying on at least one of the residualized (outcome) variables. Three cases were outliers on female RDAS, two cases were outliers on male RDAS, three cases were outliers on male Anxiety, and one case was an outlier on male RDAS, Avoidance, and Anxiety. It was also determined that the outliers were altering the findings of the study, and were therefore excluded in subsequent data analysis. The data did appear to be normally distributed, and therefore did not require any additional transformations.

All eight predictor and eight outcome variables were entered into a correlation table to determine if any significant relationships existed. The correlations of the predictors and outcomes are presented in table 6 below (this does not include the correlations within predictors or within outcomes as that was not part of the study).

Table 6: Correlations between outcome and predictor variables

		Supervision Frequency	Supervision Avg. Level	Time in Minutes	Level 1 by Time	Level 2 by Time	Level 3 by Time	Live	Video
Female RDAS	*r*	-.091	.170	-.087	-.095	-.027	-.053	.060	-.008
	Sig.	.546	.259	.564	.532	.858	.726	.692	.960
	N	46	46	46	46	46	46	46	46
Female OQ	*r*	.068	.093	.075	.011	.114	.005	.059	.106
	Sig.	.592	.466	.556	.933	.370	.970	.642	.404
	N	64	64	64	64	64	64	64	64
Female Avoidance	*r*	-.056	-.341*	-.065	.177	-.063	-.083	.042	.041
	Sig.	.714	.022	.673	.245	.679	.588	.786	.789
	N	45	45	45	45	45	45	45	45
Female Anxiety	*r*	.183	.030	.044	.209	-.130	.076	-.086	.075
	Sig.	.229	.845	.774	.168	.393	.620	.573	.625
	N	45	45	45	45	45	45	45	45
Male RDAS	*r*	.029	.181	.088	.045	.061	.045	.086	.063
	Sig.	.861	.270	.593	.786	.714	.786	.602	.705
	N	39	39	39	39	39	39	39	39
Male OQ	*r*	-.214	-.033	-.090	-.039	.002	-.089	-.173	.131
	Sig.	.131	.818	.529	.786	.991	.533	.224	.359
	N	51	51	51	51	51	51	51	51
Male Avoidance	*r*	.070	.153	.182	.028	-.095	.288	.107	-.134
	Sig.	.674	.354	.268	.865	.566	.075	.515	.418
	N	39	39	39	39	39	39	39	39
Male Anxiety	*r*	-.145	-.062	-.097	-.072	.131	-.200	-.210	.033
	Sig.	.380	.709	.555	.661	.426	.222	.200	.840
	N	39	39	39	39	39	39	39	39

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

The only relationship that reached a level of statistical significance was between the variables of female avoidance and the average level of supervision (r = -.341, p<.05). More specifically, this relationship suggests that as the average level of supervision (LVLMEAN) on a case increases, females' scores of avoidance in their intimate relationships decreases. This relationship is in the expected and desired direction, as supervision is intended to help decrease clients' negative symptoms such as avoidance.

The second step of the analysis was to find out if the variable LVLMEAN could predict unique variance in female avoidance. It was determined that with a correlation of r = -.341 at p<.05, LVLMEAN was able to predict about 12% of the variance in female avoidance (R^2 = .116). However, this regression did not include the control variable of Female Therapy Alliance (FTA-assessed at session four). Before adding therapy alliance into the regression, another correlation was completed to test for a significant relationship between the control predictor (FTA) and the outcome (female avoidance). Results indicated a significant correlation (N = 44, r = .62, p<.001) which then led to the inclusion of FTA in the regression equation. When female therapy alliance was added to the regression with LVLMEAN, the original variance accounted for by LVLMEAN no longer remained as a statistically significant predictor. In contrast, FTA uniquely explained about 39% of the variance (R^2 = .39).

In sum, while a significant relationship was evidenced between LVLMEAN and female avoidance, LVLMEAN was unable to provide a unique contribution in explaining variance within change scores in female avoidance. Because no other predictors were significantly related to the outcome variables, no additional regressions were indicated.

