AN INVESTIGATION OF THE RELATIONSHIP BETWEEN A CLINICAL SUPERVISOR'S THEORETICAL ORIENTATION AND PREFERENCE FOR A MODEL OF SUPERVISION

JUDITH J. DAVENPORT

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AN INVESTIGATION OF THE RELATIONSHIP BETWEEN A CLINICAL SUPERVISOR'S THEORETICAL ORIENTATION AND PREFERENCE FOR A MODEL OF SUPERVISION

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JUDITH J. DAVENPORT

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INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the dissertation

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To Michael

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CHAPTER I

INTRODUCTION

All professional mental health disciplines acknowledge the importance of supervision in the training and nurturing of psychotherapists. Requirements for licensure as a Clinical Social Worker, Clinical Psychologist, or as a Marriage, Family, Child Therapist include hours of supervised clinical experience (State of California, Department of Consumer Affairs, 1984). Educators and trainers from the various disciplines have written extensively about its importance and complexity (Kadushin, 1976; Kersey, 1982; Mueller & Kell, 1972; Hart, 1982; Kuripus & Baker, 1977). Social Workers, in particular, have focused on the relevance of sound supervision for responsible clinical practice (Reynolds, 1942; Towles, 1954; Kadushin, 1976; Vargus, 1977). Students in training and experienced practitioners laud the merits of supervision and lament the absence of meaningful supervisorial experiences (Scher, 1983; Kadushin, 1968; Barnat, 1973; Potter & Evans, 1983). Trainees with supervised practice not only receive higher ratings from their clients than those trainees without supervised

practice (Pfeifle, 1971), their clients report more significant gains (Biasco & Redfering, 1979). Yet, in this area, beyond agreement regarding the meritorious nature of supervision, consensus exists on little else.

Definitions of Supervision

Considerable disagreement exists between those who conceptualize supervision as a process whereby a set of skills or techniques are imparted in an educational manner (Haley, 1976; Hess, 1980) and those who see supervision as an opportunity for personal growth on the part of the trainee, a growth that is thought to ultimately benefit his/her clientele (Rogers, 1949; Ekstein & Wallerstein, 1958). While all writers seem to agree that supervision is a learning situation (Towle, 1954; Hart, 1982; Carkhuff, 1969; Szurek, 1949), perspectives on outcomes for the trainee, behaviors of the supervisor or goals for the supervision differ widely (Smith, 1975). In a global sense, supervision can be seen as a relationship between individuals in which knowledge and guidance are imparted (Ciecko, 1981) and as a relationship in which professional socialization is accomplished (Kadushin, 1976).

Functions of Supervision in the Various Mental Health Disciplines

Each of the mental health disciplines has its own statement of the function of supervision. In social work, supervision is intended to assure quality agency service while helping the worker to function with

optimal effectiveness and independence in agency and private practice settings (Kadushin, 1976; Vargus, 1977). In psychology, supervision is intended to serve a myriad of purposes, including developing skills in observation, in the use of acquired data during therapy, in integrating theory and practice, and in the therapeutic use of self (Ciecko, 1981; Smith, 1982; Hart, 1976). In marriage and family therapy, the function of supervision is to prepare counselors to provide counseling services in the area of marriage and family relationships (Kersey, 1982).

These statements of purpose lack concrete guidelines as to methods for their accomplishment. What is the appropriate content and process for achievement of these goals?

The Need for Experimental Research on Supervision

Writers, theorists, and researchers in the field of supervision have consistently called for experimental investigation of the process of supervision (Hansen and Warner, 1971; Guttman, 1973; Kirchner, 1974; Arbuckle, 1974; Smith, 1975). Complaints have focused on the descriptive nature of most research and on its nondirectional, theoretical focus. Particularly in the field of social work, supervision research has been largely of an impressionistic, editorial and/or descriptive nature (Maas, 1971). Data is missing on the actual process of supervision, on its components and variables (Patterson, 1964; Lambert, 1974; Miars, Tracey, Ray, Cornfeld, O'Farrell, & Gelso, 1983).

Statement of the Problem

Available information on the process of supervision remains largely theoretical. Arbuckle (1963) believes that in supervision the relationship of the supervisor to his/her trainee is identical to that of the therapist to the client. Liddle (1979) suggests that a supervisor's theoretical orientation to supervision is the same as his/her orientation to therapy. Many writers (Kaslow, 1976; Kuripus & Baker, 1977; Mueller & Kell, 1972) discuss supervision as if there is a singular approach to supervision which all supervisors subscribe to and implement in all phases of the relationship. While there may be consensus regarding the desired end product in supervision, it appears that there are multiple approaches and orientations to how the goals of supervision are achieved. A critical component of the supervisory relationship is the person of the supervisor--his/her values, attitudes, and beliefs. One reflection of these values, attitudes, and beliefs is the supervisor's theoretical orientation (Peterson & Bradley, 1980; Sundland & Barker, 1962; Steiner, 1978; Chwast, 1978; Strupp, 1978; Herron, 1978; Rosso, 1973; Loew, 1975). There is, however, little information available regarding if or how these values, attitudes, and beliefs are brought into the supervisory process. Available research focuses on the supervisor-trainee interaction or on how the supervisor sees his/her role as supervisor. Additionally, this data is generally based upon self-report (Ciecko, 1982). More information about what the supervisor brings to supervision is essential in order to facilitate in

the quantification and delineation of the supervision process.

Purpose

The purpose of this study was to investigate and determine if the variable of a supervisor's theoretical orientation impacts upon the supervision process. In this study the supervisory process was viewed within the framework of three particular models of supervision: skill development, personal growth, and collaboration as delineated by Hart (1978, 1982). This study examined the relationship, if any, between a supervisor's theoretical orientation and his/her preference for a supervision model.

Value to the Field

A study focusing on the relationship between theoretical orientation and preference for a supervision model will provide those social workers and other clinicians interested in supervision with more understanding of the complexities involved in preparing clinicians to provide supervision. If a relationship is established between theoretical orientation and preference for a supervision model, it will be well to consider the impact of values and attitudes upon the choice of a supervision model and how, or if, these values and attitudes might constrict the range of interventions utilized by supervisors. If such a relationship is found to exist, the teaching of supervision models must address the impact the supervisor's theoretical orientation has upon

his/her learning. The issue of how supervisors can be prepared to meet the developmental needs of trainees within a framework that considers and utilizes their values and attitudes as manifested by their adherence to a particular theoretical orientation will emerge as vital for planning of meaningful preparation of supervisors for supervision. If there is not a relationship between a supervisor's theoretical orientation and preference for a supervision model, bringing to light this inconsistency will allow the supervisor to reconsider and, perhaps, modify his/her expressed beliefs. If values and attitudes as manifested in adherence to a theoretical orientation are not pertinent factors in preference for supervision models, this knowledge will also allow those charged with training supervisors to consider the foundation upon which supervision instruction might most effectively build.

An important contribution of this study is to further research of a systematic nature on supervisor variables impacting upon the supervision process. A further contribution of this study is the provision of additional information regarding the validity of the instruments utilized to measure theoretical orientation, practice orientation, and preference for a supervision model.

Research Questions

1. To what extent is there a relationship between theoretical orientation as measured by the AID scale and the Counseling Orientation Scale and preference for a supervision model as measured

by the Expectations About Supervision Test?

2. Given that the different mental health disciplines have varying definitions of the function of supervision, is there a relationship between professional discipline and preference for a supervision model?

Definitions

Some of the terms important to the present study are difficult to define and appear to have contradictory definitions in the literature. They were used in this study as follows:

Supervision. Supervision was defined as an ongoing educational process in which one person, in the role of supervisor, helps another person, in the role of supervisee, acquire appropriate professional behavior through an examination of the supervisee's professional activities.

Clinical supervision. Clinical supervision focuses on the work of the supervisee in relation to his/her clients. Clinical Supervision examines the supervisee's performance of specific clinical tasks such as assessment, diagnosis, counseling, or psychotherapy that affect the recipients of the service.

Supervision/Clinical supervision. The two terms, supervision

and clinical supervision, were used synonymously in this study.

Supervisory variables. Supervisory variables refers to those elements of the supervisor under observation in this study - supervisor theoretical orientation and supervisor preference for supervision model.

Supervisory process. Supervisory process refers to all of the events that occur in the supervision session.

Supervision model. Supervision model refers to one of the three models (skill development, personal growth or collaboration) outlined by Hart (1978, 1982). Preference for supervision model was measured by the Expectations About Supervision Test.

Theoretical orientation. Theoretical orientation refers specifically to supervisor's philosophical and behavioral beliefs regarding therapy and was measured by the AID scale and the Counseling Orientation Scale.

Supervisee/Trainee. The two terms, supervisee and trainee, were used synonymously in this study.

Mental health discipline. Mental health discipline refers to social worker, psychologist, psychiatrist, marriage family therapist, pastoral counselor, occupational therapist, and psychiatric nurse.

Mental health discipline/Professional Discipline. The two terms, mental health discipline and professional discipline, were used synonymously in this study.

Supervision Modality. Supervision modality refers to the modalities in which supervision can be offered (peer, individual, or group). In this study, supervision modality referred to individual supervision.

Chapter II

REVIEW Of THE LITERATURE

The present study was designed to investigate the relationship between the variables of supervisor theoretical orientation to psychotherapy and preference for supervision model. Areas of supervision pertinent to the study were discussed as follows: (a) clinical supervision, (b) supervision process, (c) supervisor attributes of professional discipline and gender, (d) supervisor variable of theoretical orientation, (e) supervision models, and (f) supervisor's theoretical orientation and supervision model.

Clinical Supervision

Since the late 1940's, researchers and clinicians have been articulating and questioning basic assumptions regarding both the dimensions of effective therapeutic behavior and the correlated effectiveness of supervision. A considerable portion of this discussion has focused on the nature of the learning process itself, and on the validity of the one-to-one supervision format as a vehicle for clinical learning.

Many writers have concurred on the factors essential to effective clinical learning. These include a high motivation to learn, success and rewards in the learning experience, active involvement in the learning process, regard for the learner's uniqueness, movement from the familiar to the unfamiliar so that the learner's coping mechanisms are not overwhelmed, and the arrangement and presentation of content into some comprehensive, internally consistent framework which satisfactorily explains the mysteries of human behavior ((Szurek, 1949; Towle, 1954; Kadushin, 1976). The acceptance of these basic concepts has led to an examination of the impact of individual supervision upon their accomplishment.

