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THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

THE EFFECTS OF FACE-TO-FACE SUPERVISOR-CLIENT CONTACT ON THERAPY OUTCOME AND THE PERCEPTIONS OF THE SUPERVISOR, COUNSELOR, AND CLIENT

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

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THE EFFECTS OF FACE-TO-FACE SUPERVISOR-CLIENT CONTACT ON THERAPY OUTCOME AND THE PERCEPTIONS OF THE SUPERVISOR, COUNSELOR, AND CLIENT

A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

BY

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Dedication

It is fitting that I dedicate these four years of education to the memory of my mother, Elsa Jerez Moreno, who met her untimely death during the course of this endeavor. My mother taught me many important and invaluable lessons, but germane to this venture she instilled in me the honorable respect and hunger for education which has served me throughout my life and this course of study. I know she is proud of me and my accomplishments.

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Abstract

This study aims to address concerns associated with ethically and legally implied practice of face-to-face supervisor-client contact. A two group, repeated measures design was employed to examine if there are differences between groups on therapy outcome measures, and client's, counselor's, and supervisor's perceptions of the impact of face-to-face client-supervisor contact on therapy variables. Repeated measures ANOVAs were used to test group differences and found that there are no significant differences between audio-visual supervision and face-to-face supervisor-client contact when measuring symptom reduction and global functioning. However, the client and the supervisor both perceived that face-to-face client contact by the supervisor would have a greater impact on the outcome of therapy and on the ethical practice of psychotherapy. Implications for ethical, legal and supervisory processes are discussed.

Introduction

The topic of legal and ethical issues in supervision within the psychology and counseling fields have received much attention in both the journal and hardbound literature (McCarthy, Kulakowaki, & Kenfield, 1994; Robiner & Schofield, 1990; Stoltenberg, McNeill, & Delworth, 1998; Vasquez, 1992). The adoption of the Ethical Principles of Psychologists and Code of Conduct (EPPCC) in August 1992 (American Psychological Association [APA], 1992) has further incited psychological professionals to consider the ethical and legal aspects of clinical supervision. From as far back as the late 1960's (Sternbach, Abroms, & Rice, 1969) to this present day, (Stoltenberg et al., 1998) authors have attempted to impress on the profession the criticality of practicing ethical supervision. Whitman and Jacobs (1998) claim supervision to be "...a complex task, requiring teaching and clinical skills, as well as an awareness of the responsibilities of the position." Cormier and Bernard (1982) suggested that supervisor responsibilities, to the supervisee, the client, the training program and the profession, and him or herself (Whitman & Jacobs, 1998), should be paramount in the ethical practice of supervision. Rubin (1997) exerts that supervisors have a responsibility to ensure that treatment meets standards of care for both the supervisee as a therapist and the client as the care recipient. Many others (Bernard, 1987; Harrar, Vande-Creek, & Knapp, 1990; Sternbach et al., 1969; Tanenbaum & Berman, 1990; Upchurch, 1985) have echoed the call for ultimate responsibility to rest on the supervisor. Discussions of supervisor

responsibilities to clients, seem to focus on a consensus (American Association for Counselor Education and Supervision, 1989; Harrar et al., 1990; Stoltenberg et al., 1998; Saccuzzo, 1996) of areas which need to be considered: "(a) informed consent; (b) confidentiality and limits to confidentiality; and (c) the umbrella of vicarious liability" (Cormier & Bernard, 1982, p. 487).

Due to it's legal implications, direct and vicarious liability, seems to be of ultimate importance. Speaking to the issue of direct liability, both the American Association of State and Provisional Psychology Boards (AASPPB, 1979) and EPPCC (APA, 1992), have set clear guidelines. Both associations make the supervisor "responsible for the planning, course, and outcome of the supervisee's work" (Harrar et al., 1990, p. 39). Vicarious liability is somewhat more complicated. Several authors (Cormier & Bernard, 1982; Harrar et al., 1990; Stoltenberg et al., 1998) have examined essential definitions in the deliberation of vicarious liability. The doctrine of *respondeant superior* ("let the master respond") places the person in position of authority and responsibility, the supervisor, responsible, not only for the acts of the supervisee but also for the welfare of the client (Cormier & Bernard, 1982). However, other authors (Whitman & Jacobs, 1998) suggest that supervisors are also responsible to the supervisee, the institution they are working for, the profession as a whole, and to their own personal ethics. Rubin's (1997) implications of supervision as a dual contract with both the supervisee and client, parallels Cormier and Bernard's (1982) explanation of *respondeant superior*. Kitchener (1984) describes two

ethical principles that apply directly to supervisory ethics and legal issues and are closely tied to the doctrine of *respondeant superior*. Fidelity and *nonmaleficence -beneficence* (Sherry, 1991). "Fidelity, in this case, refers to the responsibility that the supervisor assumes for the supervisee and his or her clients. Fidelity implies that the supervisor and supervisee are entering into a contractual agreement in which each member has a responsibility for carrying out certain obligations" (Sherry, 1991, p. 571). The principle of *nonmaleficence*, above all do no harm, implies, by it's very definition, another important moral principle. The principle of *benficience*, which suggests that we should engage in practices that are beneficial to others. Thus, in the case of the supervisor, this means that practices must promote the good of the supervisee and the client.

In order to facilitate supervisors in carrying out the moral principles mentioned above (respondeant superior, fidelity, nonmaleficience, benficience), Whitman and Jacobs (1998) suggest that central to "... the understanding of supervision is seeing the supervisor as a *participant* in the therapy process, rather than an outside observer of the therapy process." In the pursuit of ethical and moral supervisory practice, several other authors (Harrar et al., 1990; Sherry, 1991; Stoltenberg et al., 1998) have proposed a minimal course of action. First, and of utmost importance, supervisors must insure that face-to-face supervisory contact with the counselor occurs in a regular and responsible manner (Cormier & Bernard, 1982). In order to provide the most benefit, to ensure no harm occurs, and to faithfully fulfill the responsibilities of the

supervisory relationship, supervisors should be familiar with each case of each supervisee. This can be accomplished in several ways: 1) review case notes with supervisee, 2) review audio/visual recording of counseling sessions with the supervisee, and/or 3) face-to-face meeting with the client. Most psychologists are very familiar with the first two methods, but few practice, and limited research is available on, face-to-face meetings with the supervisee's clients. Face-to-face meetings can accomplish several important clinical and ethical responsibilities. Cormier and Bernard (1982) cite the American Personnel and Guidance Association (1981)(now the American Counseling Association) to impress that all clients have the right to be informed (informed consent) of any factor that may influence the counselor-client relationship (i.e., taping, observation, supervision, etc.). They further suggest that the client may be best served by meeting the supervisor during the initial stages of therapy in order for the supervisor to provide information about the supervisor's role in the supervisor-counselor-client relationship and to ensure that misrepresentation of the setting or the circumstances under which counseling is being conducted does not occur. Additionally, meeting clients face-to-face can give the supervisor supplementary information about the client and case management. The literature (Slovenko, 1980; Van Hoose & Kottler, 1985) has repeatedly warned supervisors that failure to properly supervise a counselor with a disturbed client is one of the leading causes of psychological malpractice suits. Reflecting on the famous Tarasoff case, Slovenko (1980) refers to the comments

made by the plaintiff's attorney to suggest that if the clinic supervisor had examined and made an independent assessment of the client and determined that Tatiana Tarasoff was not in danger, there would have been no cause of action based on foreseeability. Another area of potential gain in face-to-face client contact is to assess the competence and ability of the counselor to manage and counsel the client (Cormier & Bernard, 1982). This is particularly important when dealing with uncredentialed counselors such as in a university training clinic and practicum/internship sites. Although limited, the literature on live supervision focuses on the benefits of face-to-face supervisor-client contact but makes no reference to the possible problems associated with this practice. Peer and professional consultations on this topic has provided insight on possible problematic areas. Of primary concern, is the question of time verses benefit. That is to say; Is the benefit to the supervisor, counselor, and client worth the energy, time, and logistical effort expended on face-to-face client contact? Others have suggested that supervisory presence in the counseling session may negatively impact the client by implying that the severity of their problems warrants a supervisory visit. Additionally, several counselors-in-training have suggested that they may feel that the supervisory visit would be intrusive in the counseling process. Several student colleagues submit that they would experience a certain amount of discomfort at the presence of their supervisor being present during a counseling session. They also added that this process may undermine the credibility of the counselor in the eyes of the client.

Many studies have been conducted to explore the impact of supervision using both the case note review and the audio/visual methods of supervision (See "Review of the Literature") (i.e., Fennell, Hovestadt, & Harvey, 1986; Fisher, 1989; Friedlander, Siegal, & Brenoch, 1989). Although several studies (Berger & Dammann, 1982; Jaynes, Charles, Kass, & Holzman, 1979; Kivlighan, Angelone, & Swafford, 1991; Kniskern & Gurman, 1979;) have explored the implications of live supervision (supervisor "watches ongoing interview, enters the session and intervenes in the therapy process, and debriefs the supervisee at the end of the interview" [Kivlighan et al., 1991 p. 489]), none have examined the impact of the face-to-face supervisor-client meetings aimed at fulfilling ethical responsibilities. Therefore, the purpose of this study is to examine the effects of supervisor face-to-face client contact on the counselor, supervisor, client, and outcome measures of psychotherapy and supervision.

Review of the Literature

Ethical Issues in Supervision

The recent interest in the area of supervision is reflected in several literature reviews. Ideal supervisory characteristics (Carifio & Hess, 1987), empirical studies of psychotherapy supervision (Lambert & Arnold, 1987), developmental of models of supervision (Stoltenberg & Delworth, 1987; Worthington, 1987), and evaluation of supervisee's perceptions of supervisory practices (Allen, Szollos, & Williams, 1986) are just a few of these reviews. Although many of these reviews focus on the process and content of supervision, ethical and legal responsibilities of supervisors are equally important. Supervisors not only have the responsibility to carry out their duties as supervisors in an ethical manner, but also to teach or train their supervisees of ethical and legal concerns in the conduct of counseling and psychotherapy. Several ethical standards and codes of ethics have been developed and adopted to aid in ethical practices. The American Psychological Association (APA) has adopted several guidelines: 1) Ethical Principles of Psychologist and Code of Conduct (APA, 1992), and 2) General Guidelines for Providers of Psychological Services (APA, 1987). Additionally, other organizations have also set forth guidelines to guide ethical conduct: The Standards for Counseling Supervisors (The Association for Counselor Education and Supervision, 1989), and the Guidelines for the Employment and Supervision of Uncredentialed Persons Providing Psychological Services (American Association of State and

Provisional Psychological Boards, 1979). Even though these guidelines exist, several authors (Kitchener, 1984; Rest, 1984) have developed models to aid in carrying out the ethical behaviors set forth by the various codes.

Before addressing how these models can help supervisors and counselors in ethical practices, one should consider one main principle that is central to ethical supervision. It will become clear how the general principle of "Professional and Scientific Responsibility" effects the ethical conduct of supervision. This principle reads as follows:

> Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and adapt their methods to the needs of different populations. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interest of their patients, clients, or other recipients of their services. Psychologists' moral standards and conduct are personal matters to the same degree as is true for any other person, except as psychologists' conduct may compromise their professional responsibilities or reduce the public's trust in psychology and psychologists. Psychologists are concerned about the ethical compliance of their colleagues' scientific and professional conduct. When appropriate, they consult with colleagues in order to prevent or avoid unethical conduct (APA, 1992).

Additionally, responsibility in a supervisory context, may not only infer responsibility for the clinical behaviors of the supervisee, but also responsibility for the welfare and treatment of the client (Cormier & Bernard, 1982; Harrar et al., 1990), to the training program and profession, and him or herself personally (Whitman & Jacobs, 1998).

Vasquez (1992) presents two models for moral behavior (Kitchener, 1984;

Rest, 1984), that if applied to supervisory conduct, should promote ethical practices. The first model was developed by James Rest (1984). Rest (1984), proposed a four process model for ethical and moral behavior. The first component of Rest's (1984) model is to be empathically "...(distress felt by the self that is triggered by the perception of distress in another person)..." (Vasquez, 1992; p. 196) able to perceive, role take, and imagine consequences of behavior and recreate mental representations of probable chains of events. Rest (1984), along with other authors (e.g., Batson, Schoenrade, & Ventis, 1993; Hoffman, 1981), submit that empathy is a central element in the ability to engage in understanding how different parties would be affected by one another's behavior. The development of a caring, empathic attitude is a prominent element in the development of the ethical awareness necessary for Component I. Therefore, supervisors must develop the empathic ability to understand how their behavior could impact their supervisees and their clients, the training program and institution, the profession, and themselves.

Ethical decision-making is a process full of uncertain and sometimes vague options. Rest's second component challenges the supervisor with choosing the morally right and fair option, the option that comes closest to one's own ideal. To accomplish this, the literature (Stoltenberg et al., 1998; Vasquez, 1992; Welfel, 1992) suggests that educators should expose trainees to various ethical dilemmas and present them with the opinions and conclusions of experts in the field of ethical practice.

The third component, is to have the ability to select a course of action by adopting one among competing values. In this component, trainees are challenged to explore their own motivation for ethical decision making. Rest (1984) suggests that exploration of possible motivations (genetic altruism, learned social behavior, social responsibility, a sense of reverence for the scared, empathy, care, justice, a concern for self integrity) can promote self awareness and clearer understanding as to why one might make the decisions one makes.

Finally, Rest proposes that perhaps the most difficult and challenging of the components is this fourth and final module; execution and implementation of a course of action. Hindered by a series of possible negative social and professional consequences, implementing an ethical course of action requires perseverance, resoluteness, character, and ego strength (Vasquez, 1992). This step calls for social and self confidence as well as professional support. Rest's Four Component Model serves as a guide to ethical decision making.

Kitchener (1984) submits what she considers to be the most critical principles in the evaluation of ethical quandary. These principles, autonomy, beneficence, nonmaleficence, justice, and fidelity, will be defined and discussed in the subsequent section. Supervisors can be helpful in increasing the understanding of these principles by employing these and other principles in the delivery of supervision.