DISCUSSION

Many experts have asserted that the pragmatic nature of supervision research complicates studies and often limits what can be empirically validated (Bernard & Goodyear, 2004; Ellis, Ladany, Krengel, and Schult, 1996). That reality surfaced once again in this research endeavor, as the findings of this study were not able to provide an unequivocal link between supervision and client outcomes in therapy. Nonetheless, a couple of interesting results were found, and are discussed in the following pages.

Summary

Because supervision literature is so underdeveloped, this study did not hypothesize any specific findings. Instead, the researcher investigated a potential link between the supervision variables of quality, quantity, and type and the client outcome variables of relationship adjustment, symptom distress, and experiences in close relationships. Of all variables included in the initial correlation, the only significant relationship detected was between the quality of supervision and females' avoidant experiences in their intimate relationships. This relationship was moderate in strength, and in the expected direction—as higher quality supervision is intended to help decrease clients' negative symptoms such as avoidance in relationships. The avoidance scale of the ECR is a measure of adult attachment, and those who score high in avoidance are often categorized as having a dismissing attachment style (Brennan, Clark, & Shaver, 1998). The finding that there is a relationship between higher quality (more in-depth,

process oriented) supervision and lesser avoidant tendencies is noteworthy. John Bowlby is one of the preeminent attachment researchers, and as his work and other literature suggests, adult attachment styles have a strong bearing on relationship satisfaction and overall functioning (Bowlby, 1988). This study's finding that supervision quality is related to decreased avoidance is a new contribution. Due to methodology (lack of experimental design) causation cannot be inferred, but it is nonetheless an important link in the attempt to delineate the impact of supervision on client outcomes in psychotherapy.

When this correlation was fit into a regression with the control predictor of therapeutic alliance, the quality of supervision no longer provided unique variance in the avoidance measure. But before dismissing the supervision link, readers are encouraged to consider just how strong of a correlation there is between therapeutic alliance and the attachment scale ($r = .62$). That said, also note that when the therapeutic alliance is included, supervision did lose statistical significance, but only by a minimal margin ($t = -1.99$, $p = .053$). Considering the sample size was only 45, this non-significant contribution to variance becomes quite a bit more significant for practical purposes. In sum, while the quality of supervision cannot statistically predict unique variance in females' avoidance scores, it is noteworthy that it came so close to significance when included with therapy alliance in the small sample.

While this finding was unable to indisputably predict unique variance, the uniqueness of these results should not be minimized. There may be a lack of enduring statistical significance in the aforementioned findings, but the contribution to the literature is quite significant. This study is distinctive in the field of marriage and family therapy in that it attempted to link supervision with objective client outcomes. As

discussed in the literature review, supervision and client outcomes have been studied numerous times in isolation from one another. However, when supervision and client outcomes are studied together, the "outcome" measures tend to assess things like client satisfaction with therapy and comfort with supervision (e.g. Locke & McCollum, 2001). This tendency to over-rely on satisfaction measures has been criticized (Goodyear & Bernard, 1998) and the call to investigate a more direct link between supervision and client outcomes is loud and clear (Ellis & Ladany, 1997; Goodyear & Bernard, 1998; Stein & Lambert, 1995). Harkness and Hensley (1991) tried to examine this link in their research, but were unable to detect significant results as related to their client outcome measure (depression). Other studies and attempts could not be found. Considering the strong recommendation for increasing knowledge regarding the supervision-client outcome link, this is precisely what the current study set out to investigate. And once again while the results may have been less than extraordinary, the study still provides a unique contribution—particularly concerning the relationship between avoidance in adult females' attachment and supervision.

Limitations

The small sample size is the major limitation of this study. With a total of only 82 cases, and available data for certain measures as low as 39, the small sample size limits the power of the tests and creates challenges in trying to find significant results. The size of the sample, however, is not its only challenge. The study's data was collected in a University setting in the South, where the vast majority of the participants were Caucasian. The findings have come from a non-representative, convenience sample, and therefore complicate the applicability of the findings to populations in different regions

and of different races. Another limitation of the sample is that the client outcome measures are based solely on self report. This, of course, limits the available data to that which participants are comfortable sharing, and requires the assumption that all given information is truthful.