In 1964, Hansen and Barker measured the effect of the quality of the supervisory relationship upon the trainees' level of experiencing. They found a significant relationship between the trainees' rating of the supervisory relationship and their level of experiencing. This was interpreted to mean that students having the poorest supervisory relationship were more remote from their experiencing and from their feelings and were more likely to be cautious and defensive in their therapeutic relationships (Matarazoo, 1971).

In 1966, Goldstein, Heller, and Sechrest concluded that there was considerable empirical support for the contention that the nature of the supervisory relationship is a powerful variable in determining a trainee's openness and receptivity to education toward change.

A study by Pagell, Carkhuff and Berenson (1967) determined that the level of functioning of the supervisor according to the criteria of empathy, positive regard, genuineness, concreteness and self-disclosure

determined if volunteers in a mental health counselor training program made significant gains in the program and completed the program ($p=.05$).

Ornston, Cicchetti, LeVine, and Fierman (1968) investigated the verbal behaviors of supervised versus non-supervised psychiatrists and demonstrated that the verbal behavior of trained and untrained psychiatrists was different. Trained psychiatrists used three times as many non-question words and twice as many comments of a non-questioning nature as did untrained psychiatrists. Untrained psychiatrists focused on the words of the client rather than on the content or feeling, and tended to respond to clients with questions or information. Both groups asked an equal number of questions; the difference was in the quality and quantity of non-questioning responses used by the two groups.

In 1969, Carkhuff studied 16 professional and subprofessional programs involved in counselor training. He concluded that the most critical variable in effective counselor training is the level at which the supervisor is functioning on those dimensions related to constructive trainee change.

Berger and Freebury (1973) reviewed several studies and determined that psychotherapy supervision allows the trainee to be engaged as an individual with his/her own individual patterns of learning and is perhaps the major vehicle for promoting clinical learning.

In 1974, Childers studied the change in trainees exposed to systematic and unsystematic supervision. Members of the former group became more objective in viewing their counseling behavior and were more able to identify desired behaviors (Smith, 1975).

Lambert (1980) in reviewing studies on interpersonal skills training suggested that supervised training was superior to unsupervised training and that a systematic training procedure produces both increased skill development and personal adjustment.

Summary

The review of the research on clinical supervision confirms the importance of supervision for clinical learning. However, these studies suggest nothing about how supervision facilitates accomplishment of this learning, nor do they distinguish between the impact of the variables impinging on the supervision process.

Supervision Process

Literature examining the process of supervision is contradictory and confusing. Some studies cite the person of the supervisor as the most powerful influence on the trainee's acquisition of therapeutic skills (Searles, 1955; Blatt, 1963; Pierce & Schauble, 1970; Barnat, 1974; Ronnestad, 1977), while other studies suggest that the supervisor's actual behavior have little to do with the ultimate competence of the trainee (Wedeking & Scott, 1976). Pierce, Carkhuff and Berenson (1967) concluded that much supervision may be ineffective given that superviors are often chosen on the basis of credentials in academic research while the effective professional therapist/supervisor may be ignored.

Congram (1968) studied the degree of influence supervisors had on the behaviors of trainees. He found that supervisors had considerable influence on the behavior of trainees and that those with the most influence used indirect methods such as praise, encouragement, and acceptance of feeling, whereas the least influential used more lecturing.

Pierce, Carkhuff, and Berenson (1967) and Pierce and Schauble (1970) suggested that effective supervision depended upon the establishment of a supervisory environment that permitted the trainee to learn by experiencing a therapeutic type of relationship. Effective supervisors were similar to effective therapists (Carkhuff and Berenson, 1967) and exhibited the same facilitative behaviors of empathy, warmth, and genuineness in their supervisory sessions.

Lambert (1974) challenged this conclusion when he examined the behaviors of supervisors in both supervisory and therapeutic situations. He found, on the facilitative dimensions, that supervisors manifested similar respect and genuineness in both situations but they showed significantly less empathy in supervision. Lambert suggested that supervision may, in fact, be cognitive and that many skills including the facilitative skills are learned through a cognitive rather than an experiential process. The contradictory results of the Pierce, Carkhuff, Berenson/Pierce, Schauble, and Lambert studies reflect the inconclusive nature of the research on supervision process.

Another possible variable on the supervision process is the trainee's judgement of the quality of supervision and his/her satisfaction with supervision. Lanning (1971), Lemons (1974) and

Wassmer (1974), in separate studies, investigated the correlated variables of trainee's satisfaction with supervision. Important factors were effectiveness of communication, trainee's valuing the person of the supervisor, the education and experience of the supervisor, and the level of effectiveness of the communication between the supervisor and the trainee. Lanning, in fact, stated that the supervisor was important in the outcome of the trainees' clients. How the trainees perceived the relationships with their supervisors was significantly related to what the trainee expected of their therapeutic relationships and how they expected to be perceived by their clients.

Doehrman (1976), in a study of the supervision process, suggested that transference and countertransference within both the supervisor/trainee and the trainee/client dyads influenced both relationships in a cybernetic fashion. This complex set of interpersonal interactions, labeled "paralle process", had potential for facilitating or undermining client treatment.

The final area for examination in this section is the concept of modeling--the process by which a person learns behavior by imitating another's behavior (Bandura, 1971). Several researchers in supervision have examined the impact of modeling on the teaching of psychotherapeutic behaviors (Pierce and Schauble, 1970; Elsenberg and Delany (1970); Ronnestad, 1973; Silverman and Quinn, 1974). They concur that modeling is an effective training device, perhaps the most crucial variable in supervision (according to Pierce and Schauble). Trainees modeled their supervisors in attending behavior, responding to feeling, summarization of session themes (Ronnestad, 1973), changing their

therapeutic behaviors (Elsenberg and Delany, 1970), and in all of the other dimensions measured. Thus, it appears that, with or without the intent of the supervisor, his or her behaviors within the supervisory context are a most potent teaching vehicle.

Summary

The supervision process is complex. In order for it to be studied, it must be simplified in ways that allow for experimental control and evaluation. By studying variables of the process separately, the critical parts constituting the whole can be delineated and examined. It is apparent that therapists are changed by their supervision and that a fundamental variable in this change is the supervisor. To some extent, the attributes and characteristics of the successful supervisor have also been examined empirically.

Attributes and Charactistics of the Supervisor: Professional Discipline and Gender

Nelson (1978) surveyed trainees in counseling, clinical psychology, social work, and psychiatry regarding their experiences in supervision. He found that the trainees' supervisory preferences were unrelated to their professional discipline. All groups preferred supervisors who allowed and encouraged trainees to develop their own style, explored the feelings of therapists toward their clients and the clients' problems, were actively practicing therapy on a regular basis

themselves, offered feedback on areas that needed improvement, and offered helpful therapeutic techniques and approaches.

McNair and Lorr (1964) found that preference for therapeutic technique, contrary to supervisory preferences, was clearly associated with professional discipline. Their study focused on psychotherapists' reports of their preferred psychotherapeutic techniques. These techniques were divided into three dimensions: psychoanalytically-oriented techniques, impersonal or personal affective approaches to the client, and direct/active therapeutic method. Their more general aim was to determine common patterns of therapeutic technique and to study the relations of therapeutic approach to other therapist characteristics such as profession. Their sample consisted of 270 psychotherapists at 44 Veterans Administration Hygiene Clinics. There were 67 psychiatrists, 103 psychologists, and 95 social workers in the sample. A questionnaire of 57 questions on an 8-point Likert scale was developed (the "AID scale"). Each therapist was assigned one of eight technique pattern scores. Pattern scores were derived by dichotomizing the three AID scores at their medians and classifying therapists as high (H) or low (L) on each factor. Scores were then compared according to profession, sex, experience, and amount of personal psychotherapy.

In this study preference for therapeutic technique was associated with professional affiliation. Psychiatrists, psychologists, and social workers endorsed distinctly different dimensions, and each profession exhibited a preference for one or two dimensions. Psychiatrists preferred psychoanalytically-derived techniques, impersonal relationship to the client and direct control of the course of the

therapy. Psychologists preferred techniques stressing a personal and affective relationship between the therapist and the client and preferred to leave the goals and direction of the therapy to the client. Social Workers fell into two principal patterns: a non-analytic approach with a personal relationship to the client and direct control of the course of therapy, or a non- analytic approach with an impersonal relationship to the client and direct control of the therapy.

There were also differences attributable to the gender of the therapist but none to the therapist's clinical experience. Relatively more men than women endorsed the personal, non-directive approach and the analytic-personal-directive pattern. More women than men preferred the impersonal-directive approach. The authors speculated that women therapists may generally behave more impersonally or that, since most Veteran's Administration patients are men, this finding may reflect a tendency of therapists to be more reserved with patients of the opposite sex.

McNair and Lorr concluded that these differences in preference for therapeutic technique attributable to discipline "probably reflected training differences" (p. 269).

Summary

As the literature lacks research on supervisors' preference for a supervision model based upon the discipline of the supervisor, speculation that there may be such a relationship is inferential and is

based upon differences in definition of supervision tasks by discipline and upon the differences in preference for therapeutic technique by discipline. Clearly, research is needed to determine if there is a relationship between the two variables of supervisor discipline and preference for a supervision model.

Supervisor Variable of Theoretical Orientation

This review of literature pertaining to theory and research on theoretical orientation will be divided into two sections. The first section will examine theoretical orientation as a reflection of values, personality and beliefs and its influence on clinical practice.

Reviewing the literature on the supervision process conveys the impression that the supervisor's theoretical position is somehow a constant in his/her work with trainees. Although little research has been done on how or if the supervisor's theoretical orientation impacts upon the supervision process, many researchers and theoreticians imply that the techniques utilized by the supervisor and the style of his/her supervision are largely attributable to theoretical orientation. Patterson (1964) believed that the basic assumptions regarding behavior change were the same whether applied to supervision or psychotherapy. Hansen and Warner (1971) in their review of the literature on supervision found variations and contradictions in articles and concluded that the theoretical orientation of the supervisor may effect the trainee. Liddle (1979) suggests that there is a "parallel relationship between one's theoretical approach to therapy and to

to supervision" (pg. 22). Leddick and Bernard (1980) reviewed the history of supervision and concluded that there was a lack of a theoretical base for supervision. Therefore, they hypothesized that supervision was closely linked to the theoretical assumptions of psychotherapeutic practice. As there has been almost no specific research on the relationship between a supervisor's theoretical orientation and its impact upon supervision, data on this relationship must be extrapolated from the theory and research on therapist's theoretical orientation and its effects on the process and outcome of psychotherapy. . .