A model of the supervisory role is presented by the ACES (1993) in the

Ethical Guidelines for Counseling Supervisors. The Guidelines suggest that inherent to the role of the supervisor are responsibilities for:

1) Monitoring client welfare,

2) Encouraging compliance with relevant legal, ethical, and professional standards for clinical practice,

3) Monitoring clinical performance and professional development of supervisees, and

4) Evaluation and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment, and credentialing purposes.

These models provide the framework for the execution of the ethical principles that will be discussed in the following section.

Ethical Principles

Principles of ethics, just as the General Principles in the EPPCC (APA, 1992), are "aspirational goals to guide psychologists toward the highest ideals of psychology" (Introduction). Although not enforceable edicts, ethical principles are often used by ethics committees to clarify, explain or expound on Ethical Standard and therefore should be regarded by the supervisor/ psychologist in establishing an ethical plan of action. Kitchener (1984) has set forth five principles that she believes are foundational in the practice of psychology.

Respondeat Superior. According to Cormier and Bernard (1982), *respondeat superior* may be the most important legal doctrine applied to supervisor's

responsibilities. They suggest that according to this principle, "someone in a position of authority or responsibility, such as a supervisor, is responsible for the acts of his or her trainees or assistants" (p. 113). Harrar et al. (1990) suggest that this doctrine implies a master - servant metaphorical relationship that places the master/supervisor liable for the actions of their servant-trainee. They further claim that it is this doctrine that establishes vicarious liability by arguing that not only is the supervisor in a position of authority and responsibility but, also stands to profit from the actions of the supervisee. "Succuzzo (in Stoltenberg et al., 1998) notes that there is little doubt that where actions of an unlicensed supervisee negligently results in damages to clients or patients, the supervisor may be liable" (p.179). Stoltenberg et al.,(1998) present the doctrine of the *borrowed servant* and claim that this principle is particularly significant in placing trainees in mental health facilities outside the educational program. Knowing who is the supervisor in direct control, or who was the "master" at the time of the negligent act, may be critical in determining liability for the actions of a supervisee. *Baxter v. Morningside* (1974) established criteria for the *respondeat superior* principle or vicarious liability to be substantiated. First, the supervisee must voluntarily agree to work under the direction and control of the supervisor and act in ways that benefit the supervisor. It seems reasonable that students would ordinarily be viewed as volunteers who are seeking professional training and credentials of their own. Secondly, the supervisee must have acted within the defined scope of tasks permitted by the supervisor and finally, the supervisor

must have the institutional or organizational power to control and direct the supervisee's work (Kapp, 1984). Additionally, Stoltenberg et al. (1998) cites *Masterson v. Board of Examiners of Psychologist* (1995) and *Tarasoff v. The Regents of the University of California* (1974) as existing legal examples where the supervisor was found liable for the actions of their supervisees.

Autonomy. Stoltenberg et al. (1998) describes the autonomous person as having responsibility for one's own behavior and having the freedom to choose as long as that choice does not interfere with the rights and freedoms of others. Sherry (1991) reports that many mental health codes have been passed in order to insure that individual autonomy is protected. Vasquez (1992) presents the principle of autonomy as the principle that underlies confidentiality. Although we should all be familiar with the ethical standards that regulate autonomy or confidentiality of the client, the right to autonomy and confidentiality of the supervisee is somewhat ambiguous. In a study of the clinical supervisory practices of licensed psychologist, McCarthy, et al. (1994) report that one fifth of the participants were not sure whether their supervisors maintained confidentiality about counseling sessions and clients. In fact, the same study relates that 3% of the supervisors claim not to have maintained confidentiality. Additionally, supervisors should avoid pressuring the trainee to adopt to the supervisor's own theoretical orientation or to employ certain techniques, when the scientific and professional literature suggests that the techniques favored by the supervisee are the most appropriate to treat the client's problem. Autonomy

would also infer, that the supervisee should not only have the right to know the credentials, theoretical orientation, and years of experience (professional disclosure) of the supervisor, but also have the right to choose their supervisor (Sherry, 1991). Due to organizational structures and limits of most training programs, the trainees' rights to choose their own supervisors may be hampered. However, the trainees' right to choose their own supervisor may be exercised when they accept a placement at a training program. The Ethical Guidelines for Counseling Supervisors (ACES, 1993) says that supervisees have the right to ongoing feedback, both formal and informal, clear boundaries when supervisors have more than one role (instructor, department chair, committee person, etc.) with the supervisee, clear requirements, expectations, and due process. Furthermore, Cormier and Bernard (1982) suggests that meeting the supervisor and having an opportunity to discuss his or her treatment, may facilitate the client in giving informed consent. In summary, autonomy applies to the supervisor, supervisee, and the client. Each having the right to choose as long as that choice does not interfere with the rights of others. The principle of autonomy is the underlying doctrine that grounds informed consent and confidentiality.

Nonmaleficence. Standard 1.14, of the EPPCC (APA, 1992) reads as follows:

> Psychologists take responsible steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

Vasquez (1992) suggests that this doctrine is perhaps the most critical of

the ethical principles because it implies that supervisors and supervisees understand the impact of their actions well enough to insure that no harm is done. Other standards that call for responsible use of assessments, understanding individual differences (racial, cultural, and religious), a cognizance of civil rights, and competency, rises from the need to prevent harm. Clearly, at the other end of the spectrum of this ethical principle is the next doctrine of *beneficence*.

Beneficence. Stoltenberg et al. (1998) characterize *beneficence* as an "attempt to contribute to the welfare of those with whom we work" (p. 175). The preamble to the EPPCC (APA, 1992) promotes the use of psychological knowledge to advance human welfare. It is in the balancing of the principles of *nonmaleficence* and *beneficence* that many ethical dilemmas are founded. In fact, Vasquez (1992) would argue that the process of psychotherapy itself can pose potential benefit or harm. Sherry (1991) adds that "These two principles then present the horns of the dilemma inherent in supervising the work of a less experienced therapist. Namely, will the benefits of receiving treatment from a less experienced therapist be as beneficial as receiving either no treatment or treatment from a more experienced senior professional" (p. 570). The predicament forks to ask the question of whether the benefit of experience and education to the supervisee is worth the potential harm to the client. It should be clear that as the risk of harm to the client or the supervisee rises, so should the prohibitions and restrictions of behavior (Sherry, 1991). Supervisory monitoring

of the trainee's performance and client progress in therapy is essential in order to insure both *nonmaleficence* and *beneficence*.

Justice. Clearly, the supervisory relationship is not equal. A senior, sometimes more powerful and influential, is given the task of training a junior, less experienced, and at times, vulnerable person. Additionally, licensed supervisors have legal authority and responsibility for their actions and for actions of the supervisee, thus equality is limited by legal authority. Therefore, justice, being the equal treatment of persons (fairness), may have it's difficulties manifesting itself in the supervisor-supervisee relationship (Stoltenberg et al., 1998; Vasquez, 1991). However, Sherry (1991) claims that if sufficient attention is paid to the differences of power, experience, and influence, the supervisory relationship can experience justice and fairness. Justice or fairness is not only applicable to the supervisor-supervisee relationship but also to the relationships of the supervisor and the therapist to the client, and to the institution and profession. Close to this principle, and at times going hand-in-hand, is the principle of *fidelity*.

Fidelity. According to Vasquez (1991), the principle of *fidelity* involves the encouragement of honesty and satisfaction of obligations and contracts such as respect of confidentiality and being consistent. Additionally, *fidelity* encompasses interacting in a genuine and consistent manner (Stoltenberg, et al., 1998). The principle of *fidelity*, according to Sherry (1991), is a basic concept in many relationships in Western cultures. Relationships, such as the

triad of supervisor-supervisee-client, should be characterized by this principle. The practices and standards that demand informed consent, confidentiality and releases of confidentiality are all founded on the principles of *justice* and *fidelity*.

Live Supervision

Live supervision has gained most of it's popularity in the family therapy arena (Lewis & Rohrbaugh, 1989), and an intensive literature search has produced just a few articles outside of this domain. According to Kivlighan et al. (1991), supervision is defined as "live if the supervisor watches an ongoing interview, enters the session and intervenes in the therapy process, and debriefs the supervisee at the end of the interview" (p. 489). The literature asserts that the main advantage of live supervision is that trainees are able to perform distinct counseling skills more rapidly. Berger and Dammann (1982) explain this rapid performance by suggesting several reasons:

> First, the supervisory feedback is immediately available, allowing the therapist trainee to implement suggestions in a more efficient and timely manner. Second, the supervisor can provide in vivo modeling for the trainee. Third, the supervisor can help to shape the trainee's behavior by offering incremental suggestions. Fourth, there is a synergistic effect, with one supervisory intervention building on a previous supervisory intervention (Kivlighan et al., 1991, p. 489).

Researchers (Jaynes et al., 1979) have used a retrospective method of reviewing patient's charts who's therapists have been receiving different methods of supervision. They found significant differences between the live supervision group and videotape supervision group. Patients who's therapists

had received live supervision remained in active treatment longer or terminated after successful short-term treatment twice as often and received less pathological diagnosis and prognosis as those receiving the more conventional method of supervision. The author's believe that the "live" participation of the supervisor in treatment may be the factor responsible for clients receiving a less pathological diagnosis. A recent study (Kivligham et al., 1991) compared live and videotaped individual psychotherapy supervision in the training of novice therapists. They found similar results as their predecessors. Changes in performance was significantly higher for those that received live supervision with noticed improvements in use of more supportive and relationship intentions, and limit setting. However, although clients report a stronger working alliance with counselors who received live supervision, they also reported the session as rougher than those counselors receiving videotaped supervision. Lastly, Fenell et al., (1986) compared live and non-live supervision on a Family Therapist Rating Scale and, although they found trends favoring live supervision, found no significant differences between the two supervisory conditions on any of the variables examined.

Supervision and Client Change

A review of the literature reveals a scarcity of controlled studies, and none that specifically investigate the effects of ongoing psychotherapy supervision on client change. The previous statement, similar to a claim made by researchers (Steinhelber, Patterson, Cliffe, & LeGoullon, 1984) more than fourteen years

ago, is still true today. Even before the Steinhelber et al. (1984) study, other researchers (Lambert, 1980; Matarazzo, 1978) had suggested significant weaknesses in the literature and recommended the use of patient outcome measures in testing the effects of supervision on client change. Steinhelber et al., (1984) identified two aspects of psychotherapy supervision - the amount of supervision and the congruence of theoretical orientation between supervisor and trainee - and related these to a direct rating of patient change as measured by the Global Assessment of Functioning Scale. Although they found that amount of supervision was not related to therapy outcome, clients showed significantly greater improvement when supervisor-trainee theoretical orientations were congruent. Crane, Griffin, and Hill (1986) surveyed master's and Ph.D. students to study client's perceptions of trainee skills and the relationship of these perceptions to therapy outcome. They found that client perception of fit of treatment predicted client outcome, and that the most important client-perceived skill was the trainee's ability to convey concern.

Counselor Development

The function of the supervisor, according to Stoltenberg et al. (1998), is one of the most important roles in the mental health professions. In recent years, developmental models of supervision have been some of the most influential and empirically tested models (Stoltenberg et al., 1998; Stoltenberg et al., 1994; Worthington, 1987). Developmental models all have one thing in common, they are grounded in the understanding of how people change over

time. It is this understanding, says Stoltenberg et al., (1998), that is fundamental to the practice of clinical supervision. Some theories would propose that change occurs as we learn new information, acquire new skills, and then add this information to existing information and skills. These theories would submit that development occurs linearly. As knowledge and experience increase, we should see higher levels of functioning. However, empirical reports do not support this notion. What we do experience, says Stoltenberg et al. (1998), is a less linear course that encounters periods of growth, periods of delay, and at times even periods of regression. McNeil, Stoltenberg, and Pierce, (1985) surveyed ninety-one doctoral students from eight counseling or clinical training programs and found significant differences for beginning versus intermediate trainees in Self-Awareness and Dependency-Autonomy. Additionally, they found differences between intermediate versus advanced trainees in Dependency-Autonomy and Theory-Skills Acquisition. Differences between beginning versus advanced trainees were found in Self-Awareness, Dependency-Autonomy, and Theory/Skills Acquisition. These varying differences would lend validity to the proposition of a less linear course of counselor development.

An understanding of cognitive and motivational processes would add insight to the workings of development and learning. Cognitive models (Anderson, 1985) propose that people learn skills in three steps or stages:

1) A declarative verbal or image representation of the procedure is learned.

2) Associative Stage: Receive feedback, correct errors, streamline

procedure.

3) Autonomous Stage: Practice, skill proficiency, automacy.

Additionally, Anderson (1985) has increased our understanding of how we learn by exposing us to the process by which experts deal with problems. Whether examining the master chess player, the mathematician, or the expert physicist, it is the fine-tuning of skills in subject specific situations that allows for the development of reasoning forward, from known information to the problem at hand rather than reasoning backward from the problem to existing knowledge. Therefore, cognitive theory would submit that simple acquisition of added facts and skills is insufficient in resolving how people move from novice to expert. Similarly, early models of psychotherapist development have proposed a simplistic model that implies that growth occurs in broad stages (Level 1, 2 & so on). Stoltenberg et al., (1998) suggests that psychotherapists develop at different levels of professional maturity in different areas of mental health service. For example, psychologists-in-training may be on one level when working with a certain type of client and at another level of development when confronted with a different type of client. Additionally, research (Tracey, Ellickson, & Sherry, 1989) has suggested that supervision should be tailored to the supervisee's level of expertise with a particular clientele. This complicates things for the supervisor. No longer can we simply determine the level of development of the supervisee and treat them accordingly, the supervisor needs to assess the level of development of the supervisee with each particular client

across various domains (intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment planning and goal setting, and professional ethics) of psychotherapy. In their presentation of the Integrated Developmental Model (IDM) for supervising counselors and therapists, Stoltenberg et al. (1998) presents three overriding structures which they suggest provide indications of professional growth:

1) Self and other awareness: The cognitive and affective elements that give indication as to the development of self-preoccupation, client and self awareness.

2) Motivation: Reveals the psychotherapist's interest, investment, and effort toward clinical and professional advancement. Motivation will greatly vacillate.