Another limitation involves the method of acquiring supervision data. Once again due to the relative novelty of supervision research, there is not a strong base in the literature attesting to the most effective way(s) to gather reliable data. The supervision data collected in this study was tested by the MFT program faculty, but only to ensure reliability in interpretation of each part of the measure. There were no safeguards implemented to ensure that supervision was distributed equally among cases, or that each case received supervision at all. Once again the practical nature of the supervisory process greatly complicates the availability of "clean" data. Instead, student therapists often bring their toughest cases to supervision in hopes of getting guidance and suggestions on how to handle resistant or multi-needs cases. With repeated occurrences, this trend could easily lead to what would appear to be a negative relationship between supervision and client outcomes as these difficult cases are often those with the most distressed client outcome scores. Such a finding was not detected in the current study, but the unstructured method of supervision data collection surely limited the possibilities of statistically significant findings.

Another challenge supervision research presents is that the lessons and advice learned in any given supervisory session is not limited only to the case that was being discussed. This phenomenon is referred to as the bleed effect, and is yet another limitation of any supervision related study. Cases similar to those discussed in

supervision may reap carry-over benefits despite not having direct supervision, and therefore no record is kept showing the related gains the therapist and/or clients enjoy. In sum, the bleed effect makes the interaction of supervision variables on therapy outcomes very difficult to objectify.

Future Research

Despite the numerous limitations, this study offers invaluable information regarding the relationship between supervision and client outcomes in therapy. A significant relationship was evidenced between supervision and outcomes, and with larger sample sizes even greater findings should be possible. Looking back at this sample, there were approximately ten to twelve additional correlations that were approaching significance, and could likely reach a statistically significant level in a larger sample. Future research should aim to increase sample size in order to maximize potential for new findings and to replicate findings from previous studies. Unfortunately, the current sample was unable to detect some of the trends previously mentioned in the literature (e.g. live supervision enhances the therapeutic alliance; Kivlighan, Angelone, & Swafford, 1991), but future studies with larger samples may be better equipped for replication.

Subsequent researchers are also encouraged to develop a more objective method of data collection for their supervision variables. Due to its nature, there will never be a perfect way to capture all the elements that encompass supervision, but a few small steps such as ensuring each case has a minimum amount of supervision could make a huge difference.

The possibilities for new and different research ideas in the field of supervision are only limited by the time and effort researchers are willing to invest. The challenges in completing this study gave the researcher a strong sense of appreciation as to why there is such a dearth of literature relating supervision to client outcomes; it seems impossible! Nonetheless, the strong emphasis of supervision in the training process of mental health practitioners necessitates perseverance on the part of researchers to better delineate the supervision-client outcome link. The various mental health fields rely upon it, and for the sake of their well-being, the clients deserve it.

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APPENDICES

Appendix A

Couple Therapy Alliance Scale (CTAS)

Instructions: The following statements refer to your feelings and thoughts about your therapist and your therapy right NOW. Please work quickly. We are interested in your FIRST impressions. Your ratings are CONFIDENTIAL. They will not be shown to your therapist or other family members and will only be used for research purposes. Although some of the statements appear to be similar or identical, each statement is unique. PLEASE BE SURE TO RATE EACH STATEMENT.

Each statement is followed by a seven-point scale. Please rate the extent to which you agree or disagree with each statement AT THIS TIME. If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in-between to describe variations between the extremes.

Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
7	6	5	4	3	2	1

1. The therapist cares about me as a person	7	6	5	4	3	2	1
2. The therapist and I are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
3. My partner and I help each other in this therapy.	7	6	5	4	3	2	1
4. My partner and I do not feel the same ways about what we want to get out of this therapy.	7	6	5	4	3	2	1
5. I trust the therapist.	7	6	5	4	3	2	1
6. The therapist lacks the skills and ability to help my partner and myself with our relationship.	7	6	5	4	3	2	1
7. My partner feels accepted by the therapist.	7	6	5	4	3	2	1
8. The therapist does not understand the relationship between my partner and myself.	7	6	5	4	3	2	1
9. The therapist understands my goals in therapy.	7	6	5	4	3	2	1
10. The therapist and my partner are not in agreement about the about the goals for this therapy.	7	6	5	4	3	2	1

11. My partner cares about the therapist as a person.	7	6	5	4	3	2	1
12. My partner and I do not feel safe with each other in this therapy.	7	6	5	4	3	2	1
13. My partner and I understand each other's goals for this therapy.	7	6	5	4	3	2	1
14. The therapist does not understand the goals that my partner and I have for ourselves in this therapy.	7	6	5	4	3	2	1
15. My partner and the therapists are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
16. The therapist does not understand me.	7	6	5	4	3	2	1
17. The therapist is helping my partner and me with our relationship.	7	6	5	4	3	2	1
18. I am not satisfied with the therapy.	7	6	5	4	3	2	1
19. My partner and I understand what each of us is doing in this therapy.	7	6	5	4	3	2	1
20. My partner and I do not accept each other in this therapy.	7	6	5	4	3	2	1
21. The therapist understands my partner's goals for this therapy.	7	6	5	4	3	2	1
22. I do not feel accepted by the therapist.	7	6	5	4	3	2	1
23. The therapist and I are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
24. The therapist is not helping me.	7	6	5	4	3	2	1
25. The therapist is in agreement with the goals that my partner and I have for ourselves as a couple in this therapy.	7	6	5	4	3	2	1
26. The therapist does not care about my partner as a person.	7	6	5	4	3	2	1
27. My partner and I are in agreement with each other about the goals of this therapy.	7	6	5	4	3	2	1
28. My partner and I are not in agreement about the things that each of us needs to do in this therapy.	7	6	5	4	3	2	1
29. The therapist has the skills and ability to help me.	7	6	5	4	3	2	1
30. The therapist is not helping my partner.	7	6	5	4	3	2	1

31. My partner is satisfied with the therapy.	7	6	5	4	3	2	1
32. I do not care about the therapist as a person.	7	6	5	4	3	2	1
33. The therapist has the skills and ability to help my partner.	7	6	5	4	3	2	1
34. My partner and I are not pleased with the things that each of us does in this therapy.	7	6	5	4	3	2	1
35. My partner and I trust each other in this therapy.	7	6	5	4	3	2	1
36. My partner and I distrust the therapist.	7	6	5	4	3	2	1
37. The therapist cares about the relationship between my partner and myself.	7	6	5	4	3	2	1
38. The therapist does not understand my partner.	7	6	5	4	3	2	1
39. My partner and I care about each other in this therapy.	7	6	5	4	3	2	1
40. The therapist does not appreciate how important my relationship between my partner and myself is to me.	7	6	5	4	3	2	1

Individual Therapy Alliance Scale (ITAS)

Instructions: The following statements refer to your feelings and thoughts about your therapist and your therapy right NOW.

Please work quickly. We are interested in your FIRST impressions. Your ratings are CONFIDENTIAL. They will not be shown to your therapist or other family members and will only be used for research purposes. Although some of the statements appear to be similar or identical, each statement is unique. PLEASE BE SURE TO RATE EACH STATEMENT.

Each statement is followed by a seven-point scale. Please rate the extent to which you agree or disagree with each statement AT THIS TIME. If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in-between to describe variations between the extremes.

Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
7	6	5	4	3	2	1

1. The therapist cares about me as a person	7	6	5	4	3	2	1
2. The therapist and I are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
3. The people who are important to me would be willing to help me in this therapy.	7	6	5	4	3	2	1
4. Some of the people who are important to me and I do not feel the same ways about what I want to get out of this therapy.	7	6	5	4	3	2	1
5. I am satisfied with the therapy.	7	6	5	4	3	2	1
6. The therapist lacks the skills and ability to help me with my important relationships.	7	6	5	4	3	2	1
7. I trust the therapist.	7	6	5	4	3	2	1
8. The therapist does not understand some of my important relationships.	7	6	5	4	3	2	1
9. The therapist understands my goals in therapy.	7	6	5	4	3	2	1
10. Some of the people who are important to me would not agree about the about the goals for this therapy.	7	6	5	4	3	2	1