Throughout the literature on theoretical orientation and its relationship to psychotherapy, two themes reoccur. These themes explore the source on the therapist's theoretical orientation and the impact of this orientation of the therapist's practice. Meltzoff and Kornreich (1970) stated that available research indicated that there were apparently genuine differences in approaches to techniques of psychotherapy as a function of the school or orientation of the therapist. They concluded that therapists tend to conceptualize, plan treatment and use techniques reflecting their orientation. Lowe, Grayson, and Lowe (1975) hypothesized that each therapist was drawn to a theory and style of psychotherapy that fit his/her personality and thought style. They concluded that change in the client occurs when the therapist's method is congruent with his/her personality. Schneider (1973) and LaCrosse and Barak (1976) concurred that while counselor behavior is an important source of variance in a client's perceptions (of him/her) it seemed likely that a person's "implicit personality

theory (Schneider, 1973, p. 172)" would be an important source of this behavior and, therefore, an important source of this variance. Lazarus (1978) offered that specific techniques derived from school affiliations are altered by the therapist to fit his/her personality.

Fiedler (1950) explored the influence of theoretical orientation on the therapist's behavior during a therapeutic session and concluded that the nature of the therapeutic relationship is a function of experience rather than theoretical orientation. Recorded interviews were obtained from ten psychotherapists representing the psychoanalytic, the nondirective, and the Adlerian schools of therapy. One therapist from each school was considered nationally prominent and the other was a novice. The sessions were assessed by three trained judges and one judge unfamiliar with therapeutic theory or method. The study investigated early therapeutic hours (the sixth through the seventeenth sessions) and rated only the factors of communication, status role and emotional distance. Using the Q-technique, a method of intercorrelation between persons, the judges listened to each interview and sorted statements into appropriate categories. While there were school differences in terms of status role and emotional distance, these differences were not significant. The "relationships created by the experts approximated the generally accepted concept of the Ideal Therapeutic Relationship more closely than relationships created by therapists who are not considered experts" (p. 439). This study, which consisted of a small sample, did not evaluate the effectiveness of therapeutic schools, the use to which these therapeutic relationships were being put by the various schools, nor did it compare schools that

did not have a common Freudian heritage. It evaluated only the therapeutic relationship on three factors. Fiedler noted that the later phases of psychotherapy may require greater theoretical knowledge and that relationship is insufficient without therapeutic technique.

Strupp (1955) attempted an empirical comparison between the psychotherapeutic techniques used by psychologists identifying themselves as Rogerians and those identifying themselves as psychoanalytically oriented. He felt that it was "evident that differences in emphasis do exist among the major theories (p. 2)" and wanted to explore technique to determine if these differences in theory translate into actual practice. His study investigated whether the operations of psychotherapists proceeded in accordance with the theoretical precepts to which they claimed allegiance and whether different theories led to specific therapeutic procedures predictable from the theory. His 15 subjects (7 of whom had more than 5 years of experience) responded to 27 preselected paragraphs of representative cross sections of typical patient verbalizations. Their responses were categorized by Bales' system of interaction process analysis. The results indicated highly significant differences between the Rogerians and the analytically-oriented therapists in almost all applicable categories. The differences between the experienced and inexperienced practitioners seemed due to chance. The Rogerians relied heavily on reflective techniques while the non-Rogerians preferred exploratory responses, passive acceptance, structuring, interpretation and direct factual questions. This study, also having a small sample, differed from Fiedler's in documenting pronounced differences in preference for

therapeutic technique specifically attributable to the clinician's theoretical viewpoint.

Sundland and Barker (1962), in a study of 139 American Psychological Association psychotherapists, drew conclusions contrary to those of Fiedler (1950) and in agreement with Strupp (1955). Two hypotheses were tested: (1) there will be no significant differences between the attitudes of the proponents of the different schools of therapy, and (2) there will be no significant differences between the attitudes of therapists with differing amounts of experience. Sundland and Barker developed the Therapist Orientation Questionnaire composed of 133 items designed to reflect both views of 13 scales on attitudes and methods about which psychotherapists disagreed. The psychotherapy orientations focused on were Freudian, Rogerian and Sullivanian. Answers to the questionnaire, which utilized a five-point Likert-type scale, revealed that experienced therapists were more similar to inexperienced therapists of their own theoretical orientation than they were to other experienced therapists. The subscales yielded 6 factors and a general factor labeled Analytic vs. Experiential. Additionally, the three orientations differed on over half of the subscales. The Freudians were on the analytic end, the Sullivanians were in the middle and the Rogerians were on the experiential (adverse) end. The Freudians were found to stress discussion of childhood in therapy, the concept of unconscious motivation, the importance of interpretation, and the importance of the therapist's training and knowledge. The Sullivanians emphasized planning, conceptualizing, having goals and inhibiting spontaneity. Rogerians stressed the personality of the therapist,

spontaneity in the session and the usefulness of a personal approach. In this study interaction effects between levels of experience and theoretical orientation reached the .05 level of significance. The rationale for Sundland and Barker's study was as follows:

> "The attitudes which the therapist holds have an influence on his behavior; his behavior influences the perception that the patient has of him; these perceptions interact with the perceptions which the patient has learned previously concerning other people and himself; this interaction leads to changed perceptions and attitudes; and the perceptual-attitudinal changes in the patient show themselves by changes in his behavior. If we wish to predict the way in which a therapist influences the patient we could start with either the attitudes of the therapist or his behavior and relate these to any of the variables of the patient (p. 201).

Chien and Appleton (1970), in a study of 24 first year psychiatry residents on a psychopharmacology rotation, explored the impact of ideology on learning. Based on Factor E of Mason and Sachs Chemotherapy Attitude Questionnaire and a psychopharmacologic knowledge questionnaire, the physicians were divided into "psychotherapeutic" and "eclectic" groups. The same questionnaires were administered six months later when the systematic course in psychopharmacology had been completed. After the six month program the eclectic group has acquired a significantly greater amount of knowledge about psychopharmacology than had the psychotherapeutic group. The authors speculated that the psychotherapeutic group, having less concern with speed of recovery and more faith that greater self knowledge would prevent further relapses, was less motivated to learn about psychopharmacology and, therefore, in

fact, learned less. Chien and Appleton concluded that greater flexibility was required in psychiatric teaching and that it must address the rigidities arising from the value systems of all participants since the impact of values (theoretical orientation) upon learning was so apparent.

Rosso and Frey (1973) assessed differences between the intended counseling behavior and the actual practices of beginning counselors. A paradigm developed by Frey was used to divide counseling behavior into four types: (a) rational-insight counseling, (b) affective-insight counseling, (c) affective-action counseling, and (d) rational-action counseling. The instructor of the counseling theory classes presented these various theories to 43 graduate students in counselor education. These students marked the quadrant in the Frey paradigm that best described their intended counseling behavior (theoretical position). The students then met with one of two distinctly different coached clients in a four-minute videotaped microcounseling interview, in which both self and peer ratings were obtained. No significant differences were found between intended and actual behavior as perceived by the counselors themselves, but their intended behavior was significantly different from peer perceptions of interview behavior. Client type had no effect. Both groups, regardless of their intended style and client type, were more cognitive, more rational, and more invested in insight than they thought. These results suggest that beginning counselors need to impose a theoretical grid to their counseling behavior and are willing to force the grid to the data even when the parameters of the grid are inappropriate. Rosso and Frey noted that these results emerged

in a single and initial interview and questioned whether the data would hold for experienced counselors working with clients over a longer time. Based on the results of this study, it appears that beginning students in counseling either lack a theoretical orientation or do not apply one to their practice.

Walton (1978) sought to explore the relationship of selected personality variables among therapists representing different theoretical orientations. His study attempted to define dimensions of self-concept that may or may not be distinctive among therapists having different theoretical orientations. The 134 subjects were male psychologists and were classified into one of five theoretical orientations (Behavioral, Rational-Emotive, Psychodynamic, Humanistic, Eclectic) based upon their own self-reports. A 98 item semantic differential instrument based on existing theory was developed by the author, and the subjects responses to the instrument were factor analyzed using the matrix of intercorrelations. Eight factors were extracted and each of these resulting factors was subjected to an analysis of variance to determine the presence, if any, of significant differences among therapists of different theoretical orientations. The results indicated that there were significant differences among the therapists on these factors: Complexity ($p=.044$), Seriousness ($p=.048$), and Rationality ($p=.059$). Scheffe's post hoc comparisons indicated that on both the Complexity and Seriousness factors, the critical difference was between the rational-emotive and the psychodynamic therapists, with the psychodynamic therapists viewing themselves as more serious and more complex. No other factor approached

a .05 level of significance. Walton questioned whether these differences resulted from training or personality but concluded that, in any case, therapists' self-concept variables as measured by a semantic differential technique were related to theoretical orientation.

Steiner (1978), in a study using a sample of 30 licensed psychologists, investigated the factors contributing to the therapist's selection of a particular theoretical orientation. Her survey included the respondent's orientation, the reasons for shifting from an earlier preference, if that occurred; the various influences determining the present choice, life experiences which might be syntonic with one's chosen orientation and the relationship between the type of interventions used and personality factors. Demographics included age, sex, years in independent practice and birth order in the family of origin. In this study the factors critical in selection of theoretical orientation, in order of importance, were as follows: the influence of one's own psychotherapist; the influence of graduate or post graduate course work and readings; the influence of instructors' orientations in graduate or post graduate training; the orientations of one's seniors or colleagues in clinical settings; and the influence of assigned clinical supervisors. Steiner found that therapists in practice the longest selected theoretical orientations in the psychodynamic model while younger therapists tended to be eclectic or to utilize "newer" therapeutic approaches. Based on the results of this study, Steiner concluded that "the trainers of therapists perpetuate their own therapeutic biases to the next generation of therapists" (p. 374). Results of this small sample study appear to underscore the subjective

basis for the selection of therapists' theoretical orientation.

Herron (1978) surveyed research on the relationship between therapists' personalities and their theories of psychotherapy and did some exploratory research on the topic. He cited Henry, (1973), Ellis (1974) and Thompson (1975) as references supporting the factor of the therapist's personality as influencing his/her choice of a theoretical orientation. He summarized the determinants crucial to selection of theoretical orientation as exposure to an orientation, treatment success while utilizing an orientation, adaptability of an orientation to a variety of treatment situations, satisfaction of the therapist's emotional needs available from utilization of this orientation, and client demand for treatment utilizing the orientation. Herron concluded that the complexity of the theory must fit the complexity of the therapist for him/her to be truly connected with the theory. Herron's research utilized 21 doctoral level psychologists doing psychotherapy under supervision as part of their clinical training. They were given the Personal Orientation Inventory (Shostrom, 1972) as well as a questionnaire giving them a choice of three described theoretical orientation and three modes of therapy. The theoretical orientations described (but unnamed) were psychoanalytic, humanistic and behavioral. The students were asked to rate the orientations in order of their preferences. The favored orientation was psychoanalytic, with humanistic next and behavioral last. These results tended to conform to the professed orientations of the supervisors of these students and may well have reflected that influence. The results of the Personal Orientation Inventory suggested that there was a probable link between

personality characteristics and choice of a theoretical orientation, but these results were tentative. The possible interaction of theoretical preference, supervisor's orientation, therapeutic modality and other possible interconnections were not explored. Herron concluded that the choice of a relatively durable theoretical orientation probably develops after some time in practice and that learning why therapists choose their theories is one way to improve the success of psychotherapies.