3) Autonomy: Degree of independence demonstrated by the supervisee.

They (Stoltenberg et al., 1998) emphasize, that although novice therapists are expected to function at Level 1 and more experienced therapists at Level 3, it would be erroneous to assume that all novices operate at Level 1 and all experienced therapists operate at Level 3, there is a certain amount of variability to be expected. Below is a summary of the model conceptualized by Stoltenberg in the early 1980's and further developed by him and his colleagues in their recently released book.

The Level 1 Therapist.

Motivation: Highly motivated

Highly anxious

Focused on skill acquisition

Autonomy: Highly dependent on supervisor

Need for structure

Requires positive feedback

Minimal direct confrontation

Awareness: Limited self-awareness

Highly self-occupied

Apprehensive of evaluation

Unaware of their strengths and weakness

Transition to Level 2

Motivation: May decrease for new approaches and techniques

Autonomy: Is likely to want more than they are ready for

Awareness: Movement toward client awareness and away from self-occupation

The Level 2 Therapist.

Motivation: Vacillating, highly confident at times

As complexity increase confidence is jarred

Bewilderment, despair, fluctuation

Autonomy: Conflict between dependency and autonomy

Assertively oriented toward own agenda

Movement toward independence

May only desire requested input from supervisor

Evasive at times

Awareness: Client focused

Increased ability to empathize

Sensitivity to client views increases

May become overly involved with their clients

Confusion is possible

Accomplishing balance my become problematic

Transition to Level 3

Motivation: Personalization of theoretical orientation

Autonomy: More situationally autonomous

Limitations become apparent

Awareness: Focuses on their reactions to the client

The Level 3 Therapist.

Motivation: Stable

Doubts are not crippling

Movement toward total professional identity

Autonomy: Firmly autonomous

Aware of when consultation is required

Takes responsibility

Awareness: Embraces strengths and weaknesses

Highly empathic and understanding

Focus is multifaceted (client, process, & self)

Comprehends how understanding him/her self translates to therapeutic behavior

Transition to Level 3i Therapist

Motivation: Strives for stable motivation across domains

Autonomy: Increases conceptually and behaviorally across domains

Solid professional identity across domains

Regulates impact of personal life on professional life

The authors reminds the supervisor that trainees may be at different levels of development in different domains.

The Supervisory Relationship

The therapeutic relationship between client and counselor has proven to be an essential ingredient in the outcome of psychotherapy (Beutler, Machado, & Neufeldt, 1994; Butler & Strupp, 1986; Loganbill, Hardy, & Delworth, 1982). Stoltenberg et al., (1998) claim that the supervisory relationship is the "base of all effective teaching and training" of psychotherapists (p. 110). The supervisory relationship encompasses various roles (teaching, mentoring, consultation and evaluation), contributes to self awareness of the supervisee, and is a time consuming endeavor. In fact, Efstation, Patton and Kardash (1990) present the supervisory relationship as a reciprocal process by which supervisors provoke and encourage the learning of the supervisee. Early theorists (Eckstien & Wallerstein, 1972; Mueller & Kell, 1972) propose that the supervisory

relationship develops and grows in stages. Beginning with development of trust and familiarity, and ending with issues of termination and conflict resolution within the supervision alliance. However, other authors (Stoltenberg, et al., 1998) suggest that overemphasis on conflict resolution is not always appropriate due to it's restriction to one level of development. Further research (Allen, et al., 1986; McNeill & Worthen, 1989; Mueller & Kell, 1972; Nelson, 1978; Worthington & Roehlke, 1979) has submitted that supervisees differ in their needs across developmental level. Needs reflect expected developmental issues that are most frequently encountered by the supervisee in their counseling experiences (intake skills → didactic training → self awareness → conceptualization skills → personal development → working within a connected theory → complex personal development issues → transference and countertransference → client and counselor resistance → defensiveness). Additionally, there seems to be common characteristics that define a good supervisory relationship. Much like what is found in the psychotherapy literature, a good supervisory relationship is trusting, accepting, understanding, warm, mutually respectful, and self disclosing (Nelson, 1978). Other research (Kennard, Stewart, & Gluck, 1987) has suggested that congruence in theoretical orientation between supervisor and trainee is an additional characteristic of a positive supervisory experience.

In order to understand the nature of the supervisory relationship, it is important to review the characteristics of counselors and supervisors within this

alliance. Krause and Allen (1988) surveyed doctoral supervisors and their doctoral students to empirically analyze the perception of supervisor behaviors. Supervisors perceived themselves as varying their behavior with trainees of different developmental levels in a manner consistent with Stoltenberg's (1981) model. However, trainees did not perceive these differences and suggested a more collegial, self-reflective, and mutually respectful interaction is what is needed for an effective working relationship. Nelson and Holloway (1992) used a classification scheme with supervisors and graduate student trainees to investigate the dimensions of power and involvement as they relate to trainee and supervisor gender. They found both male and female supervisors reinforced their female trainee's high-power messages with low-power and encouraged male trainees with high-power more so than their female counterparts. Female trainees were found to be significantly less likely to assume an expert role in response to supervisor low-power than were male trainees. Similarly, Robyak, Goodyear, and Prange (1987) studied the extent to which gender, amount of supervisory experience, and supervisory focus affect supervisor's preference for use of referent, expert, and legitimate power bases. They found that male, and less experienced supervisors, reported greater preference for the referent power base, while supervisors that focused on self-awareness preferred the expert power base. Schiavone and Jessell (1988) have also taken an interest in the effects of status and gender and examined it's effects on trainee's perceptions of the supervisory characteristic of expertness

and competence. They found that perceptions of expertness was not affected by any interaction of supervisor gender, trainee gender, or attributed to supervisor expertness.

Much of the characteristics of a good counselor-client working relationship can be extended to the supervisor-counselor working relationship. Bordin's (1983) suggestion that building a strong working alliance that is distinguished by trust and caring, could offset the tension associated with the differences (power, experience, knowledge, etc.) that exist in the counselor-client relationship. This is also true about the supervisory relationship. The essential components of the working alliance, according to Bordin (1979), is the collaboration between two people (supervisor and supervisee) based on goals, tasks, and the development of an attachment bond. Several recent studies (Kivlinghan & Shmitz, 1992; Tryon & Kane, 1993) on the relationship between working alliance and therapy outcome suggest that the faster and stronger the alliance grows, the greater the possibility for reports of positive outcomes to therapy. Allen et al's., (1986) investigation of trainee's perceptions of their best and worst supervisory experience has shed some light on what elements contribute to a positive supervisory experience. They found that quality supervision was best discriminated by perceived expertise and trustworthiness of the supervisor, duration of training, and an emphasis on personal growth issues. Additionally, they found that the more important discriminators of supervision expertise were the specific rating of "skill" and "reliability", which

contributed to the summary evaluation of trustworthiness. In fact, high scores on trainee performance scales (competence, professional attitude, counseling behavior, knowledge, and supervision attitude) have been positively correlated to ratings of supervisor expertness, attractiveness, and trustworthiness.

Efstation et al., (1990) have amended the Working Alliance Inventory (Horvath & Greenberg, 1989) and developed, what initially seems to be a reliable and valid instrument, the Supervisory Working Alliance Inventory (SWAI). Factor analysis results suggest that *Client Focus* (understanding the client), *Rapport* (harmony), and *Trainee Identification* with the supervisor are all interwoven in the essence of the supervisory working alliance. Further, a qualitative investigation by Worthen and McNeill (1996) reflects four distinct phases of supervision: The *Existential Baseline* (vacillating level of confidence and disillusionment), *Setting the Stage* (perceived need), *A Good Supervision Experience* (manifested empathy, unconditional positive regard, validation and affirmation, encouragement to explore) and *Outcomes of Good Supervision* (strengthened supervisory alliance, increased confidence, polished professional identity, therapeutic perception and ability to conceptualize and intervene). In summary, good supervisory experiences have been associated with previous positive supervisory experiences and less favorable supervisory experiences with previous negative supervisory relationship (Marziali, & Alexander, 1991; Worthen & McNeill, 1996). Several studies (Marziali, & Alexander, 1991; Worthen & McNeill, 1996) suggest surprising rates of ineffective supervision.

However, these authors also point to possible solutions that prioritize interpersonal aspects and expression of warmth, acceptance, understanding, respect, support, and empathy in supervisor development (Stoltenberg et al., 1998).

Supervisory Relationship as Applied to IDM. "In our view (Stoltenberg et al., 1998), hypothesized stages of the supervisory relationship put forth by pervious theorists applicable across all levels of training are somewhat problematic. ... Our developmental conceptualization of supervision suggests that therapists at varying levels bring different expectations to the supervisory relationship, based in part on previous such experiences" (p. 114). Therefore, the authors (Stoltenberg et al., 1998) of IDM suggest that counselors at different levels of development have different needs from the supervisors across domains. Following is a summary of the needs of therapists at each level of development.

Level 1

1. Due to high anxiety, Level 1 counselors will display limited self disclosure.
2. Communicate empathy and understanding of where they are at by disclosing the supervisor's own experience of becoming a therapist.
3. Provide validation and regard.
4. Be explicit concerning expectations in order to establish trust, support, and acceptance.
5. Acknowledge the inevitability of making mistakes.

Level 2

1. Possible conflict and stress in the relationship: Use personal disclosure and acknowledge strengths and weaknesses across domains in order to stabilize the relationship.
2. Expectations about supervision are present due to past supervisory relationship, therefore assess the counselor's perceptions.
3. Show respect and understanding of supervisee's developmental level.
4. Foster a sense of independence.
5. Be open to process personal issues of self awareness, defensiveness, transference and countertransference, and impasses in the supervisory relationship.

Level 3 or 3i

1. Assess impact of previous supervisory relationships.
2. Counselors at this level of development view good supervisory relationships as empathic, non judgmental, with encouragement to experience and explore. Normalized struggles are viewed as positive.
3. Establish an effective supervisory alliance characterized by a supportive and safe environment.
4. Attempt to increase insight of supervisee to the impact of interpersonal characteristics on the therapeutic process.
5. Establish a relationship characterized by mutual respect and collegial exploration.

6. Beware that damage to the supervisory relationship at this stage usually occurs by misassessment of developmental level and/or rigid techniques similarly applied to all levels of development which fail to attend to the needs of the level 3 counselor.

Summary

In view of the professional literature presented here, the supervisory process is a thought provoking and intriguing practice. The ethical and legal implications to this practice, although at times in conflict, are intended to promote the highest ideals and moral conduct by those providing supervision. In short, ethical principles of practice ensure an equal and safe environment in which to conduct supervision and psychotherapy. It has been argued by the authors in this review, that the practice of face-to-face supervisor-client contact can be beneficial in promoting the rights of all involved in the practice of psychotherapy and supervision. However, this practice has little empirical support. Only a few articles have actually reported on the effects of live supervision on the practice of supervision and psychotherapy. This study aims to examine the effects of this supervisory practice by analyzing the perceptions of the client, counselor, and supervisor. Additionally, this study will examine the effects of the supervisory process on the outcome of therapy as measured by several measures and instruments.

Method

Ellis, Ladany, Krengel, and Schult (1996) examined 144 studies in their critical review of the methodology of clinical supervision research from 1981 to 1993. In keeping with their suggestions, this study will be designed in such a way as to address potential threat from rival hypotheses, confounds (supervisee developmental level, supervision environment, and supervisor-supervisee working alliance), statistical power, cohort effects, and psychometrically sound measures. This supervision study is conducted in conjunction with The University of Oklahoma Counseling Psychology Clinic Research Program. The University of Oklahoma Counseling Psychology Clinic provides approximately 5000 hours of direct service per year for about 500 cases (individuals,couples, families) involving about 1000 individuals by utilizing 30-40 masters and doctoral level counselors-in-training and 6-8 faculty supervisors and 6-8 advanced doctoral student supervisors-in-training.

Design

This study is a 2 group (varying in supervision type) repeated measures design. Each supervision group consists of eleven counselor/client pairs. Each counselor was randomly assigned two clients for the purposes of this study. One client received face-to-face supervisory contact, the other received only audio-video supervision. Audio/Visual Supervision Group 1(AVS-1) served as the control/ supervision-as-usual group. Individual supervision was provided at the rate of one hour per week by using supervisor-counselor meetings, review of

case notes, and review of video tapes of the therapy session. Additionally, group supervision was conducted by a faculty supervisor at the rate of approximately two hours per week with the supervisee's cohorts. Just as with AVS-1, Audio/Visual Supervision Group 2 (AVS-2) was provided individual and group supervision using review of case notes and video tapes of therapy sessions. Additionally, AVS-2 was provided with in therapy face-to-face supervisor-client contact sometime between the 2nd and 5th session. Each group contained eleven (n = 11) individual adult clients who were in therapy with eleven first-year master students from the community counseling program at the University of Oklahoma. Client assignment to counselors followed a rotational pattern among eleven counselors that was modified based on scheduling contingencies. Assignment was not based on any other systematic considerations such as counselor skill or client diagnosis.

Supervision was provided by eight (n = 8) second-year doctoral students in Counseling Psychology at the University of Oklahoma. Supervisors had been pre-assigned counselors prior to the study based on faculty appraisals of the best matches in terms of personality, interests, experience, skill and scheduling contingencies. Finally, random assignment was used to place each supervisor-counselor-client triad to either the control or intervention group.

In order to avoid the confounds of counselor developmental level and working alliance, average scores from the Supervisee Levels Questionnaire-Revised (SLQ-R; McNeill et al., 1992) and the Supervisory Working Alliance

Inventory (SWAI; Efastation et al., 1990) were used to describe the subjects (counselors and supervisors) in the study. Table 1 below illustrates the design and number of clients and counselors-in-training assigned to each group.