11. The people who are important to me would approve of the way my therapy is being conducted.	7	6	5	4	3	2	1
12. I would feel safe talking with the people who are important to me about this therapy.	7	6	5	4	3	2	1
13. The people who are important to me would understand the goals for this therapy.	7	6	5	4	3	2	1
14. The therapist does not understand me.	7	6	5	4	3	2	1
15. The therapist is helping me with my important relationships.	7	6	5	4	3	2	1
16. The therapist does not understand some of the people who are important to me.	7	6	5	4	3	2	1
17. The therapist cares about my important relationships.	7	6	5	4	3	2	1
18. I do not feel accepted by the therapist.	7	6	5	4	3	2	1
19. The people who are important to me would understand what I am doing in this therapy.	7	6	5	4	3	2	1
20. The people who are important to me would care about and want me to be in this therapy.	7	6	5	4	3	2	1
21. The therapist and I are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
22. Some of the people who are important to me would distrust the therapist.	7	6	5	4	3	2	1
23. The therapist has the skills and ability to help me.	7	6	5	4	3	2	1
24. I do not care about the therapist as a person.	7	6	5	4	3	2	1
25. The people who are important to me would think that the therapy is helping me.	7	6	5	4	3	2	1
26. The therapist is not helping me.	7	6	5	4	3	2	1
27. The people who are important to me and I would be in agreement about my goals for this therapy.	7	6	5	4	3	2	1
28. Some of the people who are important to me and I would not be in agreement about what I need to do in this therapy.	7	6	5	4	3	2	1
29. The therapist understands the goals I have for my	7	6	5	4	3	2	1

important relationships.

30. The therapist does not appreciate how important some of my relationships are to me.	7	6	5	4	3	2	1
31. Some of the people who are important to me would not be pleased with what I am doing in this therapy.	7	6	5	4	3	2	1
32. The people who are important to me would feel accepted by the therapist.	7	6	5	4	3	2	1
33. The therapist does not agree with the goals I have for my important relationships.	7	6	5	4	3	2	1
34. Some of the people who are important to me would not trust that this therapy is good for my relationships with them.	7	6	5	4	3	2	1
35. The therapist understands what the people who are important to me would want me to achieve in therapy.	7	6	5	4	3	2	1
36. Some of the people who are important to me would not be accepting of my involvement in this therapy.	7	6	5	4	3	2	1
37. I am comfortable disagreeing with or challenging my therapist.	7	6	5	4	3	2	1
38. I want to share more with my therapist but keep pulling back.	7	6	5	4	3	2	1
39. My therapist wants to know too much about me.	7	6	5	4	3	2	1
40. I feel that I am wasting my therapist's time.	7	6	5	4	3	2	1

Appendix B

Weekly Supervision Record

Therapist in training name: _____

SUPervision Type: 1. Individual Planned 2. Group In-Class 3. Group Night Live 4. Individual Extra S#: Session Number

	Client Code	Date	SUP	S#	Lim	Mod	Exten	<5	5-15	15-30	31-45	46-60	61-75	Live	Video
1.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24.					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Appendix C

Revised Dyadic Adjustment Scale (RDAS)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasional Agreement	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Religious matters	5	4	3	2	1	0
2. Demonstrations of affection	5	4	3	2	1	0
3. Making major decisions	5	4	3	2	1	0
4. Sex relations	5	4	3	2	1	0
5. Conventionality (correct or proper behavior	5	4	3	2	1	0
6. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
8. How often do you are your partner quarrel?	0	1	2	3	4	5
9. Do you ever regret that you married (or live together)?	0	1	2	3	4	5
10. How often do you and your mate “get of each other’s nerves”?	0	1	2	3	4	5

	Every Day	Almost Every Day	Occasionally	Rarely	Never
11. Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas	0	1	2	3	4	5
13. Work together on a project	0	1	2	3	4	5
14. Calmly discuss something	0	1	2	3	4	5