Chwast (1978) constructed an eight-item questionnaire to explore factors contributing to the choice of theoretical orientation. He administered the questionnaire to five male, experienced psychotherapists. The questions were subjective and inquired about the impact of personality on respondents' preference for an orientation. The respondents felt that their personalities had impacted heavily on their selection of theoretical orientation and believed this to also be true for their colleagues. Respondents felt that change in preference for theoretical orientation during the course of their professional lives was attributable to developmental evolution, reflecting resolution of some developmental issues and emergence of others. As this study was extremely small and its method subjective, results must be viewed with considerable caution. Yet this study adds to research linking choice of theoretical orientation with subjective factors.

A study by Peterson and Bradley (1980) further investigated the relationship between counselor's attitudes and his/her theoretical orientation. Their sample consisted of 54 psychotherapists, an externally defined subject affiliation with a behavioral, Gestalt, or rational-emotive counseling (RET) agency, and an orientation

questionnaire. Self-report verification of theoretical orientation represented the internal criterion. The authors developed a questionnaire presenting a series of items reflective of the values and beliefs of each of the theoretical orientations. A 5-point Likert-type scale was utilized for response purposes. Mean values were computed for each subject group and four one-way analyses of variance were conducted. Scheffe multiple comparisons for the theoretical categories were also computed. Ten of the 12 comparisons were significant at greater than the .01 level. These results confirmed that there was a significant relationship between counselor orientation and theoretical tenets chosen as most crucial. On the behavioral subscale, behaviorists achieved the highest mean (4.25), followed by rational-emotive (3.46), with Gestalt counselors the lowest (2.80). On the Gestalt subscale, Gestalt counselors were the highest (4.24), with no significant difference existing between the means of behaviorists (2.75) and RET counselors (2.64). The RET counselors were the highest (4.56) on the RET subscale, followed by the behaviorists (3.25) and Gestalt counselors (2.62). The results of this study indicated that attitudinal differences did exist among the subjects and were primarily a function of theoretical orientation. (Therapist experience level was not found to be a significant factor in determining subject responses.)

Summary

These studies investigating the impact of values and attitudes upon theoretical orientation and the impact of theoretical orientation upon clinical practice offer sometimes contradictory and somewhat

nonconclusive results. Methodological difficulties of sample size and composition and of instrumentation have been problems for some of these researchers and all of them have noted the limitations of their work. Yet the research to date appears to suggest that therapists do have theoretical orientations and that these orientations are likely based upon personality factors consisting of values, attitudes and beliefs. Though this orientation may change as the result of the therapist's growth and experience, the theoretical orientations are distinct and do impact upon therapists' clinical practice.

Major Theoretical Orientations

This section of the literature review on the variable of theoretical orientation will delineate the theoretical orientations to be used in this study and will elucidate the rationale for their classification into three major categories of theoretical orientation: Psychodynamic; behavioral; and humanistic/existential.

In attempts to comprehend the factors influential in the total range of psychological treatments, the following features have been repeatedly cited as basic to all psychotherapies: an emotionally charged, confiding relationship; a therapeutic rationale (myth) that is accepted by client and therapist; the provision of new information, which may be transmitted by precept, example, and/or self discovery; the strengthening of the client's expectation of help; the provision of success experiences; and the facilitation of the arousal of one's

emotions (Frank, 1971).

However, originators and proponents of individual systems of psychotherapy have felt the need to differentiate themselves from their predecessors and peers and to underscore the differences in psychotherapy (May, Angel, Ellenberger, 1970; Janov, 1970; Eysenck, L970; Ellis, 1975). In addition, comparative conceptual studies of various forms of psychotherapy typically cite striking contrasts among various therapeutic approaches (Harper, 1975; Patterson, 1973; Ford & Urban, 1965). More recently, experimental studies of different schools have lent some quantitative support to the existence of these differences. Noteworthy of such findings are the systematic studies of analytically oriented psychotherapy versus behavior therapy supporting the view that these are, in sum, highly contrasting styles of treatment (Staples, Sloane, & Whipple, 1975; Sloane, Staples & Cristol, 1975). Moreover, the treatment procedures created, developed and chosen in one society or within the context of a particular belief system may not be transposable to another. This is particularly apparent in attempts at cross-cultural psychotherapy (Whittkower & Warnes, 1974).

In early attempts to schematize the many psychotherapeutic methods, Menninger (1955) and Bromberg (1959) subsumed the various forms into two dichotomies: those which they thought used a principle of suppression in their treatment approach versus those which represented the use of a principle of expression. Harper (1959), describing 36 established Freudian and post-Freudian psychotherapeutic schools, attempted to divide the various approaches into two categories: those

reflecting emotionally oriented or affective forms of treatment versus those intellectually oriented or cognitive. Offenkrantz and Tobin (1974) suggested that all learning (including psychotherapeutic learning) occurs in three modes: by identification, by conditioning and by insight. Thus, Karasu (1977) concluded that "one might attempt to unite the various psychotherapies on the basis of their primary modes of therapeutic learning or the major ways in which they presume to effect change in or cure of the patient (p. 853)". With this in mind, he organized the predominant therapeutic systems according to the basic themes around which each distinctively pivots. Each theme represents a unity of beliefs regarding the nature of man and his ills and has a bearing on one's concept of therapeutic modes or curative processes, the nature of the therapeutic relationship between client and therapist and, ultimately, on one's methods of treatment. The following will be a delineation of Karasu's three themes.

Karasu (1977) described three themes which he thought predominated in the development of psychotherapies: the dynamic, the behavioral, and the experiential. Again, these themes represent different conceptualizations of the fundamental nature of man, of the therapeutic processes or change agents, of the basic nature of the therapeutic relationship and of the primary techniques and methods utilized in treatment.

The dynamic theme focuses on the concept that all mental phenomena are the result of an interaction of forces. The primary concerns of this model include: 1) a preoccupation with the

vicissitudes of man's instinctual impulses, their expression and transformation, their repression (by which is meant the pervasive avoidance of painful feelings or experiences by keeping unpleasant thoughts, wishes, and affects from awareness); 2) the belief that such repression is of an essentially sexual nature and that the roots of disturbance reside in faulty psychosexual development; 3) the idea that faulty psychosexual development has its origins in early past and childhood conflicts or traumata, especially those concerning a parental oedipal configuration; 4) the belief that underlying oedipal conflicts remain alive but unconscious and that most mental life is unconscious; 5) the idea that the therapist deals essentially with psychic struggle and the torments of biological man's innate instincts (id), their derivatives, and the primarily defensive mediation with external reality (ego) in light of one's moral precepts (superego); and, finally, 6) adherence to the concept of psychic determinism or causality according to which mental phenomena as well as behaviors are not chance occurrences but meaningfully related to events that preceded them and, unless made conscious, subject to repetition.

The goal or task of the dynamic model is the making conscious of the unconscious through the attainment of insight. The dynamic therapist accomplishes this via the slow unraveling of the largely historical meanings of mental events and the devious ways in which they may serve to ward off the underlying conflicts through defensive camouflage. The therapeutic cure is seen as the total reorganization of the personality.

The nature of the therapeutic relationship in the dynamic model is seen as unequal and relationship is seen as the critical factor in the cure (Strupp, 1970). Rosen (1972) describes the relationship as a "complex, emotionally charged, parent-child kind (p. 126)".

The techniques and methods of the dynamic model include free association and analysis of transference reactions and resistances. The tools utilized in treatment include confrontation, clarification, interpretation, and working-through (repetition). The stance of the therapist is reflective and ambiguous.

In comparison with other forms of treatment, certain techniques would be considered expressly anti-dynamic, i.e., to block or lessen one's insight rather than facilitating it (therefore, too much abreaction would be thought to have a negative impact), direct suggestion or advice, manipulation and deliberate or conscious assumption of roles or attitudes by the therapist.

The above description of the psychodynamic theme is that of classical psychoanalysis. Variations on the dynamic theme reflect modifications of theoretical conceptualizations as well as methodological and technical applications in practice. These include attempts to partially or completely transcend the biological focus of Freud with more interpersonal, social, ethical and cultural considerations (e.g., Adler - Individual Psychology, Horney - Character Analysis, Sullivan - Interpersonal Psychiatry, Fromm - Cultural School, Fromm-Reichmann - Intensive Psychotherapy, Meyer - Psychobiological Therapy, Masserman - Biodynamic Therapy); to extend or enhance the ego

with earlier or more adaptive endowments (e.g., Federn, Klein - Ego Analysis); to enlarge man's temporality with time focus on his primordial past (Jung - Analytical Psychology), his present, and/or his future (e.g., Adler, Stekel - Active Analytical Therapy, Rank - Will Therapy, Rado - Adaptational Psychodynamics); to expand treatment procedures by alternating the range and goals of therapy (e.g., Rank, Alexander - Chicago School, Deutsch - Sector Therapy, Karpman - Objective Psychotherapy); to develop guidelines for short-term therapy with anxiety-provoking techniques (e.g., Sifneos - Short-term Psychotherapy); to revise the role of the therapist's personality and relationship to the client by making the therapist a more direct, flexible and/or active participant in the therapy (e.g., Adler, Sullivan, Rank, Alexander, Stekel, Rosen - Direct Analysis); to substitute an approach to therapeutic cure from the somatic side by trading the traditional change mode of insight for a reversal back to the earlier catharsis by means of the bodily release of conflictual tensions (e.g., Reich - Character Analysis) (Karasu, 1977).

The behavioral theme presumes that all behavior, both normal and abnormal, is a product of what man has or has not learned. Neuroses or neurotic symptoms are construed as simple learned habits, involuntarily acquired, repeated, reinforced responses to specific stimuli (Eysenck, 1959). Behavioral psychotherapy is an outgrowth of animal laboratory experiments on classically conditioned responses in which animals were observed to have habits that resembled human phobias. Traditionally, behavioral psychotherapy also presumes that human neuroses have the same

basic vicissitudes as those of the animal, in which anxiety (equated with fear) is regarded as the central manifestation (Wolpe, 1969).