Instruments

Supervisee Levels Questionnaire-Revised (SLQ-R; McNeill, Stoltenberg, & Romans, 1992). It has been noted that counselor development may influence psychotherapy outcome, and the counselor's and supervisor's assessment of supervision. Therefore, the SLQ-R will be used to describe the counselors who volunteered to participate in this study. The SLQ-R is a 47-item self-rated questionnaire used to assess Self-Other Awareness (24 items), Motivation (12

Table 1

Graph of the Repeated Measures Design

	CONTROL AVS-1 N=11	TREATMENT AVS-2 N=11
$COUNSELOR_1$	$CLIENT_{1.1}$ *	$CLIENT_{1.2}$ *
$COUNSELOR_2$	$CLIENT_{2.1}$ *	$CLIENT_{2.2}$ *
. . . .	. . . .	. . . .
$COUNSELOR_{11}$	$CLIENT_{11.1}$ *	$CLIENT_{11.2}$ *
	REPEATED MEASURES ↓	

* Repeated measures on the following measure:

1. Global Severity Scale (GSI) of the Brief Symptom Inventory (BSI)
2. 3 Subscales of the Counselor Rating Scale Form-Short (CRF-S)
3. Quality of Life Subscale and 4 separate items of the Client Evaluation of Counseling (ClientEC) and Supervision Question 2
4. 5 Subscales of the Counselor Evaluation of Counseling (CounselorEC) and Supervision Question 3, 4, 5 & 6

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items) and Dependency-Autonomy (13 items). Participants respond to items on a 7-point Likert scale with 1= never and 7 = always. Possible scores for Self-Other Awareness, Motivation, and Dependency-Autonomy are 24-168, 12-84, and 13-91 respectively. The authors report coefficient alpha on scores from 105 clinical and counseling graduate students for total, Self-Other Awareness, Motivation, and Dependency-Autonomy as .88, .83, .74, and .64 respectively (See Appendix D).

Supervisory Working Alliance Inventory (SWAI; Efastation et al., 1990). Conceptually based on the work of Greenson (1976), and Pepinsky and Patton (1971), the SWAI was developed to measure the relationship in counselor supervision. The SWAI has two versions, the Supervisor version (SWAI-S) and the Trainee version (SWAI-T). The SWAI-S consists of 3 factors: Client Focus (9 items), Rapport (7 items), and Identification (7 items). The SWAI-T consists of 2 factors: Rapport (12 items) and Client Focus (7 items). Both inventories are in a 7-point Likert response format (1 = almost never to 7 = almost always). Alpha coefficients for the SWAI-S were .71 for Client Focus, .73 for Rapport, and

.77 for Identification. Alpha coefficients for the SWAI-T were .90 for Rapport and .77 for Client Focus. Correlations observed between the SAWI and the Supervisory Style Inventory (SSI; Friedlander & Ward, 1984) scales offer some support for the convergent and divergent validity of the SWAI (See Appendix E). This scale will be used to describe the strength of working alliance in the supervisor-supervisee dyads.

Brief Symptom Inventory (BSI; Derogatis, 1993). The BSI is a short-self-report, multiphasic, 53 item, 5 point Likert-scale (0 = none existent to 4 = severe) symptom inventory used to assess nine areas (Somatic, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideations, and Psychoticism) of psychological interest. The instrument also presents three Global Indices: Global Severity Index (GSI), Positive Symptom Total (PST), and the Positive Symptom Distress Index (PSDI). The alpha coefficients for all nine dimensions of the BSI are very good, ranging from a low of .71 on the Psychoticism dimension to a high of .85 on Depression. Two week test-retest reliability coefficients, a test of consistency over time, range from .68 on Somatization to .91 on Phobic Anxiety. The Global Indices also reveal excellent stability coefficients ranging from .87 to .90. Independent studies of convergent and discriminant validity using the Minnesota Multiphasic Personality Inventory (MMPI; Dahlstrom, 1969), the Wiggins content scales of the MMPI (Wiggins, 1966) and the Tryon cluster scores Tyron, 1966) have demonstrated that the BSI is a highly valid instrument. One of the attractive

feature of this instrument is the short eight to ten minute administration time. The BSI has been used in repeated administrations with no practice effect reported. Additionally, several authors (Baider, Amikam, & DeNour, 1984; Thompson, Gallagher, & Breckenridge, 1987; Johnson & Thorn, 1989) report that the BSI has proven to be highly discriminating in the evaluation of both individual and group psychotherapy. The BSI will be used as one of the psychotherapy outcome measures .

Counselor Rating Form - Short (CRF-S; Corrigan & Schmidt, 1983). The CRF-S (Corrigan & Schmidt, 1983) is a shortened version of the Counselor Rating Scale (CRF; Barak & LaCrosse, 1975). The CRF was originally a 36 item questionnaire which measured three social influence attributes - attractiveness, expertness, and trustworthiness (12 items each). Corrigan and Schmidt (1983) reduced the CRF to a 12 item (4 items each), seven point Likert, bipolar scale. Reported reliabilities (.89-.93, .85-.94, .82-.91) exceeded those of the CRF for the attractiveness, expertness, and trustworthiness scales. The CRF-S was used as one of the measures for client assessment of the counselor (See Appendix A).

Client's Evaluation of Counseling (ClientEC). The ClientEC is a questionnaire that was developed by Terry M. Pace, Ph.D. (1997) with the intent of measuring client's perceptions of their counselor, the counseling process, and the problems presented in counseling. Questions address the present situation with work/employment, school/education, family and intimate relationships,

social and recreational, physical health, self-image and overall satisfaction with life. The questionnaire seeks to assess the severity of the presenting problems, motivation for change, attitude toward counseling, and satisfaction with the clinic service. Finally, the ClientEC addresses the client's assessment of the counselor's caring, understanding, trustworthiness, communication skills, expertise, commitment to help, and overall satisfaction with the counselor. The ClientEC has a total of 26 items, most of which are rated on a seven-point Likert scale. Higher scores on all the items indicate a more desirable answer. However, item 10 may be misleading. Item 10 asks the client to assess their level of distress, difficulty, or uncomfortableness. One might think that a higher score on this items would indicate more distress, but to keep this item consistent with other item, low scores represent a less favorable response while higher scores symbolize more promising responses. One week test-retest item reliability coefficients range from .36 to .97 with a Quality of Life (a subscale of this instrument) coefficient of .76. The alpha coefficient for the instrument was .91. Items 9, 13, 14, 16. 17, 18, 26, and 27 are responded to in a short answer format. The following questions were be added to the ClientEC and are responded to on a seven point Likert scale (1 = none to 7 very significant (See Appendix B)).

Supervision Question 1. You are aware that your counselor is being supervised. How important is it to you for your counselor to be receiving supervision?

Supervision Question 2. How much impact do you believe that supervision has

had on your progress in counseling?

Counselor's Evaluation of the Client (CounselorEC). This questionnaire was developed by Terry M. Pace, Ph.D. (1997) to allow the counselor to provide information as to the format, theoretical approaches, the process of counseling, and his/her perception of the client. Questions about the process of counseling and perceptions of the client generally parallel these sections on the ClientEC. The CounselorEC includes 19 items most of which are scored on a seven-point Likert scale with lower scores indicating less favorable responses and higher scores representing the more favorable response. This measure includes five subscales: Process Information, Client Problem, Client Motivation, Client Functioning, and Counseling Outcome. One week test-retest item reliability coefficients range from .32 to .97 with an instrument alpha coefficient of .89. The following questions regarding supervision were added to the CounselorEC and are responded to on a seven point Likert scale (1 = none to 7 = very significant)(See Appendix C).

Supervision Question 3. How much do you believe supervision has impacted client change with this client?

Supervision Question 4. How much impact has supervision had on the counseling process?

Supervision Question 5. How much impact has supervision had on your professional development with this client?

Supervision Question 6. How much impact has supervision had on your ethical

conduct with this client?

Supervisor Questionnaire. The Supervisor Questionnaire is a seven question instrument developed for the use of this study. This instrument was developed to gather information from each supervisor which would aid in differentiating the two supervisory experiences (face-to-face supervisor client contact (AVS-2) and audio-visual supervision (AVS-1) along several domains. The supervisor is asked to answer the same seven questions for each supervisory condition. The first seven questions ask the supervisor to answer the questions as they pertain to their face-to-face supervisor-client contact experience and the second seven questions are answered for the audio-visual-only supervisory process. Each question is answered on a seven point Likert scale (1 = NOT MUCH - 7 = VERY MUCH)(Appendix G).

Procedures

The eleven volunteer therapists completed the SLQ-R (McNeill et al., 1992) and the SAWI (Efastation et al., 1990) at the third and sixteenth week of the fall semester. It has been suggested that novice counselors may lack the insight to provide an accurate self report on the SLQ-R. Therefore, supervisors simultaneously completed the SLQ-R on each supervisee in order to provide a check and balance measure on the counselor's SLQ-Rs. As supervisees were assigned clients, their clients were asked to complete an informed consent form, a demographic intake form, two instruments (CRF-S & ClientEC) to assess several aspects of the counseling process (the strength of the client-counselor

relationship, the severity of and clients ability to cope with presenting problems, counselor ability and effectiveness) and one instrument to measure present symptoms and symptom severity (BSI). The entire packet of instruments required between ten to fifteen minutes for completion. The counselors were asked to complete the CounselorEC. This battery of instruments and scales (both the clients' and the counselors') were completed after the first and fifth session (face-to-face supervisor meeting with the clients took place between the first and the fifth session). Additionally, the supervisors completed the Supervisor Questionnaire at the end of the semester. The entire process was accomplished in the Fall semester, the first semester of community counseling practicum for the counselors and the first semester of the supervision practicum for the supervisors.

Procedures for the AVS-2. At sometime between the second and fifth session, during what is traditionally the assessment period, the supervisor made face-to-face contact with the client during a regular psychotherapy session. During the face-to-face encounter the supervisor spent five to fifteen minutes introducing themselves to the client, doing a verbal assessment of the status of the client's presenting problem, and discussing the progress of psychotherapy. The following is an example of how this dialogue typically proceeds.

Supervisor: Hi, my name is Jon Smith and I am Darlene's supervisor. The purpose of this visit Joe, is to introduce myself to you so that you get to meet your counselor's supervisor and to check on how you

are doing. Darlene tells me that you came in presenting some depressive symptoms (i.e. blue moods, problems sleeping, problems eating). How are you feeling today?

Client: Client's respond: "Well Mr. Smith ..."

Supervisor: It sounds like things are somewhat better and that things are working fine between you and Darlene. Let me try to explain to you how Darlene and I work in order to provide you with the best care possible. Darlene and I meet once a week to discuss all of her cases. Additionally, Darlene, her classmates, and I all meet together weekly. Each counselor is given the opportunity to present their clients to the rest of the class. All this is done in order to provide you with the best, most comprehensive treatment available at our clinic. Darlene and I also put together a treatment plan. That is to say, we try to figure out how best to help you deal with your problems. In an attempt to develop a time table and establish goals for therapy, we will also speculate as to the course and progress of your treatment. This process not only helps us as your treatment team but as we present and discuss this plan with you, you become part of the treatment team for your own care. We want to hear how you feel about our ideas and approaches to your care. After all, it is your mental health which we are planning for. How do you feel about the process that I just described to you?

Client: (The client may respond in variety of ways.)

Supervisor: Do you have any questions or concerns that you would like to discuss with me? Well, I just wanted to meet you and give you the opportunity to meet Darlene's supervisor and air any questions and concerns you may have. I'll leave you both to continue with your therapy and say that it was a pleasure to meet you and wish you success in your therapy.

Participants

Counselors. Participants are eleven first-year masters level students from the University of Oklahoma Community Counseling program, participating in the first semester of community counseling practicum. Demographically, counselor were of an average age of 25, two of which are male, two Native Americans with the balance being female and Caucasian. Thirty-three percent were married and the remainder reported never having been married. Counselors averaged less than 1.5 years of counseling experience and are from a wide range of theoretical orientations.

The results of the SLQ-R are provided in Table 2 (Appendix H, page 104). The descriptive statistics for the SLQ-R by supervisee level provided by McNeill et al. (1992) is the only normative data available and was used to give insight into the scores on the SLQ-R collected on these counselor. The first data collection (at the beginning of the semester) produced means below the 95% confidence interval for Self and Other Awareness and Dependency-Autonomy of

the Beginning Level (Level 1). Although extremely close to the lower end of the 95% confidence interval, Motivation was within the 95% confidence interval for the Beginning Level. At the second data collection, at the end of the semester, SLQ-R scores were all within the 95% confidence interval of the Beginning Level (Level 1). It can be said that by the end of the semester the mean score for this sample of counselors are those expected from Level 1 counselors.

The results of the SWAI-T are provided in Table 3 (Appendix H, page 105). The descriptive statistics for the SWAI-T provided by Efstation et al. (1990) is the only normative data available and was used to give insight into the scores on the SWAI-T collected on the counselor. The first data collection (at the beginning of the semester) produced means within one standard deviation above the mean. However, the mean was just 0.03 below the upper limit of the one standard deviation above the mean. At the second data collection, at the end of the semester, means were all greater than one standard deviation above the mean. The sample used by Efstation et al. (1990) were advanced practicum and intern students in both counseling and clinical psychology programs being supervised by doctoral level psychologists.

Clients. Clientele at The University of Oklahoma Counseling Psychology Clinic include adults (60%), adolescents(20%), and children (20%). Forty percent of the sessions are individual, 20% are couples, 20% families, and 20% are a combination. Axis I diagnoses range from mood disorders to thought disorders with 30-40% carrying an Axis II diagnosis. Sixty percent of the clients

are from the surrounding metropolitan area, 20% are from smaller rural surrounding communities, and 20% are university students and staff. Approximately 60% are working-uninsured clients, 20% working-insured clients, and 20% are unemployed-uninsured clients. The Program operates on a sliding scale fee schedule ranging from $10-55 per session based on gross family income (average fee is $7 and the modal fee is $10).

The twenty-two clients assigned to eleven counselors each for the purpose of this study were subsequently randomly assigned to one of the two groups comprising this study. The Control Group AVS-1 was composed of eleven clients as follows. There were 5 men and 6 women averaging 34.6 years of age having achieved an educational level of approximately 15 years. Thirty-Six percent of this group were married, 46% divorced and 18% single. In accordance with the design all clients were in individual therapy presenting with Axis I diagnosis of anxiety, adjustment disorder, relational problems and mood disorder. None of the clients were diagnosed with a personality disorder or mental retardation. The average Global Assessment of Functioning (GAF) was 63.