Appendix D

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I get along well with others					
2. I tire quickly					
3. I feel no interest in things					
4. I feel stressed at work/school					
5. I blame myself for things					
6. I feel irritated					
7. I feel unhappy in my marriage/significant relationship					
8. I have thoughts of ending my life					
9. I feel weak.					
10. I feel fearful					
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")					
12. I find my work/school satisfying					
13. I am a happy person.					
14. I work/study too much					
15. I feel worthless.					
16. I am concerned about family troubles					
17. I have an unfulfilling sex life.					
18. I feel lonely					
19. I have frequent arguments.					
20. I feel loved and wanted					
21. I enjoy my spare time					
22. I have difficulty concentrating					
23. I feel hopeless about the future					
24. I like myself					
25. Disturbing thoughts come into my mind that I cannot get rid of					
26. I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never")					
27. I have an upset stomach					
28. I am not working/studying as well as I used to					
29. My heart pounds too much					
30. I have trouble getting along with friends and close acquaintances					
31. I am satisfied with my life					

32. I have trouble at work/school because of drinking or drug use (If not applicable, mark never)
3. I feel that something bad is going to happen
34. I have sore muscles
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
36. I feel nervous
37. I feel my love relationships are frill and complete
38. I feel that I am not doing well at work/school
39. I have too many disagreements at work/school
40. I feel something is wrong with my mind
41. I have trouble falling asleep or staying asleep
42. I feel blue
43. I am satisfied with my relationships with others.
44. I feel angry enough at work/school to do something I might regret
45. I have headaches

Appendix E

Experiences in Close Relationships-ECR

Instructions: The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Responding to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale

Disagree strongly			Neutral/mixed			Agree strongly
1	2	3	4	5	6	7

_____ 1. I prefer not to show a partner how I feel deep down.
_____ 2. I worry about being abandoned.
_____ 3. I am very comfortable being close to romantic partners.
_____ 4. I worry a lot about my relationship.
_____ 5. Just when my partner starts to get close to me I find myself pulling away.
_____ 6. I worry that romantic partners won't care about me as much as I care about them.
_____ 7. I get uncomfortable when a romantic partner wants to be very close.
_____ 8. I worry a fair amount about losing my partner.
_____ 9. I don't fell comfortable opening up to romantic partners.
_____ 10. I often wish that my partner's feeling for me were as strong as my feelings for him/her.
_____ 11. I want to get close to my partner, but I keep pulling back.
_____ 12. I often want to merge completely with romantic partners, and this sometimes scares them away.
_____ 13. I am nervous when partners get too close to me.
_____ 14. I worry about being alone.
_____ 15. I feel comfortable sharing my private thoughts and feelings with my partner.
_____ 16. My desire to be very close sometimes scares people away.
_____ 17. I try to avoid getting too close to my partner.
_____ 18. I need a lot of reassurance that I am loved by my partner.
_____ 19. I find it relatively easy to get close to my partner.
_____ 20. Sometimes I feel that I force my partner to show more feeling, more commitment.
_____ 21. I find it difficult to allow myself to depend on romantic partners.
_____ 22. I do not often worry about being abandoned.
_____ 23. I prefer not to be too close to romantic partners.
_____ 24. If I can't get my partner to show an interest in me, I get upset or angry.
_____ 25. I tell my partner just about everything.
_____ 26. I find that my partner(s) don't want to get as close as I would like.
_____ 27. I usually discuss my problems and concerns with my partner.

_____ 28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.
_____ 29. I feel comfortable depending on romantic partners.
_____ 30. I get frustrated when my partner is not around as much as I would like.
_____ 31. I don't mind asking romantic partners for comfort, advice, or help.
_____ 32. I get frustrated if romantic partners are not available when I need them.
_____ 33. It helps to turn to my romantic partner in times of need.
_____ 34. When romantic partners disapprove of me, I feel really bad about myself.
_____ 35. I turn to my partner for many things, including comfort and reassurance.
_____ 36. I resent it when my partner spends time away from me.