The goal or task in the behavioral model is the direct teaching and learning of new behavioral associations, i.e., stimulus-response connections. These new alternatives must be directly rehearsed. Thus, in direct contrast to the dynamic schools, the behavioral approaches think that insight is not only unnecessary but, in fact, is viewed as hindering the treatment (Cautela, 1970). As treatment is concerned with habits existing in the present, their historical development is largely irrelevant, and the focus is, therefore, on the present rather than the past (Eysenck, 1959).

Hollander (1975) states that the nature of the relationship in the behavioral model is essentially educative, teacher-pupil. In contrast to the psychodynamic model, the therapist directly and systematically manipulates, shapes and inserts his/her own values into the treatment and the therapist-client relationship is focused upon only to the extent necessary to secure the client's cooperation with the therapist's treatment plan. The therapist's role is that of adviser.

The methods and techniques of the behavioral therapist include a large variety of conditioning, training, and other directive techniques, including any or all of the following: the more classical conditioning techniques of systematic desensitization combined with deep muscle relaxation, implosion, or assertiveness training; the operant techniques of positive or negative reinforcement; aversiveness training; shaping or modeling; and/or the more flexible directive techniques pertaining to

the direct transmission of advice, guidance, persuasion, and exhortation. The behavioral counterpart of a psychodynamic formulation consists of identifying the behaviors needing modification in conjunction with the specific stimuli or environmental situations triggering them. Specific treatment goals, which are made explicit to the client, are derived from this formulation. Assignments and behavioral rehearsal are the behavioral counterparts of psychodynamic concept of working through.

Variations on the behavioral theme include: the primary use of systematic desensitization or extinction of anxiety techniques based on the early classical Pavlovian paradigm (e.g. Wolpe's reciprocal inhibition therapy); the use of direct reinforcement by means of reward/punishment procedures based on an operant Skinnerian paradigm (e.g., Allyon and Azrin's token economy); use of direct modeling or shaping procedures based on a human social learning paradigm (e.g., Bandura's Modeling Therapy or Trait-Factor Therapy). The latter types of therapies extend to a variety of new systems of directive psychotherapy that expressly aim at attitudinal or philosophical restructuring using behavioral methods. These so-called integrity therapies share the fundamental behavioral learning or problem-solving stance, but they are usually more actively advisory and/or exhortative in their therapeutic techniques (e.g., Ellis' Rational Therapy, Glasser's Reality Therapy, and Sahakian's Philosophic Psychotherapy). Recent behavioral approaches venture into inaccessible and involuntary mental and physiological states and responses, such as blood pressure

and heart rate (e.g., biofeedback).

The humanistic/existential theme renounces the deterministic, dynamic conceptualization of man as the predominantly passive or instinctually regressive recipient of his conflictual drives, subservient to his unconscious aspects (Karasu, 1977).

The goal or task of treatment in the humanistic/existential model is maximal awareness and a higher state of consciousness. Treatment strives to facilitate the integration of the mind, the body, and the soul. The experience of what one is doing is seen as far more important than the knowledge of why something is being done. Psychopathology is viewed as the reduced expression of one's potential. Like the dynamic model, the humanistic/existential model sees the neurotic as suffering from repression and fragmentation, but repression is construed as ontologically rather than instinctually rooted. Neurosis is the manifestation of fundamental human despair. Anxiety refers to the concept of man facing the limits of his existence with the fullest implications of death and nothingness (May, Angel & Ellenberger, 1970) rather than the behavioral concept which equates anxiety with specific, circumscribed fears.

In the humanistic/existential model, the therapeutic change process trades the dynamic concepts of insight and cognition for emotion and experiencing. The focus is on experiencing in the immediate present and the spontaneous expression of this experiencing.

The humanistic/existential therapeutic relationship is seen as authentic rather than transferential (dynamic model). The relationship

is intended to be emotionally-arousing and to include mutual dialogue and encounter. This theme aspires to an egalitarian treatment model, human-to-human rather than doctor-patient, parent-child (dynamic) or teacher-student (behavioral).

The humanistic/existential model renounces specific techniques or methods. What distinguishes this therapy is not what the therapist would specifically do but the context of his/her treatment (Chessick, 1974). It does not concern itself with the client's past, diagnosis, insight, interpretation or transference/ countertransference like the dynamic model, nor does it set goals, direct, advise, confront or otherwise impose the personality of the therapist on the client like the behavioral model. The aim is to enter the experiential world of the client.

Although they share the emphasis on the therapeutic encounter and on feelings, other schools under the humanistic/existential umbrella may be anti-verbal in approach. These schools view overintellectualization as a defense against experiencing or feeling and aim to combine action with introspection. The main thrust of therapy is to actively arouse, agitate, or excite the client's experience of himself/herself. Among the techniques for self-expression in such schools is role-playing, performing fantasies and dreams, methods for the direct release of physical tension, manipulations of the body and meditation.

Further variations on the humanistic/existential theme include; a philosophic type, which reflects existential tenets as a basis for the conduct of psychotherapy and pivots on the here-and-now, mutual dialogue

or encounter while retaining essentially verbal techniques (e.g., Roger's Client-Centered Therapy and Frankl's Logotherapy); a somatic type, which reflects a subscription to nonverbal methods and aspiration to an integration of self by means of focusing attention on subjective body stimuli and sensory responses (e.g., Perls' Gestalt Therapy) and/or physical-motor modes of intense abreaction and emotional flooding in which the emphasis is on bodily arousal and release of feeling (e.g., Lowen's Bioenergetic Analyses and Janov's Primal Scream Therapy): and, finally, a spiritual type which emphasizes the final affirmation of self as a transcendental or transpersonal experience, extending man's experience of himself to higher cosmic levels of consciousness that ultimately aim to unify him with the universe. This is primarily accomplished by means of the renunciation of the individual ego in the establishment of an egoless state by meditation (e.g., Transcendental Meditation), a spiritual synthesis that may be amplified by various techniques of self-discipline and and will-training and practice of disidentification (e.g., Assagioli's Psychosynthesis) (Karasu, 1977).

Summary

While there are commonalities among the multitude of therapeutic schools, it appears that there are three broad themes under which these schools have proliferated since Freud. Under each of the broad themes of dynamic, behavioral and humanistic/existential each dimension is generally compatible with the others in its domain and is seemingly

antithetical to those dimensions described in the other two themes. Out of these broad themes emerge differences in world view, the needs of the client, the roles of the therapist and the client, the nature of the hierarchical (psychological) distance between the therapist and the client, and the focus, content and task of the psychotherapy.

Supervision Models

This section of the review of the literature delineates and describes the development and contents of various conceptualizations of the supervision process. While much has been written about diverse aspects of supervision, some authors described only goals and others described only processes (Hart, 1982). Few have put these concepts together into models for the training and practice of supervision (Leddick & Bernard, 1980; Loganbell, Hardy & Delworth, 1982). Hart (1982) defines a supervision model as a "cluster of elements remaining relatively consistent from supervisor to supervisor" (p. 3).

Differences in models of supervision imply different perceptions and orientations toward the definitions and goals of psychotherapy. Also implied are different underlying theories of learning and change, of what the trainee needs to increase his/her effectiveness as a psychotherapist, of the roles of psychotherapist, supervisor, trainee and client, of the nature of the psychological distance between the

them, of the scope of the content dealt with in the supervisory session, and of the goals and definition of supervision (Gurk & Wicas, 1979; Hart. et.al., 1976). These philosophical differences on the part of the supervisor may be conscious, unconscious, intentional or haphazard, rational or irrational. They may be functions of stylistic preference or of deeply held cognitive beliefs (Gurk & Wicas, 1979).

In 1942, Reynolds enunciated a learning and teaching model for the practice of social work that included client, learner, evaluation, practice location, professional identity and supervision modality.

This narrative account of preparation for social work practice defined the practice of social work as an art, implying that while its elements eluded quantification conditions conducive to the care and nurture of social work "artists" could, and should, be delineated and replicated.

She saw the learner as a "biological organism" (p. 68) and believed that instruction must address the whole person with his/her biological, social, conscious and unconscious components. Therefore, integration of the entire learning process is essential, with no gaps between theory and practice.

Reynolds postulated five developmental stages in the use of conscious intelligence: 1) the stage of acute consciousness of self; 2) the stage of sink-or-swim adaptation; 3) the stage of understanding the situation without power to control one's own activity in it; 4) the stage of relative mastery, in which one can both understand and control one's own activity in the art which is learned; and 5) the stage of

learning to teach what one has mastered. Reynolds viewed these stages as neither discrete nor as ever completely mastered.

Reynolds very early account of training for mental health practice focused on the dynamic process of learning to be a social worker via instruction, modeling, nurturing, self exploration and practice and on the complexity and delicacy of integrating these concepts.

An early formalized conceptual model of supervision was articulated by Eckstein & Wallerstein (1963). Control Analysis was a conceptualization of the psychoanalytic supervisory process in which the process was viewed as identical to psychoanalysis itself but the content of the free associations was the self of the trainee and his/her therapeutic work and clientele. This conceptualization evolved into the counseling or experiential models of supervision (Arbuckle, 1963, 1965; Lister, 1966; Kaplowitz, 1967; Carkhuff, 1968).

The counseling and experiential models have as their goal the personal growth of the trainee. In the extreme of these models, supervision is utilized solely for the self-exploration and growth of the trainee. A more moderate application of these models would explore the trainee's thoughts and, perhaps, his/her history as a link to the trainee's behavior with clients. The experiential supervisor would function in a responsive, rather than a directive manner with the trainee and, frequently, might focus on the supervisor/trainee relationship. The intent is to communicate values and attitudes rather than techniques (Gurk & Wicas, 1979). These models were based on the

assumptions that trainees need more insight and affective sensitivity than they already possess and on research indicating that certain personality traits have a critical impact upon psychotherapeutic performance (Wicas & Mahan, 1966; Gruberg, 1969; Mezzano, 1969; Silverman, 1972).

Simultaneously with the development of the counseling/-experiential models of supervision, a "didactic", or instructional, supervision model emerged that emphasized acquisition of knowledge of specific techniques of psychotherapy or of client behavior (Matthews & Wineman, 1953; Krumboltz, 1967; DeWald, 1969; Delaney, 1972).