The experimental group, AVS-2, also consisted of eleven clients, 5 men and 6 women averaging 30.2 years of age and having an educational level of approximately 16 years. Twenty-Seven percent of the group were married, 55% divorced, and 18% single. They presented with similar diagnoses as AVS-1 but with a slightly higher GAF of 70. A significant difference in educational level

between the groups was noted ($F(1, 20) = 5.20$, $MSE = 16.41$, Sig. of $F = 0.03$). See Table 4 (Appendix H, page 106) and 5 (Appendix H, page 107).

Supervisors. Supervision was provided by eight second-year doctoral students as part of their first semester of the supervision practicum. Demographically, they are portrayed as being approximately 30 years of age, one being male, one is Native American while the balance is female and Caucasian (43% were married and 43% single). Collectively, they average approximately 18 years of education, 3 years of counseling experience and have a variety of theoretical orientations. Each supervisor was asked to complete the supervisor's portion of the SWAI and the results are reported in Table 6 (Appendix H, page 108). Using Efstation et al's. (1990) instrument development study as normative data, the results show that the sample of supervisors used in this study were within a standard deviation of the means provided on the first data collection and exceeded one standard deviation above the mean on Rapport and Identification on the second data collection. It is important to note that the supervisors reported a significant gain in supervisory working alliance between the first and second data collection on Client Focus and Identification. The means and standard deviations which were used as normative data were provided by doctoral level psychologists as they were working with advanced interns and practicum students.

Hypotheses

Several articles (Kivlighan, et al., 1991; Steinhelber, et al., 1984) which dealt directly with live supervision and the impact of supervision on client change facilitated the formation of these hypotheses. Although, not consistent in their findings, both articles seem to suggest that when clients are asked direct questions about the impact of supervision on the outcome of counseling significant differences were noted. However, less direct measures, such as instruments that measure symptom reduction, where unable to detect differences. These implications were used as the foundation for the formation of the hypotheses.

H_{01}: There will be no significant differences between groups on therapy outcome measures: Global Severity Index (GSI) of the Brief Symptom Inventory (BSI), the 3 subscles of theCounselor Rating Form - Short (CRF-S), the Quality of Life Subscale and 4 separate items of the Client's Evaluation of Counseling (ClientEC), and the 5 subscales of the Counselor's Evaluation of the Client (CounselorEC).

H_1: There will be a significant difference between the groups on client and counselor's (perception) evaluation of the impact of supervision on the outcome of therapy. The Audio/Visual Supervisory Group 2 will have significantly higher scores on questions (Supervision Questions 2, 3 & 4) pertaining to the impact of supervision on therapy outcome than Audio/Visual Supervisory Group 1.

H_2: There will be a significant difference between groups on the counselor's evaluation of the impact of supervision on their development and training. Audio/Visual Supervisory Group 2 will have significantly higher scores on the questions (Supervision Question 5 & 6) pertaining to the impact of the supervisory process on the development of the counselors.

H_3: There will be a significant difference between groups on the supervisor's evaluation of the impact of supervision on client change and counselor and supervisor development. Audio/Visual Supervisory Group 2 will have significantly higher scores on all the questions on the Supervisor Questionnaire (Appendix F).

Results

Ellis et al. (1996) suggests that in order to control for escalating Type I and Type II error many investigators have used a combination of methods (i.e. Bonferroni adjusted alpha levels, multivariate analysis, planned comparisons, and a priori power analysis). A power analysis for the interaction effect, wanting to detect a medium effect size, was computed using a $df_{num} = 5$, $df_{demon} = 66$, $\alpha = .05$, $n = 34$, and $\phi = 1.47$. This priori power analysis approximated .80. However, a reduction in the expected incoming Masters class, from 17 to 13, and two Masters students who did participate in the study, decreased the n to 22. Therefore, in order to achieve power for the interaction effect approximating .80, it was necessary to settle for the detection of a large effect size ($\omega^2 = .14$).

H_{01}: Outcome Measures

All the data used for these analysis were gathered in the fall semester of the first year of Masters level community counseling practicum and the first semester of the second year of doctoral level supervision practicum. The analysis reported in this section were conducted with the aid of SPSS+ Graduate Statistical Package (Norusis, 1994). This study examines many variables which are thought to be influenced by the practice of face-to-face supervisory-client contact. A statistical description of each variable is provided in Table 7 (Appendix H, page 109) by furnishing the mean and standard deviation by group and by data collection session. It is noteworthy to report that, with the exception of the clients' report of their motivation in counseling,

whose mean decreased from the first to the second collection for both groups, all other variables seem to show improvement. However, these are but trends in the data and establish no statistically significant differences nor do they address the hypotheses of focus in this study. In order to answer the questions delineated in the null hypotheses a repeated measures ANOVA on the GSI scores and MANOVAs on the CRF-S, ClientEC, and CounselorEC were performed. None of the analysis showed any significant differences between the control (AVS-1) and the treatment (AVS-2) group (GSI: $F(1, 20) = 0.31$, $MSE = 0.02$, $p > 0.05$; CRF-S: Pillais $F(6, 15) = 2.71$, $p > 0.05$; ClientEC: Pillais $F(10, 11) = 1.20$, $p > 0.05$; CounselorEC: Pillais $F(10, 11) = 2.08$, $p > 0.05$).

H_1: Impact of Supervision on Therapy as Reported by the Client and Counselor

Descriptive statistics for three supervision questions (2,3, & 4) are provided in Table 8 (Appendix H, page 110). A MANOVA was performed on all three questions. This analysis showed a significant difference (Pillais $F(6, 15) = 7.23$, $p \leq 0.05$) and subsequently three univariate repeated measures ANOVAs were performed. As shown in Table 9 (Appendix H, page 111), only one of the three repeated measures ANOVAs returned a significant difference between groups. Clients who experienced face-to-face supervisor-client contact (AVS-2) reported that supervision had a significantly ($F(1, 20) = 22.50$, $MSE = 16.57$, $p \leq 0.05$) stronger impact on counseling than did clients who had no contact with their counselor's supervisor (AVS-1).

H_2: Impact of Supervision on the Development and Ethical Practice of the

Counselor as Perceived by the Counselors

Descriptive statistics are provided for the two additional supervisory questions in Table 10 (Appendix H, page 112). A MANOVA was computed and it concluded that there was no significant differences (Pillais $F(4, 17) = 0.28$, $p > 0.05$) between groups in regards to the impact of supervision on the professional development of the counselors and their ethical conduct in counseling. That is to say, counselors perceived that, although they thought supervision was an important factor on their development and ethical practice overall, face-to-face supervisor client contact did not have an additional benefit to their development and ethical practice.

H_3: The Supervisor's Questionnaire

The Supervisor's Questionnaire is a seven item instrument which asks the supervisor to compare both modalities of supervision (AVS-1 and AVS-2). Table 11 (Appendix H, page 113) provides descriptive statistics for each of the questions by supervisory experience (AVS-1 and AVS-2). The MANOVA yielded significant differences (Pillais $F(7, 8) = 4.32$, $p \leq 0.05$) between groups. Subsequent univariate repeated measures ANOVAs were performed on each question and the results are reported in Table 12 (Appendix H, page 114 & 115). As noted in Table 12, three significant differences between groups were discovered. Supervisors reported that they were significantly ($F(1, 7) = 23.62$, $MSE = 90.25$, $p \leq 0.05$) better able to provide information to the client as to their role in treatment planning and supervision when they were able to meet with the

client. Question four, which asks the supervisor to respond to which supervisor experience best allowed them to fulfill their ethical responsibilities, showed a significant difference ($F(1, 7) = 7.00$, $MSE = 1.00$, $p \leq 0.05$) between groups. Additionally, supervisor reported that they believed that meeting with the client would have a significantly greater ($F(1, 7) = 7.00$, $MSE = 1.00$, $p \leq 0.05$) impact on client change than if they never met with the client.

Collapsed Groups

Analysis were performed on variables to determine if an overall, both groups collapsed into one sample, displayed significant changes between the first data collection (1st session) and the second data collection (5th session). Table 13 (Appendix H, page 116) and 14 (Appendix H, page 117) shows the means and standard deviations for all variables. Table 15 (Appendix H, page 118) illustrates the results of Multivariate ANOVAs on all groups of variables. No significant differences were noted between the first and second data collection. However, Univariate ANOVAs computed on variables which were noted grouped for analysis, GSI ($F(1, 21)$, $MSE = 0.36$, $F \leq 0.05$) and Supervision Question 2 ($F(1, 21)$, $MSE = 14.20$, $F \leq 0.01$), did note a significant difference between data collections. This result suggest that the entire group did experience a significant reduction in symptom severity from the first session to the fifth session. Additionally, clients claimed that supervision had a greater impact on therapy by the fifth session when compared to the responses they gave at the first session.

Discussion

The Findings

This study examines the effects or impact of face-to-face client-supervisor contact on therapy outcome, and perception of impact by the client, therapist and supervisor. The results suggest that there are no negative consequences from the supervisor's visit with the client, in fact, in regards to the perceptions of the client and the supervisor, the ethical practice of face-to-face supervisor-client meeting seems to have a positive impact. The findings show that, although the clients that experienced face-to-face supervisory-client contact perceived supervision to have a greater impact on the outcome of therapy (H_1 was substantiated), analysis of the measures of symptom reduction did not detect a significant difference between groups (H_{01} was substantiated). What this seems to imply is that, although clients in the treatment group feel or perceive supervision to be positively impacting the outcome of therapy, it is not. It is important to add, that clients did show symptom reduction, however the groups did not vary significantly to detect a significant difference.

Although, counselors did not report a significant difference between groups on their account of the impact of supervision on various variables (H_2 was not substantiated), supervisors did see several differences between the cases on which they met the client personally and those which they only observed via recordings (H_3 was substantiated). Supervisors perceived that they were better able to inform the client of their role in treatment planning,

monitor ethical conduct, and influence client change. As with the client, the supervisor's perception of their influence on client change did not find support in measures of symptom reduction. However, one of the limitations of this study is the inability to report on the long term effects of face-to-face supervisor-client contact due to early client termination. This limitation, along with others, will be discussed later. What is significant however, is that the supervisors felt that informed consent and ethical practice were best fulfilled when they met with the client.

Implications of the Findings

With the findings in hand, many ethical concerns still remain to be considered. First, is the supervisors' responsibility to monitor the clients in such a way as to fulfill their responsibility to the clients, their trainees, and then upward to the institution they works for and finally to themselves and the psychological profession as a whole. As was discussed earlier, the ethical principle of *respondeant superior* (Let the Master respond) places the burden on the supervisor to insure proper and ethical care is being provided to the client and the trainee. Although, the counselor/therapist, since he or she is actually conducting the therapy, also carries the responsibility for the client's care, the supervisor seems to be responsible at a higher level. If the counselor/therapist is carrying out the treatment plan which, he or she and the supervisor, in collaboration, both determined to be that which is indicated to treat the presenting problem, then *respondeant superior* would suggest that the

supervisor, usually more experienced and knowledgeable, would carry the heavier burden of responsibility in this dyad. However, some would point out that this should only be true if the counselor/therapist has fulfilled the criteria for proving vicarious liability. According to Knapp (1984), first the supervisee must voluntarily agree to work under the direction and control of the supervisor and act in ways that benefit the supervisor. Secondly, the supervisee must have acted within the defined scope of tasks permitted by the supervisor and finally, the supervisor must have the power to control and direct the supervisee's work. However, under usual circumstances, neither the supervisor nor the counselor/therapist have entered into such a formal agreement. In most settings, formal agreements of this sort are rarely made. Most often the reason for this is deeply grounded in the principle of autonomy. The principle of *respondeant superior*, and particularly the criteria to establish vicarious liability, seem to be in conflict with the principle of autonomy. However, remembering the earlier discussion on this topic, the autonomous person is described as having responsibility for one's own behavior and having the freedom to choose as long as that choice does not interfere with the rights of others (Stoltenberg et al., 1998). Still others (McCarthy et al., 1994; Sherry, 1991) would focus on the counselor/therapist's right to adopt their own theoretical perspective and techniques in therapy. The conflict lies with who's rights should be emphasized and under what circumstances. The right of the supervisor to protect themselves against vicarious liability by becoming a more integral part of the counseling process or imposing their own counseling techniques, verses the

rights of the counselor to autonomy. The psychological profession has tackled such ethical dilemma in the conflict between *beneficence* and *nonmaleficence* as it pertains to the rights of the client to have the best therapist (more experienced and more education) available and the rights of the trainee to have adequate counseling experiences by emphasizing the use of informed consent and realizing the importance of training for the future of the profession. However, the conflict between the supervisors' rights and the trainees' rights have received little attention. How do we go about solving or addressing what seems to be a conflict over whose rights are more important? I would suggest that what is most important is trying to establish a collaborative set (supervisor-trainee) which would consider and protect the rights and interests of all involved. Several psychological theories (i.e., Cognitive-Behavioral) have pointed to the importance of forming a collaborative set between the counselor and the client in order to reduce the differential of power and create an atmosphere of collaboration to achieve goals established in counseling. It may be equally as important to begin to view the person presenting themselves for treatment, not as the counselor/therapist's client, but as "our" (profession-institution-supervisor-counselor) client and creating the "Consolidated Collaborative Set". Implying that the supervisor and the trainee, acting as agents for the Consolidated Collaborative Set, have the responsibility to care for this client and join with the client in an effort to meet the goals of the entire Set including those of the supervisor and trainee, as well as the goals established in therapy. Where before supervision may have been seen as a method of helping mature the

counselor/therapist through different levels of development, the "Consolidated Collaborative Set's" perspective would equally emphasize the rights of all involved and work to protect those interests. Such an approach requires that all involved operate in a fashion characterized by fidelity and justice.