In the didactic models the assumption is that trainees are in need of specific professional skills and that demonstration of these skills indicates professional competence. The task of the therapist is to help the client solve a problem, and thus he/she needs practice, review, and instruction in developing techniques to address clients' problems (Ciecko, 1981). THerefore, the focus in the supervision is on understanding the client rather than the trainee, and the supervision is goal-oriented. The supervisor would initiate topics with the trainee, and their relationship would not be considered a significant variable in the supervision process (Haley, 1977). The didactic model is clearly based upon consequences rather than causes and its adherents cite research attesting to its efficacy over counseling/experiential supervision in improving therapist empathy (Hansel & Warner, 1971), in producing positive effects on trainees (Demos, 1962), and they underscore the preference of supervisors for rational, evaluative

responses and for a teacher-student type of supervision relationship (Walz & Roeber, 1962; Kadushin, 1974).

Much of the early research on supervision was focused on affirming the validity of these two separate positions on supervision (Truaz & Carkhuff, 1967). More recently, attempts have been made to determine whether there are additional models beyond the two traditionally identified, whether the two models are mutually exclusive in their use in supervision, and to construct supervision models that include both counseling and instructional components.

While Patterson (1964) and Arbuckle (1965) did not develop supervision models, they pinpointed some critical elements of the supervision process: power, authority, and evaluation.

Fleming and Benedek (1964) evaluated transcripts of five recorded supervisory sessions of two student psychoanalysts both supervised by the two investigators. Out of this evaluation they developed a frame of reference in which to identify and organize the process of the teaching-learning experience in the interaction between the supervisor and the student analyst. This model delineated the tasks and activities of a supervisor which focused on his/her over-all teaching aims, pedagogical diagnosis of the trainee, and the teaching targets toward which the teaching maneuvers were directed. They developed a sequence of learning objectives ranging from elementary to advanced levels and stressed the relation between the basic learning objectives and the native aptitudes of the trainee. They were investigating supervision of student psychoanalysts and their model was

based on the fundamental assumption that psychoanalytic skill depends primarily on native endowment consisting of an interpersonal sensitivity and and capacity for empathetic responsiveness that could not be imitated but must be developed. This, they concluded, was the basic task of supervision. Fleming and Benedek felt that their data demonstrated the significance and vicissitudes of the relationship between supervisor and student-analyst (the "learning alliance") and that effective learning depends on this relationship.

Hansen and Moore (1966) urged that the instruction and counseling aspects of supervision be separated, such as in a practicum in which the university supervisor helps the trainee learn about self and the on-site supervisor would be more responsible for technical instruction.

Buchheimer categorized the supervisory role into procedural, didactic, demonstration, and self-exploratory approaches (Fraleight & Buchheimer, 1969).

Danish (1971) described both didactic and experiential methods of supervision and formulated an approach which integrated the two methods and allowed them to be used simultaneously.

Hackney (1971) suggested that certain skills (e.g., listening, using silence, identifying feelings) be taught prior to the formal supervision experience so that supervision could then be on a "consultation-professional" basis.

Delaney (1972) conceptualized a developmental/behavioral model of supervision in which the following five stages were identified within

the supervision process: (1) initial session; (2) development of a facilitative relationship; (3) goal identification and determination of supervisory strategies; (4) supervisory strategies--instruction, modeling, reinforcement; and (5) termination and follow-up. Desirable supervisor behaviors and goals were specified for each stage.

Spice and Spice (1976) described a "triadic" method in which trainees learn to assume three differing roles: trainee, facilitator, and commentator. Four basic processes are taught; (1) presentation of psychotherapeutic work; (2) art of critical commentary: (3) engagement in meaningful self-dialogue; and (4) deepening of the here-and-now. Their model included both process dimensions of supervision and a functional approach to learning.

Abroms (1977) combined the supportive and interpretive function of the supervisor in a model of supervision as metatherapy. The metatherapeutic relationship occurs between the supervisor and the relationship of the trainee and his/her client. Supervision is seen as occurring through the process of analysis of metatransference, which is the manifestation of aspects of the client-therapist relationship within the therapist-supervisor relationship.

Blake and Mouton (1978) developed a "consulcube" model for supervisory behavior. In supervision, the trainee was considered the client system and the supervisor the change agent. The three dimensions of their model are units of change, kinds of interventions, and focal issues. Five categories of interventions were delineated: acceptant-cathartic, catalytic, confrontation, prescriptive, and theory and

principles. Four focal issues described were: power/authority, morale/cohesion, norms/standards, and goals/objectives. Kinds of interventions delineated span the counseling versus instruction dichotomy and suggest alternate tactics for supervisory action on a given defined issue with the individual being supervised.

Littrell, Lee-Borden, and Lorenz (1979) described another developmental supervision model in which the process of developing therapists as they move towards increasing professionalization was categorized into stages. Stage I involved establishing the relationship--goal setting, and contracting. In Stage II, the integration of counseling and teaching models occurs. Stage III allows for the therapist to engage in a consultatory relationship. In the final stage (IV), self-supervision serves a maintenance and growth-producing function.

Gurk and Wicas (1979) developed a "meta-model" of supervision based on process consultation in an attempt to organize other models. They divided the consultation process into the following components: (1) contract definition and redefinition--the more prescribed the contract the more the supervision approaches the instruction model; the more the contract becomes the working issue, the more supervision approaches the counseling model; (2) data collection--how, with regard to what and whom; (3) data analysis--how is information understood, defined, labeled, to what end, with what objectives in mind for the therapist and for the client; (4) problem solving--treatment strategies; (5) evaluation--of whom and for what purpose.

Stoltenberg (1981) conceptualized the supervision process as a sequence of identifiable stages through which the trainee progresses. His developmental model has four levels with four supervision environments deemed appropriate for the facilitation of trainee development to the next level. Level 1 views the trainee as dependent on the supervisor and the optimal supervision environment as encouraging of autonomy within a normative structure. Level 2 views the trainee as engaged in a dependency-autonomy conflict and the desired supervision enviornment as highly autonomous with a low normative structure. Level 3 places the trainee in a state of conditional dependency and describes the appropriate supervision environment as autonomous with the structure provided by the trainee. Level 4, appropriate when the trainee is a competent therapist, describes the supervision environment as collegial.

Loganbill, Hardy, and Delworth (1982) developed an elaborate supervision model that included developmental stages of the trainee, the critical issues in each of these stages and useful categories of interventions for each stage and issue. The stages are (1) stagnation, (2) confusion, and (3) integration. The issues are competence, emotional awareness, autonomy, identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics and values. Five possible categories of interventions delineated are: facilitative, confrontive, conceptual, prescriptive, and catalytic. Loganbill, et.al., conceptualized the stages, issues, and interventions as interacting along each possible dimension.

Summary

The early experiential and didactic "models" of supervision initially demonstrated possible differences in supervisory approaches. These concepts were found to be insufficient as they lacked the inclusivity necessary to describe the variety of affective and cognitive responses utilized by supervisors. Other variables have been suggested which broaden the elements impacting upon the supervisory triad. Issues such as context, supervisor and trainee characteristics, and cybernetic influences are being considered in the development of supervision models. Yet, there is much ambiguity in existing supervisory behaviors. Thus, both the selection and articulation of a model of supervision are complex phenomena.

Hart's (1978, 1982) Supervision Models

After much examination of supervisors, supervisor's-in-training, trainees, and applicable research, Hart determined that many of the described dimensions of supervision had been derived by a deductive approach. He then isolated three dimensions by which he felt all of the processes of clinical supervision could be differentiated: (1) the functional relationship between the supervisor and trainee: (2) the hierarchy between supervisor and trainee, and; (3) the focus of the supervision session. These dimensions form the descriptive basis for Hart's conceptual models of supervision.

The functional relationship between supervisor and trainee refers to how they work to attain the goals of supervision. This is

demonstrated by what they communicate to one another rather than by how they feel about each other. Each of the participants in the relationship makes statements illustrating how each of their behavior patterns fits or complements the other's. The concept of complementary interpersonal relationships was developed by Leary (1957) and applied to psychotherapy by Haley (1963). These authors stated that all interpersonal relationships could be assessed by the complementary ways in which the participants act toward one another. In complementary relationships the behaviors exchanged by the participants fit together--one is in a "superior" and the other in a "secondary" position. From many descriptions of supervisor-trainee relationships, Hart outlined three patterns of complementary supervision relationships: teacher and student; therapist and client; and collaborators. Hart proposed that each of these relationship patterns would be determined by a particular goal of supervision. As each of his models of supervision has a different goal, the functional relationship between the supervisor and trainee will differ with each model.

In the teacher-student relationship, as in the "didactic" models, theory, techniques, or professional positions must be conveyed to the trainee (Hart, 1982, p. 35). The supervisor's position is that he/she has skills and knowledge to convey to the trainee who does not have this data and requires it in order to attain competence as a professional clinician.

In the therapist-client relationship the supervisor believes that a trainee requires self-awareness of attitudes and feelings and that the means of facilitating these elements is via a replication of

the therapist-client stance in psychotherapy within the supervision relationship. Supervisors having the goal of personal awareness will use their clinical skills to help trainees learn about themselves in terms of becoming aware of their general interpersonal behavior and their feelings in those interpersonal interactions (Hart, 1982, p. 35). As in the "experiential" models, the assumption fundamental to this goal is that trainees who have greater personal awareness will be more effective clinicians.

In the collaborative relationship the supervisor believes that a supervisee has, or can acquire, sufficient skills and/or personal awareness and must integrate these two dimensions to achieve effective clinical practice. The supervisor then serves as a collaborator with the trainee with respect to the trainee-client interaction.

The dimension of hierarchy in a supervision relationship refers to the superior position that the supervisor has over the trainee. Most writers in the field believe that hierarchy is always present between supervisor and trainee and that this superior position is based on the type and amount of power the supervisor uses in order to influence the trainee (Hart, 1982, p. 37). The type of power is initially determined by the overt characteristics of the supervisor such as expertise or organizational position. As the supervisory relationship develops, the element of the trainee's identification with the supervisor becomes a factor in the type of power operating in the relationship.

The assumption is made that the hierarchy between supervisor and trainee is not an absolute but a quantity determined by perceptions of both persons. Therefore, the hierarchical distance would differ between

various supervisor and trainee dyads.

A primary determinant of hierarchical distance is the trainee's perception of the supervisor's characteristics and behaviors within the supervision session. Hart suggests that trainees who perceive the supervisor's behavior as vastly more competent than that of the trainee will have a greater hierarchical distance than trainees who perceive less distance between the competence of themselves and that of their supervisors. It would seem that this would also apply to the perceptions of the supervisors along these dimensions and that their perceptions would have equal impact upon the hierarchical distance in the relationship.

Supervisors can contribute to a large hierarchical distance by making critical observations, expressions of doubts regarding the competence of the trainee, excessive interpretations, mystification or pontification. Motivation for establishment of large hierarchical distance may come from the need to establish and maintain great distance, to gain feelings of superiority, or to control or punish the trainee. More appropriately, the supervisor may wish to maximize his/her impact on the trainee for theoretical reasons.