As noted in the discussion of IDM, the counselor/therapist would seem to be more likely to be open or accepting of such an approach at levels of development in which autonomy and self-other awareness are ripe. However, I would suggest that, once we have acknowledged the importance of the Consolidated Collaborative Set in addressing and incorporating the rights of all involved (society-profession-institution-supervisor-counselor-client-society) in the treatment of the presenting problem, creating an atmosphere were sensitivity and awareness of the importance of the agenda of all involved is beneficial and appropriate at any level of counselor development. Further, I believe that, although counselor development may be an important factor in creating and implementing the Consolidated Collaborative Set, more important is the supervisors' development. Stoltenberg et al. (1998) dedicates an entire chapter to supervisor development and training which has proven helpful in understanding supervisor development and how it may apply to the building of the Consolidated Collaborative Set. Similar to counselor development, Stoltenberg, et al. (1998) describes supervisor development along the same constructs (motivation, autonomy, and awareness) and following similar patterns of levels of development as they did for counselor development. It is apparent that, if a supervisor and trainee both possessed characteristics of autonomy and

awareness similar to those suggested for level 3, the process of creating the Consolidated Collaborative Set would be much easier. However, in describing the level 1 supervisor, Stoltenberg et al. (1998) say that supervisors at this level "depend heavily on their perceptions of their own recent or current supervisors or their recollections of how they have been supervised in the past..." (p. 160). Following this trend of thought, a trainee supervised in a Consolidated Collaborative Set approach would be more likely to conduct supervision from a similar perspective. I am suggesting that the Consolidated Collaborative Set approach may be implemented for counselors at any developmental level by supervisors at all developmental levels. The Consolidated Collaborative Set is not a level of development that is achieved. It may be seen as the underpinning of how one conducts supervision. It's understanding and integration into the practice of psychotherapy and supervision should parallel developmental levels. If this Consolidated Collaborative Set is established, it may prove to be helpful in the ethical conduct of supervision and demystifying the process of face-to-face supervisor-client contact.

If indeed the Consolidated Collaborative Set approach is accepted and acknowledgment is made that face-to-face supervisor-client contact is necessary, beneficial, and appropriate in some case, how one chooses which clients to visit requires further discussion. As noted in the Introduction Section, Cormier and Bernard (1982) cite the American Personnel and Guidance Association (1981) to impress that all clients have the right to be informed (informed consent) of any factor that may influence the counselor-client

relationship (i.e., taping, observation, supervision, etc.). They further suggest that the client may be best served by meeting the supervisor during the initial stages of therapy in order for the supervisor to provide information about the supervisor's role in the supervisor-counselor-client relationship and to ensure that misrepresentation of the setting or the circumstances under which counseling is being conducted does not occur. If for no other reason than to best fulfill the responsibility of informed consent, face-to-face supervisor-client contact deserves consideration. Additionally, meeting clients face-to-face can give the supervisor supplementary information about the client and case management. The literature (Slovenko, 1980; Van Hoose & Kottler, 1985) has repeatedly warned supervisors that failure to properly supervise a counselor with a disturbed client is one of the leading causes of psychological malpractice suits. In fact, Slovenko's (1980) commentary of the famous Tarasoff case, suggest that the supervisor may have avoided liability if he had only met with the client and assessed the threat. So it is imperative to all that are involved in the care of the client (society-profession-institution-supervisor-counselor-client-society) for the supervisor, often as the most experienced person of the Consolidated Collaborative Set, to take an active part in protecting all involved and personally assess the client that is threatening to hurt themselves (suicidal or parasuicidal) or others (homicidal or injurious).

However, which other clients should be visited? If the supervisor did not have to compromise time for other important things, one would agree that all would be best served and informed consent would best be fulfilled by visiting

every client. Since practicality suggests otherwise, here are some things to consider. The Consolidated Collaborative Set should function in such a way as to illuminate the cases which would benefit from the supervisor meeting the client in therapy. If for example the counselor was having difficulty assessing the presenting problem or seems unable to overcome a certain impasse in therapy, hypothetically a supervisory visit may prove to be the variable which helps the progression of therapy. However, due to the limitations mentioned earlier (was not able to collect data after the fifth session due to termination rate), the study was unable to determine if indeed supervisor-client contact has long-term effects on client change. Random selection of the cases may be another consideration for determining which clients to involved in supervisor-client contact. If all clients seem to be doing well and therapy is progressing as expected, it may be advisable to randomly select clients from the counselor's client list to visit and become further acquainted with each case. In summary, this study has helped in coming to several conclusions about the practice of supervisor-client contact and the conduct of supervision as a whole. This study did not provide evidence that suggest that supervisor-client contact has any positive impact on client change or that symptom reduction has taken place as a result of this practice. But what it is suggested is, that supervisor-client contact may be practiced without fear that it will hurt, damage or interfere with the client progress, counselor or supervisor development, or the counseling process in a negative way. This study then, should allow us to discuss the ethical practice of supervision in a less restrictive way (without the glooming question of are we

doing harm by the process).

Future research should attempt to address questions of the long-term implications of face-to-face supervisor-client contact. The counselor population that was used for this study were first year Master students and special consideration had to be given in the assignment of clients. This sample of counselors are usually assigned relatively straight forward, non-complicated cases which are fitting for their developmental level. These clients seem to have completed counseling in a relatively short period of time and therefore effects after the fifth session were not available. Future research should focus on other population of counselors, supervisors and clients to investigate the generalizability of the findings and explore the long-term implications of face-to-face supervisor-client contact.

Limitations

This study has limited generalizability. This study was designed with trainees in an academic/university counseling center setting. Therefore, the results of this study should not be generalized to non-student populations or settings other than university counseling centers. Additionally, generalization to other university settings should be done with caution. The reader should take care to analyze the demographics of clientele, counselors and supervisors carefully before applying the results of this study to other university settings. Efforts have been made to address confounds which the literature presents (working alliance, supervisory environment, and counselor developmental level) by collecting data which allowed us to best describe each population along

these variables. However, it is possible that in spite of these efforts, the differences between groups may be due to other unforeseen confounds. For example, the literature fails to address supervisor development as a possible root of differences within the supervisory relationship (no instrument exists which measures supervisor development). As one can imagine, supervisor development not only presents a serious concern as to how it effects the process of supervision but it's interaction with counselor development may be far reaching. Other limitations need to be considered. The subject pool at any University TrainingClinic is limited. When conducting the power analysis, it became evident that a choice needed to be made between effect size and power. The limited number of trainees and supervisors forced the use of a high effect size. Therefore, the situation may present itself where a small or medium effect size will not be detected. The results will be conservative and unable to detect significant but small to medium effects.

Counselors and supervisors were all students. This situation may be typical in university training centers but not elsewhere. Both counselor and supervisor are novice practitioners and therefore results may vary with more experienced participants. Although, IDM is the theoretical orientation of choice at the University of Oklahoma, no measure of the variables that define the process of supervision were collected. Although all supervisor were in the same supervision course and mentored by the same instructor, no measurement of what happened in weekly supervision session was taken. Additionally, many aspects of the supervisory process were not studied, including the content of

what the supervisor and trainee actually do and think and feel when they get together, and how all that effects the training and learning of psychotherapy in general.

Conclusions

The practice of face-to-face supervisory client contact has been discussed in the professional literature as a useful practice to aid in the reduction of vicarious liability and best fulfilling various ethical responsibilities. Several concerns were evident. Does face-to-face supervisory client meetings have any additional benefit than the ones mentioned above? Do the benefits justify the time consumption of this practice? Are there any negative effects of the supervisor entering the counseling process in vivo? All these concerns have been statistically examine and arguments can be made that the practice of face-to-face supervisor-client contact, not only is void of posing threats to the counseling process, the counselor, supervisor, and client but, provides benefit to the clients' and supervisors' perception of supervision. If one accepts that this practice of supervision - the supervisor actually taking the time, putting forth extra effect and demonstrating a caring attitude to the client - may be perceived as lending quality to the psychotherapeutic process, then these findings are consistent with Steinhelber et al's., (1984) assumption that it is the qualitative properties of supervision that may have a perceived effect on client change. Although one would suspect, as Kivilighan et al. (1991) did, that having a supervisor enter the room would have a negative effect both on the client's and therapist's evaluation of the session, consistent with their findings, this study

found no evidence that this is so. In fact, this study support Kivilighan et al's., (1991) finding that the clients' evaluation of the impact of supervision was enhanced by this practice.

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Appendices

Counselor Rating Form-Short (CRF-S)

Client Name _____ Date _____
Counselor's Name _____

Below are characteristics underscored by a seven-point scale that ranges from "not very" to "very." Please indicate you rating by placing an "X" at the point on the scale that best describes how you currently view your counselor. For example:

FUNNY
Not Very x : : : : : : Very
1 2 3 4 5 6 7

WELL DRESSED
Not Very : : : : : x : Very
1 2 3 4 5 6 7

The above rating indicates that while the therapist did not joke, she/he is well dressed. All the characteristics to be rated are positive, however, it is assumed that therapists differ in their strengths. We are interested in how you view these differences.

1. **HONEST**
Not Very : : : : : : Very
1 2 3 4 5 6 7

2. **FRIENDLY**
Not Very : : : : : : Very
1 2 3 4 5 6 7

3. **EXPERIENCED**
Not Very : : : : : : Very
1 2 3 4 5 6 7

4. **RELIABLE**
Not Very : : : : : : Very
1 2 3 4 5 6 7

5. **LIKEABLE**
Not Very : : : : : : Very
1 2 3 4 5 6 7

6. **EXPERT**
Not Very : : : : : : Very
1 2 3 4 5 6 7

7. **SINCERE**
Not Very : : : : : : Very
1 2 3 4 5 6 7

8. **SOCIABLE**
Not Very : : : : : : Very
1 2 3 4 5 6 7

9. **PREPARED**
Not Very : : : : : : Very
1 2 3 4 5 6 7

10. **TRUSTWORTHY**
Not Very : : : : : : Very
1 2 3 4 5 6 7

11. **WARM**
Not Very : : : : : : Very
1 2 3 4 5 6 7

12. **SKILLFUL**
Not Very : : : : : : Very
1 2 3 4 5 6 7

CLIENTS EVALUATION OF COUNSELING - ADULT FORM

Answer all questions based on how you have been feeling the past week, including today. Please answer each of these questions as honestly and completely as you can. Remember that this information is confidential. These questions should take you only a short time to complete and are very important to us. Please ask your counselor or the secretary if you have questions. When you have finished please turn the forms in to the secretary before you leave the clinic today.
Thank you.

Name:_____ Age:_____ Gender: _____

Last Four Digits of Your Social Security Number: _____ Today's Date:_____

How many appointments have you had with your current counselor: _____

Name of your counselor. _____

1. How is your work or employment situation right now?

TERRIBLE _____ GREAT
1 2 3 4 5 6 7

2. How is your school or educational situation right now?

TERRIBLE _____ GREAT
1 2 3 4 5 6 7

3. How are your family relationships right now?

TERRIBLE _____ GREAT
1 2 3 4 5 6 7

4. How is (are) your romantic, marital o intimate relationship(s) right now?

TERRIBLE _____ GREAT
1 2 3 4 5 6 7

5. How is your social and recreational life right now?

TERRIBLE _____ GREAT
1 2 3 4 5 6 7

6. How is your physical health right now?

TERRIBLE _____ GREAT
1 2 3 4 5 6 7

7. How is your self-image, self-confidence, and self-esteem right now?

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

8. Overall, how satisfied are you with your life right now?

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

9. What is the most important problem you are working on or wanting to work on in counseling?

_____

_____

_____

10. How distressing, difficult or uncomfortable is this problem for you right now?

VERY _____ NOT AT ALL

1 2 3 4 5 6 7

11. How motivated or committed are you to work on your problems and make positive changes in your life right now?

NOT AT ALL _____ VERY MOTIVATED

1 2 3 4 5 6 7

12. Overall, how much do you feel that counseling has helped you at this time?

NOT AT ALL _____ VERY MUCH

1 2 3 4 5 6 7

13. Please describe what you feel to have been most helpful to you so far about counseling.

_____

_____

_____

14. Please describe any negative experiences you have had in counseling so far.

_____

_____

_____

15. Overall, how satisfied are you with the services of this clinic?

DISSATISFIED _____ SATISFIED

1 2 3 4 5 6 7

16. Please describe what you feel to be the most positive things about this clinic.

_____

_____

_____

17. Please describe any negative things or concerns you have experienced related to the services of this clinic.

_____

_____

_____

18. Please feel free to share any other comments you might have about your counseling or the services of this clinic (use the back of this page if needed).

NOTE: Your answers on the following questions will be shared with your counselor only after your name, ID number, age, and gender is removed and only after you are no longer seeing this counselor. Please answer as honestly and objectively as you can.

19. How caring do you feel your counselor is toward you?

NOT CARING _____ VERY CARING

1 2 3 4 5 6 7

20. How well do you feel your counselor understands you?

NOT WELL _____ VERY WELL

1 2 3 4 5 6 7

21. How trusting do you feel toward your counselor?

NOT TRUSTING _____ VERY TRUSTING

1 2 3 4 5 6 7

22. How easy is it to talk to your counselor?

NOT EASY _____ VERY EASY

1 2 3 4 5 6 7

23. How professionally knowledgeable do you feel your counselor is?

KNOWS LITTLE _____ KNOWS A LOT

1 2 3 4 5 6 7

24. How motivated or committed do you feel your counselor is to helping you?

NOT AT ALL _____ VERY MUCH

1 2 3 4 5 6 7

25. Overall, how satisfied are you with your counselor?

DISSATISFIED _____ SATISFIED

1 2 3 4 5 6 7

26. Please describe what you feel are the best things about your counselor.

_____

_____

_____

27. Please describe any concerns you have about your counselor.

_____

_____

_____

_____

* 28. You are aware that your counselor is being supervised. How important is it to you for your counselor to be receiving supervision?

NONE _____ VERY IMPACTFUL

1 2 3 4 5 6 7

* 29. How much impact do you believe that supervision has had on counseling?

NOT VERY _____ VERY

1 2 3 4 5 6 7

* Denotes questions added for the purposes of this study.