Trainees can contribute to a greater hierarchical distance by eliciting evaluative and directive comments from the supervisor, by deprecating him or herself, or by attempting to convey a picture of excessive competence or incompetence. Trainees may be motivated in establishing a large hierarchical distance in order to validate their feelings of worthlessness, or to protect themselves from the results of possible clinical errors by deifying their supervisor.

Either the supervisor or the trainee may attempt to reduce the hierarchical distance between them. A supervisor may accomplish this by demonstrating confidence in the clinical abilities of the trainee, by minimizing his/her ideas and emphasizing those of the trainee, or by urging the trainee to try out his/her own ideas. The trainee may establish a low hierarchical distance by operating more independently and relying less on the supervisor for directives. The supervisor may be motivated by a desire for emotional closeness to the trainee, by a fear of his/her power and authority, or by a theoretical position advocating such a stance. The trainee may be motivated by fear or loathing of authority figures or by a desire to become a more independently functioning clinician.

Once a hierarchical distance is established, the only variable subject to change is the perceptions of those variables, and perceptions may change only as the result of the behavior of both supervisor and trainee (Hart, 1982,p. 39).

It is further believed by Hart that hierarchical distance is related to the model of supervision a supervisor implements. Supervisors using a particular model of supervision engage in behaviors that are appropriate for that model and that establish a certain hierarchical distance. Ideally, the same supervisor would have flexibility in utilizing different models when appropriate and when doing so would behave differently because the goal of each model is different.

The focus of the supervision session refers to the person or persons toward whom the supervisor directs the discussions. The session

can be focused on the trainee's client, on the trainee, or on the process in the trainee-client, trainee-supervisor, or trainee-client-supervisor relationship.

Hart (1982) examines the focus in the content of what the supervisor and the trainee discuss in the supervision session. He concludes that research provides justification for thinking of three possible major foci in supervision; one main focus on the technical and conceptual skills of trainees in their interactions with specific clients; a second, more personal, exploration of the general concerns of trainees about themselves and their development; and a third focus on the relationship between trainees, clients, and, perhaps, the supervisor.

By combining the elements of the nature of the role relationship between the supervisor and the trainee (functional relationship), the nature of the psychological distance between the supervisor and the trainee (hierarchical distance), and the main focus of the interaction between the supervisor and the trainee (focus), Hart (1978, 1982) formulated three models of supervision: the Skill Development model, the Personal Growth model, and the Collaboration model.

The goal of the Skill Development model is to impart technical skills and techniques to the trainee. The trainee is to be assisted in understanding the client's personality dynamics, his/her milieu, and the nature of his/her problem. Furthermore, the trainee is to be helped to develop an appropriate treatment plan for the client with measurable goals. In addition, the supervisor will assist the trainee in establishing strategies for carrying out the treatment plan. In this

model, the functional relationship between the supervisor and the trainee is that of teacher and student. The nature of the hierarchical distance is high in that the supervisor is superior in expertise and authority. The main focus of the supervisory interaction is on the trainee's understanding of the client's behavior and on what can and should be done with this type of client. The content of the supervision session would include methods of gathering information about the client from various sources, reviewing and assessing the data collected, identifying problem areas, establishing goals, assessing problems, and considering possible referrals.

The goal of the Personal Growth model is to assist the trainee in becoming more psychologically secure and integrated, the assumption being that the acquisition and enhancement of these attributes will render the trainee a more effective clinician. The assumption of the model is that the trainee needs to and should improve his/her interpersonal behavior. The functional relationship between the supervisor and the trainee is that of therapist and client. The nature of the hierarchical distance between the supervisor and the trainee is considerable; the trainee is seen as needing to change. The focus of the supervision sessions is on helping the trainee to understand his/her feelings, attitudes, and behaviors, and to behave in ways that are seen as appropriate to the task of psychotherapy. In this model, the content of the supervision sessions would include little or no emphasis on any particular client. Clients would be used as the vehicle to help the trainee explore his/her feelings and behaviors. Client psychodynamics, case conceptualizations, the making of particular interventions or

development of particular skills are not emphasized. The belief underlying this model is that the focus on the trainees' own dynamics and interpersonal functioning will generalize to the trainee-client situation.

The Collaboration model is likened by Hart to Eckstein and Wallerstein's (1958) process focus in supervision as a way of approaching the interaction of the trainee and his/her client. The goal of this model is to help the trainee become aware of feelings and attitudes he/she may have toward clients and to deal with these feelings and attitudes in an appropriate manner. In this model the supervisor's focus is on the powerful effect that clients, supervisors, and trainees have on one another. The general personality growth of the trainee is of secondary concern. This focus was first described by Searles (1955) as the reflection process: "The processes at work currently in the relationship between patient and therapist are often reflected in the relationship betwseen therapist and supervisor (p. 35)." Doehrman's (1976) study documented this phenomenon and, in addition, how the relationship between a supervisor and trainee is reflected in the relationship between trainee and client. Doehrman used the term parallel process to label this process. Abroms (1977), describing supervision as "the relationship between a supervisor and a therapeutic relationship (p. 83)", called this metatherapy.

In this model the functional relationship between the supervisor and the trainee is that of collaborators. There is some hierarchical distance between the supervisor and trainee but less than in the other

two models. The content of the supervision session would be the data of the trainee's verbal and non-verbal behavior in the here-and-now of the supervisory session. The parallels between the trainee's behavior toward the supervisor and his/her behavior toward clients would be investigated. This model is based on the belief that the supervision session is similiar to the psychotherapy session.

Summary

Hart formulated three models for supervision and described their components. The models build on elements of the early didactic and experiential formulations, but Hart has quantified their components, providing a way to more accurately locate supervisory behavior so that it can be assessed and, perhaps, if indicated, modified.

Hart (1982) suggests that the choice of a model of supervision by a supervisor should be a deliberate one based upon an examination of three variables: the characteristics of the supervisor, the characteristics of the trainee, and the characteristics of the context in which supervision is taking place. This study focuses on the impact of one of the supervisor's characteristics on his/her preference for one of Hart's supervision models--that of theoretical orientation.

Table 1. A comparison the the skill development, personal growth, and collaboration models of supervision according to functional relationship, hierarchical distance, and focus.

	Skill Development Model	Personal Growth Model	Collaboration Model
Functional relationship	Teacher-student	Therapist-client	Collaborative
Hierarchical distance	high	moderate	low
Focus	trainee's skills with and understanding of the case	trainee's self-insight and affective sensitivity	trainee's integration of skills and personal awareness as demonstrated in the trainee-supervisor-client interaction

Supervisor Theoretical Orientation and Supervision

There are few existing studies investigating the relationship between a supervisor's theoretical orientation and his/her supervision, and they have been conducted recently. This section of the review of the literature will examine these studies.

In 1982, Kersey completed his doctoral dissertation exploring the process and focus of supervisors as these were applied in the development and training of Marriage and Family Therapists (MFT's). One of the purposes of Kersey's study was to describe the influence of the theoretical orientation of the supervisor on the process and focus of supervision.

Kersey's subjects were 18 supervisors approved and certified by the American Association for Marriage and Family Therapy, and 36 trainees in marriage and family therapy. In order to qualify to participate in the study, a supervisor had to be supervising a beginning trainee, with less than 100 hours of clinical work, and an advanced trainee, with more than 500 hours of clinical work. For purposes of the study, each supervisor selected one beginning trainee and one advanced trainee. 5 of the supervisors were female and 13 were male. 61% of the supervisors held doctorates while 39% held masters degrees. 33% of the supervisors reported that their highest degree was in an area of psychology and 22% reported social work. When indicating the setting in which they performed supervision, 28% reported an academic setting while 72% reported they did supervision in a non-academic setting. Information regarding theoretical orientation was self-reported as

follows: 2 (11.1%) of the supervisors identified themselves as psychodynamic; 2 (11.1%) identified themselves as intergenerational; 13 (72.2%) identified themselves as systems; and 1 (5.6%) identified him/herself as behavioral. Demographic information was not provided for years of experience.

For a test instrument, Kersey developed the Supervisory Process and Focus Analysis (SPFA). This instrument measures educational/-instructional statements as opposed to therapy statements in supervision. It measures verbal content in terms of the focus of the supervisor on either his/her trainees or on their clients and identifies the talk ratio between the supervisor and the trainee in the supervisory session.

The subjects provided supervision tapes with both a beginning and an advanced trainee and independent rators, using the SPFA, tallied every five seconds of the sessions into sections depending on the nature of the verbal communications.

The results of this study indicated that all of the supervisors spent approximately twenty-two minutes focusing their statements on clients with the beginning trainees and about twenty minutes focusing their statements on clients with the advanced trainees. In addition, the majority of time spent in supervision with both beginning and advanced trainees was spent by the trainees talking. The next largest quantity of time was spent by the supervisors making educational types of statements with a focus on the clients. Because there were too few supervisors in each of the theoretical orientations, Kersey decided to place the supervisors into two categories: systems (structural,

strategic, communications and integrative) and non-systems (psychodynamic, symbolic and contextual). The author stated that these categorizations were based on theoretical orientations which emphasize personal growth aspects of supervision and affective lives of trainees (non-systems) and those focusing on defining particular sets of therapist's skills and techniques (systems). He did not indicate his rationale for this position. The only significant finding pertinent to theoretical orientation was that non-systems supervisors made significantly more responses with beginning trainees than did the systems therapists ($p=.05$). This was an interesting finding in that the systems therapists would be expected to be more directive. The differences in the number of responses with the advanced trainees was not significant. In addition, there was no significant difference between the average amount of time spent talking by the supervisor attributable to setting, degree, professional discipline or to gender. On the whole, the supervisors made significantly more educational than counseling statements ($p=.05$). This result was consistent across theoretical orientation, beginning and advanced trainees, gender and professional discipline. The non-systems supervisors made slightly more counseling than educational responses but this difference was not statistically significant. Overall, the supervisors spent significantly more time making client-focused responses rather than trainee-focused responses ($p=.000$). There were no significant differences between supervisors' with beginning or advanced trainees, by theoretical orientation, degree, gender, or setting. When the specific SPFA sections were crosstabulated with theoretical orientations only one

significant relationship was found between Counseling/Therapy - Trainee Focus scores and the supervisors' theoretical orientations: The experience level of the trainees had little effect on the focus of supervision while theoretical orientation had a significant effect on trainee focus in supervision. Supervisors with a non-systems theoretical orientation were significantly more likely to focus on the trainee ($p=.02$). There were no significant differences between non systems supervisors and systems supervisors in terms of their focusing on the clients. These differences did not vary depending on the experience level of the trainees, the degree, or setting of the supervisor.