COUNSELOR'S PROCESS & OUTCOME EVALUATION FORM

Today's date: _____

Counselor Information:

Name:_____ Age: _____ Gender:_____ Ethnicity: _____

Marital Status: _____ Are you a Parent?:_____

Years in Graduate School in Counseling:____Total Years of counseling Experience: _____

Client Information:

Name: _____ File Number: _____

Counseling Information:

How many sessions have you had with this client?:_____

What percent of your sessions with this client have been in the following formats?:

Individual: _____ Couples:_____ Family:_____ Parent-Child: _____

What percent of your counseling with this client has been based on the following approaches?:

Cognitive:_____ Behavioral: _____ Systems:_____

Client Centered/Humanistic: _____ Psychodynamic/Object Relations: _____
Other: _____ (Specify: _____)

Process Information:

1. How do you feel about your relationship with this client right now?

VERY NEGATIVE _____ VERY POSITIVE
1 2 3 4 5 6 7

2. How well do you believe you understand this client right now?

NOT AT ALL _____ VERY GOOD
1 2 3 4 5 6 7

3. How much do you believe you know right now about working with this type of client?

NOTHING _____ VERY MUCH

1 2 3 4 5 6 7

4. How experienced are you with counseling clients with problems similar to this client?

NO EXPERIENCE _____ VERY EXPERIENCED

1 2 3 4 5 6 7

5. Overall, how comfortable are you working with this client at this time?

NOT AT ALL _____ VERY COMFORTABLE

1 2 3 4 5 6 7

Client Problem:

What do you believe is the most important problem your client needs to work on in counseling?

_____

_____

_____

6. How distressing, difficult or uncomfortable do you believe this problem is for your client right now?

VERY _____ NOT AT ALL

1 2 3 4 5 6 7

Client Motivation:

7. How motivated or committed do you believe your client is to work on their problems and make positive changes in their life right now?

NOT AT ALL _____ VERY MOTIVATED

1 2 3 4 5 6 7

Client Functioning:

Please rate your client's current level of adjustment, coping and distress in the following areas.

8. Vocational or work life:

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

9. School or educational life:

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

10. Family relationships:

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

11. Romantic, marital or intimate relationships):

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

12. Social and recreational life:

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

13. Physical health:

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

14. Self-image, self-confidence and self-esteem:

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

15. Overall life satisfaction:

TERRIBLE _____ GREAT

1 2 3 4 5 6 7

Counseling Outcome:

16. How helpful has counseling been for your client at this time?

NOT AT ALL _____ VERY HELPFUL

1 2 3 4 5 6 7

17. Are you aware of any negative results for your client from counseling? YES NO

If yes please describe: _____

_____

_____

Please describe what counseling experiences or strategies have seemed to be most helpful to your client?

_____

_____

_____

18. How much do you believe supervision has impacted client change with this client?

NONE _____ VERY SIGNIFICANT

1 2 3 4 5 6 7

19. How much impact has supervision has on the counseling process?

NONE _____ VERY SIGNIFICANT

1 2 3 4 5 6 7

20. How much impact has supervision had on your development with this client?

NONE _____ VERY SIGNIFICANT

1 2 3 4 5 6 7

21. How much impact has supervision had on your ethical conduct with this client?

NONE _____ VERY SIGNIFICANT

1 2 3 4 5 6 7

* Denotes questions added for the purposes of this study.

Supervisee Levels Questionnaire-Revised

Thank you for your participation and cooperation!
The following instrument is designed to study the behaviors of counselors/therapists in training. The gaining of skills as a counselor/therapist is a learning process, and it is therefore necessary to gather new information continuously. Your total honesty will be greatly appreciated.
All information obtained will remain anonymous.

PERSONAL DATA

Age : _____

Sex: _____

Current educational status: _____

Highest degree earned: _____
Previous supervision received (number of semesters or quarters):_____
if less than one full term, number of hours: _____

Counseling/therapy experience (semesters, quarters, or hours): _____
Other relevant experiences:

Future career plans:

SUPERVISEE QUESTIONNAIRE

In terms of your own current behavior, please answer the items below according to the following scale.

1 = Never
2 = Rarely
3 = Sometimes
4 = Half the time
5 = Often
6 = Most of the time
7 = Always

1. Within supervisory and counseling/therapy relationships, I am sensitive to my own dynamics.

Never						Always
1	2	3	4	5	6	7

2. I feel genuinely relaxed and comfortable in my counseling/therapy sessions.

Never						Always
1	2	3	4	5	6	7

3. I find myself using the same specific techniques in most of my therapy sessions.

Never						Always
1	2	3	4	5	6	7

4. I am able to critique counseling tapes and gain insights with minimum help from my supervisor.

Never						Always
1	2	3	4	5	6	7

5. I am able to be spontaneous in counseling/therapy, yet my behavior is relevant.

Never						Always
1	2	3	4	5	6	7

6. I lack self-confidence in establishing counseling relationships with diverse client types.

Never						Always
1	2	3	4	5	6	7

7. I find it difficult to express my thoughts and feelings clearly in counseling/therapy.

Never						Always
1	2	3	4	5	6	7

8. My verbal behavior in counseling/therapy is pretty much the same with most clients.

Never						Always
1	2	3	4	5	6	7

9. I am able to apply a consistent personalized rationale of human behavior in working with my clients.

Never						Always
1	2	3	4	5	6	7

10. I tend to get confused when things don't go according to plan and lack confidence in my ability to handle the unexpected.

Never						Always
1	2	3	4	5	6	7

11. I find myself intellectualizing about my clients' problems without being in touch with their feeling states.

Never						Always
1	2	3	4	5	6	7

12. The overall quality of my work fluctuates; on some days I do well, and on other days, I do poorly.

Never						Always
1	2	3	4	5	6	7

13. I depend on my supervisor considerably in figuring out how to deal with my clients.

Never						Always
1	2	3	4	5	6	7

14. I find myself working with my clients as I think my supervisor, or some other counselor/therapist I know of, would.

Never						Always
1	2	3	4	5	6	7

15. During counseling/therapy sessions, I am able to focus completely on my client.

Never						Always
1	2	3	4	5	6	7

16. I feel comfortable in confronting my clients.

Never						Always
1	2	3	4	5	6	7

17. Much of the time in counseling/therapy, I find myself thinking about my next response instead of fitting my intervention into the overall picture.

Never						Always
1	2	3	4	5	6	7

18. My motivation fluctuates from day to day.

Never						Always
1	2	3	4	5	6	7

19. I feel most comfortable when my supervisor takes control of what we do in supervision.

Never						Always
1	2	3	4	5	6	7

20. At times, I wish my supervisor could be in the counseling/therapy session to lend a hand.

Never						Always
1	2	3	4	5	6	7

21. I find myself focusing less on learning new techniques and approaches to counseling/therapy and thinking more about my general professional development.

Never						Always
1	2	3	4	5	6	7

22. During counseling/therapy sessions, I find it difficult to concentrate because of my concern with my own performance.

Never						Always
1	2	3	4	5	6	7

23. In describing clients and/or viewing videotapes, I am very concerned about my supervisor's evaluation of my performance.

Never						Always
1	2	3	4	5	6	7

24. Because there is so much to learn, I am highly motivated to use my supervisor as an educational resource.

Never						Always
1	2	3	4	5	6	7

25. Although at times I really want advice/feedback from my supervisor, at other times I really want to do things my own way.

Never						Always
1	2	3	4	5	6	7

26. In counseling/therapy sessions, I am very concerned about my clients' evaluation of my skills.

Never						Always
1	2	3	4	5	6	7

27. The more I learn, the more impressed I am with the counseling process.

Never						Always
1	2	3	4	5	6	7

28. Sometimes my supervisor is too structured and too directive with me.

Never						Always
1	2	3	4	5	6	7

29. Sometimes the client's situation seems so hopeless that I just don't know what to do.

Never						Always
1	2	3	4	5	6	7

30. It is important that my supervisor allow me to make my own mistakes.

Never						Always
1	2	3	4	5	6	7

31. I find myself becoming so in touch with my clients' emotions that I find it difficult to regain my objectivity.

Never						Always
1	2	3	4	5	6	7

32. Given my current state of professional development, I believe I know when I need consultation from my supervisor and when I don't.

Never						Always
1	2	3	4	5	6	7

33. Sometimes I question how suited I am to be a counselor/therapist.

Never						Always
1	2	3	4	5	6	7

34. I find myself becoming so in touch with my clients' emotions that I find it difficult to help them see alternatives.

Never						Always
1	2	3	4	5	6	7

35. Regarding counseling/therapy, I view my supervisor as a teacher/mentor.

Never						Always
1	2	3	4	5	6	7

36. Sometimes I feel that counseling/therapy is so complex that I will never be able to learn it all.

Never						Always
1	2	3	4	5	6	7

37. I find myself more inclined to think about how to help clients solve their problems than to empathize with how they feel.

Never						Always
1	2	3	4	5	6	7

38. I believe I know my strengths and weaknesses as a counselor sufficiently well to understand my professional potential and limitations.

Never						Always
1	2	3	4	5	6	7

39. Regarding counseling/therapy, I view my supervisor as a peer/colleague.

Never						Always
1	2	3	4	5	6	7

40. I think I know myself well and am able to integrate that into my therapeutic style.

Never						Always
1	2	3	4	5	6	7

41. I find I am able to understand my clients' view of the world yet help them objectively evaluate alternatives.

Never						Always
1	2	3	4	5	6	7

42. At my current level of professional development, my confidence in my abilities is such that my desire to do counseling/therapy doesn't change much from day to day.

Never						Always
1	2	3	4	5	6	7

43. I find I am able to empathize with my clients' feeling states but still help them focus on problem resolution.

Never						Always
1	2	3	4	5	6	7

44. I am able to assess my interpersonal impact on clients adequately and use that knowledge therapeutically.

Never						Always
1	2	3	4	5	6	7

45. I am adequately able to assess the client's interpersonal impact on me and use that therapeutically.

Never						Always
1	2	3	4	5	6	7

46. I believe I exhibit a consistent professional objectivity and ability to work within my role as a counselor without undue over involvement with my clients.

Never						Always
1	2	3	4	5	6	7

47. I believe I exhibit a consistent professional objectivity and ability to work within my role as a counselor without excessive distance from my clients.

Never						Always
1	2	3	4	5	6	7

SUPERVISORY WORKING ALLIANCE INVENTORY - SUPERVISOR

1. I help my trainee work within a specific treatment plan with his/her client.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

2. I help my trainee stay on track during our meetings.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

3. My style is to carefully and systematically consider the material that my trainee brings to supervision.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

4. My trainee works with me on specific goals in the supervisory session.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

5. In supervision, I expect my trainee to think about or reflect on my comments to him/her.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

6. I teach my trainee through direct suggestions.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

7. In supervision, I place a high priority on our understanding the client's perspective.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

8. I encourage my trainee to take time to understand what the client is saying and doing.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

9. When correcting my trainee's errors with a client, I offer alternative ways of intervening with that client.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

10. I encourage my trainee to formulate his/her own interventions with his/her clients.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

11. I encourage my trainee to talk about the work in ways that are comfortable for him/her.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

12. I welcome my trainee's explanations about his/her client's behavior.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

13. During supervision, my trainee talks more than I do.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

14. I make an effort to understand my trainee.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

15. I am tactful when commenting about my trainee's performance.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

16. I facilitate my trainee's talking in our sessions.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

17. In supervision, my trainee is more curious than anxious when discussing his/her difficulties with clients.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

18. My trainee appears to be comfortable working with me.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

19. My trainee understands client behavior and treatment techniques similar to the way I do.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

20. During supervision, my trainee seems able to stand back and reflect on what I am saying to him/her.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

21. I stay in tune with my trainee during supervision.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

22. My trainee identifies with me in the way he/she thinks and talks about his/her clients.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

23. My trainee consistently implements suggestions made in supervision.

ALMOST NEVER ALMOST ALWAYS
1 2 3 4 5 6 7

SUPERVISORY WORKING ALLIANCE INVENTORY - TRAINEE

1. I feel comfortable working with my supervisor.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

2. My supervisor welcomes my explanations about the client's behavior.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

3. My supervisor makes the effort to understand me.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

5. My supervisor is tactful when commenting about my performance.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

6. My supervisor encourages me to formulate my own interventions with the clients.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

7. My supervisor helps me talk freely in our sessions.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

8. My supervisor stays in tune with me during supervision.

9. I understand client behavior and treatment techniques similar to the way my supervisor does.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

11. My supervisor treats me like a colleague in our supervisory sessions.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

12. In supervision, I am more curious than anxious when discussing my difficulties with clients.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

13. In supervision, my supervisor places a high priority on our understanding the client's perspective.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

14. My supervisor encourages me to take time to understand what the client is saying and doing.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

16. When correcting my errors with a client, my supervisor offers alternative ways to intervening with that client.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

17. My supervisor helps me work within a specific treatment plan with my clients.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

18. My supervisor helps me stay on track during our meetings.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

19. I work with my supervisor on specific goals in the supervisory session.

ALMOST NEVER						ALMOST ALWAYS
1	2	3	4	5	6	7

SUPERVISOR'S QUESTIONNAIRE

Thanks for your participation!

You have just supervised counselors that have conducted therapy with under two different supervisory conditions. You have visited sessions for several clients and have not for other clients. The intent of this questionnaire to allow you to assess the impact of face-to-face supervisor-client contact on counselor and supervisor development and client change. This form will be divided into two sections. One will ask you to respond to questions as they pertains to client-counselor pairs that received only audio/visual supervision, while the other section will ask you to reflect on client-counselor pairs which you visited during session.

I. Answer these questions as they pertain to CLIENT-COUNSELOR PAIRS THAT YOU VISITED during session.

1. The supervisory process allowed me assess the severity of the problem the client brought to therapy.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

2. The supervisory process gave me a good opportunity assess the threat that the clients may have posed to themselves and/or others.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

3. The supervisory process gave me the opportunity inform the client of my role in their treatment planning.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

4. The supervisory process allowed for the fulfillment of my responsibility to see that all ethical practices were being employed.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

5. The supervisory process had an impact on the counselor's development.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

6. The supervisory process had an impact on my development as a supervisor.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

7. The supervisory process had an impact on client change.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

II. Answer the following questions as they pertain to client-counselor pairs that YOU DID NOT VISIT during therapy sessions.

1. The supervisory process allowed me assess the severity of the problem the client brought to therapy.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

2. The supervisory process gave me a good opportunity assess the threat that the clients may have posed to themselves and/or others.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

3. The supervisory process gave me the opportunity inform the client of my role in their treatment planning.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

4. The supervisory process allowed for the fulfillment of my responsibility to see that all ethical practices were being employed.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

5. The supervisory process had an impact on the counselor's development.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

6. The supervisory process had an impact on my development as a supervisor.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

7. The supervisory process had an impact on client change.

NOT MUCH						VERY MUCH
1	2	3	4	5	6	7

Table 2
Mean and Standard Deviations on the Subscales of the SLQ-R

	1st Data Collection		2nd Data Collection	
	$\bar{x}$	SD	$\bar{x}$	SD
Self & Other Awareness	50.82	6.20	56.50	2.17
Motivation	32.85	3.59	34.44	1.72
Dependency-Autonomy	39.51	4.17	42.44	3.56

Table 3

Mean and Standard Deviations on the Subscales of the SWAI-T

	1st Data Collection		2nd Data Collection	
	$\bar{x}$	SD	$\bar{x}$	SD
Rapport	6.65	0.32	6.76	0.13
Client Focus	6.48	0.62	6.48	0.33

Table 4

Analysis of Variance for Demographic Differences by AVS-1 and AVS-2

Source	D.F	Sum of Squares	Mean Squares	F Ratio	Sig of F
Client Age					
Between Groups	1	109.14	109.14	1.90	0.18
Within Groups	20	1146.18	57.31		
Total	21	1255.32			
Client Education					
Between Groups	1	16.41	16.41	5.20	0.03*
Within Groups	20	63.10	3.15		
Total	21	79.50			
Global Assessment of Functioning	1	269.50	269.50	1.33	0.26
Between Groups	20	4043.45	202.17		
Within Groups	21	4312.95			
Total					

Note: * = $p \leq .05$

Table 5

Z-tests for Comparisons of Proportional Differences between AVS-1 and AVS-2 on Demographic Variables

Variables	P_1	P_2	Z Score
Marital Status			
Married	.364	.273	0.49
Divorced	.455	.545	-0.42
Single	.182	.182	0.0
Gender			
Male	.454	.454	0.0
Female	.545	.545	0.0

P_1 = Proportion for AVS-1 (N=11) Control Group

P_2 = Proportion for AVS-2 (N=11) Treatment Group

$Z = \pm 1.96 = p \leq .05$

Table 6

Means and Standard Deviations on the Subscales of the SWAI-S

	1st Data Collection		2nd Data Collection	
	$\bar{X}$	SD	$\bar{X}$	SD
Rapport	5.78	0.60	6.13	0.36
Client Focus	5.56	0.68	6.17	0.24
Identification	4.94	0.72	6.11	0.59

Table 7

Means and Standard Deviations for Variables Included in the Null Hypothesis: H_{01}

Variables	AVS-1 Control Group				AVS-2 Experimental Group			
N = 22	1st Session		5th Session		1st Session		5th Session	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
BSI								
GSI	0.95	0.74	0.74	0.54	0.69	0.58	0.55	0.34
CRF - S								
Attractiveness	6.00	0.67	6.14	0.54	6.20	0.87	6.64	0.60
Trustworthiness	5.95	0.62	6.25	0.57	6.27	0.85	6.61	0.88
Expertness	5.84	0.38	6.11	0.47	5.64	0.91	6.09	0.71
ClientEC								
Quality of Life Scale	2.82	1.15	2.95	1.15	3.82	1.27	4.09	1.46
Severity of PP	3.53	1.04	3.87	0.89	4.64	0.88	4.77	0.79
Client Motivation	6.18	0.98	5.45	1.58	6.45	0.93	6.36	1.03
Client Attitude	4.09	1.58	4.73	1.49	4.91	1.30	5.76	1.01
Client Satisfaction	5.82	0.87	6.09	0.83	6.00	0.89	6.36	0.67
CounselorEC								
Counseling Process	4.22	1.12	4.47	0.98	4.09	0.73	4.40	1.06
Client Functioning	3.36	0.77	3.69	1.19	4.03	0.60	4.31	1.11
Severity of PP	2.82	1.54	3.18	1.54	2.82	0.98	4.18	1.54
Client Motivation	5.64	1.03	5.64	1.03	6.18	0.87	4.82	1.72
Counseling Outcome	4.18	1.25	4.45	1.29	4.00	1.55	4.18	1.40

Table 8

Means and Standard Deviations for Variables Included in the 1st Directional Hypotheses: H_1

Variables	AVS-1 Control Group				AVS-2 Control Group			
N = 22	1st Session		5th Session		1st Session		5th Session	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
ClientEC								
Question 2								
Impact of Supervision								
on Counseling Outcome								
CounselorEC	4.36	1.50	4.27	1.10	3.73	1.90	6.09	0.94
Question 3								
Impact of Supervision								
on Client Change	4.36	2.16	4.64	1.86	3.64	2.01	5.00	1.34
Question 4								
Impact of Supervision								
on the Counseling								
Process	5.00	1.48	5.18	1.25	4.91	1.87	5.36	0.16

Table 9

The Within Groups Effect for the Repeated Measures Analysis of Variance on the Three Supervisory Questions Involved in the 1st Directional Hypotheses: H_1

Source of Variation	SS	DF	MS	F	Sig. of F
Question 2 : Impact of Supervision on Counseling Outcome					
Within + Residual	14.73	20	0.74		
Question 2	14.20	1	14.20	19.29	0.00
Groups by Question 2	16.57	1	16.57	22.50	0.00*
Question 3: Impact of Supervision on Client Change					
Within + Residual	21.36	20	1.07		
Question 3	7.36	1	7.36	6.89	0.02
Groups by Question 3	3.27	1	3.27	3.06	0.10
Question 4: Impact of Supervision on the Counseling Process					
Within + Residual	26.18	20	1.31		
Question 4	1.11	1	1.11	0.85	0.37
Groups by Question 4	0.20	1	0.20	0.16	0.70

Table 10

Means and Standard Deviations for Variables Included in the 2nd Directional Hypotheses: H_2

Variables	AVS-1 Control Group				AVS-2 Control Group			
N = 22	1st Session		5th Session		1st Session		5th Session	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
CounselorEC								
Question 5								
Impact of Supervision on Counselor's Professional Development	5.27	1.62	5.27	1.27	4.73	1.95	5.36	1.29
Question 6								
Impact of Supervision on the Counselor's Ethical Conduct with this Client	4.64	2.29	4.45	2.21	4.09	2.39	4.73	2.05

Table 11

Means and Standard Deviations for the Supervisor's Questionnaire - 3rd Directional Hypotheses: H_3

Item No.	AVS-1		AVS-2	
N = 8	$\bar{X}$	SD	$\bar{X}$	SD
1-Assessment of Problem Severity	5.38	0.92	5.63	0.74
2-Assessment of Threat Client to Self and Others	5.00	1.20	5.63	1.19
3-Inform Client of Role in Treatment Planning	1.63	1.06	6.38	1.77
4-Opportunity to Monitor Ethical Practices in Counseling	5.38	0.74	5.88	0.83
5-Impact of Supervision on the Counselor's Development	6.13	0.99	5.88	0.83
6-Impact of Supervision on the Supervisor's Development	6.88	0.35	6.88	0.35
7-Impact of Supervision on Client Change	4.88	0.64	5.38	0.52

Table 12

The Within Subjects Effect for the Repeated Measures Analysis of Variance on the Supervisor's Questionnaire: 3rd Directional Hypotheses: H_3

Source of Variation	SS	DF	MS	F	Sig of F
Within + Residual	1.75	7	0.25		
Question 1	.025	1	0.25	1.00	0.35
Within + Residual	2.94	7	0.42		
Question 2	1.56	1	1.56	3.72	0.10
Within + Residual	26.75	7	3.82		
Question 3	90.25	1	90.25	23.62	0.00*
Within + Residual	1.00	7	0.14		
Question 4	1.00	1	1.00	7.00	0.03*
Within + Residual	0.75	7	0.11		
Question 5	0.25	1	0.25	2.33	0.17

Note: * = Significant Results

Continued on next page

Table 12 Continued

The Within Subjects Effect for the Repeated Measures Analysis of Variance on the Supervisor's Questionnaire: 3rd Directional Hypotheses: H_3

Source of Variation	SS	DF	MS	F	Sig of F
Within + Residual	0.00	7	0.00		
Question 6	0.00	1	0.00	----	----
Within + Residual	1.00	7	0.14		
Question 7	1.00	1	1.00	7.00	0.03*

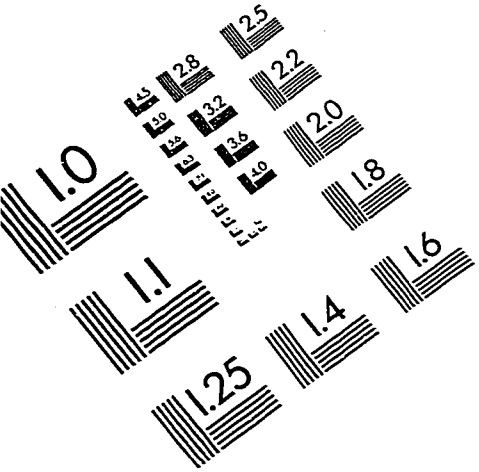
Note: * = Significant results

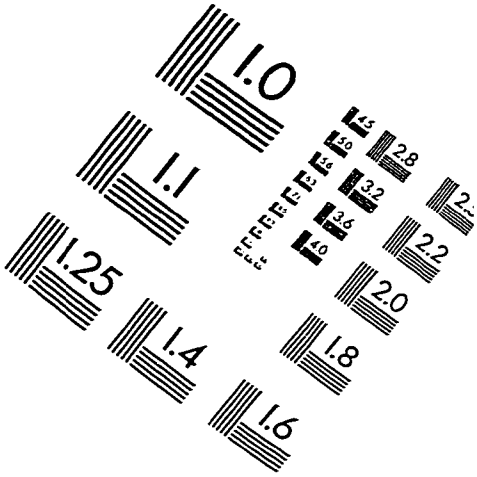
Table 13

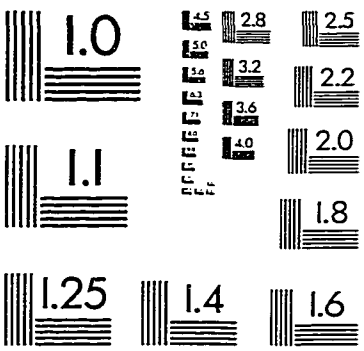
Means and Standard Deviations for the Sample: Not Divided into Groups

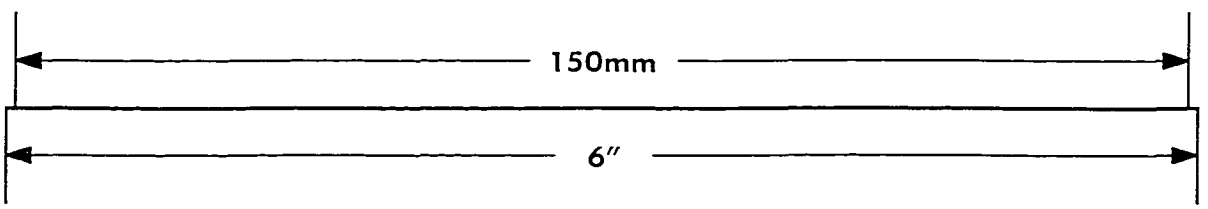
Variables	1st Data Collection		2nd Data Collection	
	$\bar{x}$	SD	$\bar{x}$	SD
BSI				
GSI	0.82	0.66	0.64	0.45
CRF-S				
Attractiveness	6.10	0.77	6.39	0.61
Trustworthiness	6.11	0.74	6.43	0.75
Expertness	5.74	0.69	6.10	0.59
ClientEC				
Quality of Life	3.32	1.29	3.52	1.41
Severity of Presenting Problem	4.08	1.10	4.32	0.94
Client Motivation	6.32	0.95	5.91	1.23
Client Attitude Toward Counseling	4.50	1.47	5.23	1.34
Client Satisfaction	5.91	0.87	6.23	0.75
CounselorEC				
Counseling Process	4.15	0.93	4.44	1.00
Client Functioning	3.70	0.76	4.00	1.17
Severity of Presenting Problem	2.82	1.26	3.68	1.59
Client Motivation	5.91	0.97	5.23	1.45
Counseling Outcome	4.09	1.38	4.32	1.32

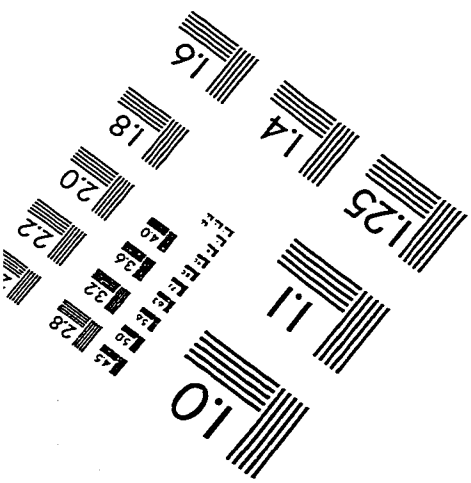
IMAGE EVALUATION TEST TARGET (QA-3)

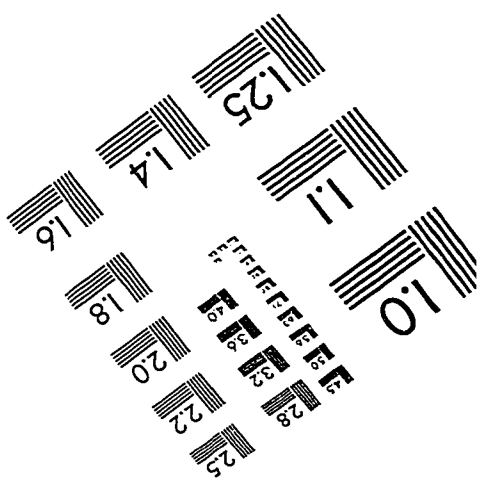












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