The results of this study indicated that while theoretical orientation may have some impact on the process and focus of marriage and family therapists' supervision, this impact was variable and depended upon which segment of supervision was being examined. Non systems supervisors talked more with beginning trainees than did the systems therapists, and non systems therapists focused more on the trainee than on the client. Overall, however, there were no significant differences in the behavior of supervisors with beginning and advanced trainees. There were significantly more educational than counseling statements made by all supervisors, and all of the supervisors made significantly more client focused than trainee focused responses. It seems that the supervisors were not adaptable in their patterns of supervision and did not take into consideration the developmental level of the trainee. It could not be determined if the lack of differences attributable to professional discipline were explained by the

socialization of the supervisors as MFT's or by the application to supervisors of Fiedler's (1950) notion that all therapists are more alike than different.

The limitations of this study included the size of the sample and the select group of supervisors. All of these supervisors were MFT's and they all tended to have systems orientations. It is difficult to determine if there were true differences in theoretical orientation, thus the tentative nature of these findings become even more apparent.

Goodyear and Robyak (1982) tested the hypothesis that a supervisor's theoretical model would influence the extent to which each of three factors were emphasized in supervision. These factors were: the person of the supervisee, i.e. attitudes/values, areas of vulnerability (factor 1); the supervisee's technical skills and techniques (factor 2); and the supervisee's conceptualization of clients' problems (factor 3).

University counseling center staff with supervisory experience provided information about their theoretical orientations, years of professional experience, number of trainees seen, and the percentage weight for each focus used in evaluating their trainees. Subjects were 67 supervisors who indicated they held behavioral or cognitive-behavioral (20), eclectic (40), or psychoanalytic (7) views.

Weights given each factor by the three groups of supervisors were compared by one-way analyses of variance. While no differences were found for factors 1 and 3, supervisors differed ($F = 3.84$, $p = .03$) in stress on factor 2: behavioral supervisors emphasized factor 2 more than eclectic and psychoanalytic ones.

The authors concluded that the study provided preliminary evidence that theoretical orientation has some influence on the focus of supervisors. Yet, this evidence appears to be descriptive only of supervisors who identified themselves as behavioral or cognitive/-behavioral. This study, too, may have provided data indicating that Fiedler's (1950) contention that more experienced therapists, regardless of their theoretical orientations, shared similar emphases, also applies to supervisors.

Miars, Tracey, Ray, Cornfeld, O'Farrell, and Gelso (1983) did a study exploring whether (a) practicing supervisors perceived themselves varying their supervision process across four trainee experience levels, and (b) whether several supervisor demographic variables were related to the degree to which some supervisors might vary the supervision process more than others. One of the variables was the theoretical orientation of the supervisor, others were experience, training, self-perceived behavioral styles and roles.

The sample consisted of 37 PhD-level counselors, counseling psychologists, and clinical psychologists (16 male, 21 female) who had supervised counseling, counseling psychology or clinical psychology graduate students. 30 of the supervisors were employed in a large university training setting, and 7 of the supervisors were in private practice or other agencies but were affiliated with the university. The sampled supervisors had a mean level of 8.2 years of post-PhD supervision experience, with the range being from 1 to 19 years. The average number of trainees in each of the experience levels worked with by these supervisors was; 23 at the first semester level (range = 0-100

trainees) 18 at the second semester level (range = 0-100 trainees), 10 at the advanced practicum level (range = 0-40 trainees), and 13 at the intern level (range = 0-40 trainees).

The authors designed a Level of Supervision Survey (LSS) to assess particular dimensions of the supervision process as it varied across the experience levels of the trainees. Most of the items were constructed based on the supervision environments postulated by Stoltenberg (1981). The resulting survey consisted of 65 items clustered in five major sections. Section I focused on the supervisor's perception of the importance of different aspects of supervision. Section II was concerned with the frequency of certain in-session behaviors by each of the participants. Section III addressed the supervisor's perception of the amount of supervision time spent on various supervisory functions. Section IV addressed the presence of different supervisor roles and behaviors. Section V of the survey assessed demographic variables of the supervisor. For the first four sections of the survey, each supervisor was asked to respond to each item four times, one response for each level of trainee. 28 of the original 65 items that met the authors' test for statistical significance were analyzed for differences in supervisor responses across the levels of trainee experience.

A one-way (4 level) multivariate analysis of variance (MANOVA) was used to examine whether supervisors perceived themselves varying their supervision depending on the level of trainee supervised. The results of the MANOVA were significant ($p = .0001$) indicating that there were differences due to trainee experience level. Some supervisors

significantly varied supervision between second practicum and advanced practicum level trainees; they did not vary the other levels. Those items stressing active direction, support, teaching, and close monitoring on the part of the supervisor attained the highest scores with respect to supervising inexperienced students (first or second semester practicum students and interns). On the other hand, some supervisory responses indicated that trainees with more experience (advanced practicum and intern levels) were given significantly less structure, direction, support, and direct instruction.

In this study, of the several demographic and self-perception variables examined, only theoretical orientation of supervisor was related to whether supervisors differentiated their supervision process across trainee levels. Supervisors who aligned themselves with psychoanalytic or psychodynamic orientations varied the supervision process significantly ($p = .003$) more than supervisors of humanistic orientations or those identified with other theoretical perspectives (mostly cognitive/behavioral). The authors speculated that this finding might be explained by the greater emphasis placed on differential diagnosis of clients (and, by implication, trainees) by those psychodynamically oriented or by the fact that a psychodynamic perspective of supervision may be inherently developmental in nature. It was speculated that supervisors process differentially to the degree that their theoretical orientation to psychotherapy endorses a differential use of techniques and processes. This suggests that certain models of supervision may be implicit in various theoretical orientations to psychotherapy. As this study was concerned with

variations in supervision process across trainee experience levels and not specifically with the impact of theoretical orientation upon supervision, the authors urged that further studies of the supervision process be conducted to specifically assess the theoretical orientation of supervisors and its impact upon supervision, as they concluded that this appears to be as significant a dimension in supervision as it is in counseling/psychotherapy studies.

The findings of this study contrasted with those of Kersey (1982). In this study some supervisors did vary their supervision depending on the experience level of the trainee. None of the following supervisor variables had a significant impact on whether supervisors differentiated their supervision process across trainee levels: psychotherapy experience, supervision experience, primary job function, self-perceived behavioral style roles or gender, and the impact of discipline on supervision, were not examined.

In 1981, Ciecko completed his doctoral dissertation examining the relationship between the variables of supervisor interests, personality, theoretical orientation, supervision expectations and the use of a supervision model during supervision. Ciecko used Hart's (1978, 1982) framework of 3 supervision models (Skill Development, Personal Growth, and Collaboration) to view the supervisory process. The variable in Ciecko's study especially pertinent to this study was that of theoretical orientation. He investigated the extent to which there was a clustering between supervisor theoretical orientation and supervisor behavior in terms of supervision model.

Ciecko's subjects were 10 doctoral student volunteers enrolled

in a 14-week seminar on supervision in the Department of Counseling Psychology at a large midwestern university. The subjects were in their second year of a four-year American Psychological Association approved program. Five of the subjects were male and 5 female. Their years of full time counseling experience ranged from 0-4 with the mean being 1.9 years. Their years of actual working clinical experience ranged from 0-3 with a mean of .5 years. 60% of the sample had no previous supervisory experience and the remainder had a superficial exposure. They were, therefore, considered beginning supervisors, and, thus, Ciecko noted that their pertinent variables, behaviors, and choice of models used may have differed from more experienced supervisors.

The testing instruments used in this study were self-report and observational ratings. The self-report instruments included the 16PF, Strong Campbell Interest Inventory, AID scale, Counseling Orientation Scale, and the Expectations About Supervision Test (developed by Ciecko). The observational ratings were made through the use of trained raters using the Supervision Assessment Scale to categorize supervisory behavior. Each of these instruments yielded ordinal data. The instruments utilized by Ciecko pertinent to the present study were the AID scale which measures a therapist's theoretical orientation in terms of therapeutic behaviors, the Counseling Orientation Scale which assesses the relative preference of therapists for seven major counseling theoretical orientations, and the Expectations About Supervision Test which was developed for the purpose of assessing a supervisor's expectations about his/her behavior in the supervisory session with his/her trainees.

Ciecko's study covered a 14-week semester. All subjects initially completed a personal data sheet, the AID scale, the Counseling Orientation Scale, and the Expectations About Supervision Test. At the beginning of the semester, each student supervisor selected two master's level counseling students to supervise. The student supervisors and their trainees engaged in supervision once a week for one hour for 14 weeks. Supervision sessions from weeks 1, 4, 7, 11, and 14 were audiotaped. Transcriptions of these sessions were coded according to the Supervision Assessment Scale by two trained raters in order to classify the supervisory sessions into one of the three supervisory models. The AID scale, the Counseling Orientation Scale, and the Expectations About Supervision Test were readministered prior to the audiotaping done on the 7th and 14th weeks. Two independent raters familiar with the three basic models of supervision were asked to review the 56 statements in the Expectations About Supervision Test and identify which statements correspond to each of the three supervisory models. Statements with high interrater reliability (mutual agreement) were kept and those with low interrater reliability (mutual nonagreement) were deleted. Additionally, two faculty supervisors (of the student supervisors in the study) were asked to fill out the Counseling Orientation Scale and the AID scale according to what beliefs and behaviors they observed the student supervisors using while engaged in therapeutic service before them, and to indicate which supervisory model each student supervisor would be likely to use as their predominant model and the percentage of use each student supervisor would make of each of these models.

Due to the low number of subjects and the descriptive nature of his study, Ciecko chose descriptive statistics to analyze his data. Significance at the .05 and the .10 level was accepted.

Ciecko found a significant relationship between some of the theoretical orientations as measured by the AID scale and the Counselor Orientation Scale and supervisory behavior in terms of model. The Skill Development supervisory model and the "Gestalt" theoretical orientation correlated negatively (-.601, p=.10). The Personal Growth supervision model correlated negatively with the "Psychoanalytic" and "Impersonal" theoretical orientation behavior categories (Personal Growth/Psychoanalytic: -.759, p.=.05; Personal Growth/Impersonal: -.575, p.=.10). These were the only results of significance pertaining to the relationship between the supervisor variable of theoretical orientation and supervisory behavior in terms of Hart's model obtained by Ciecko in his study.

Ciecko utilized the Expectations About Supervision Test to investigate how supervisors' expectations of their supervisory behavior might change in a 14 week period. The results of the analysis indicated no significant changes in supervisor's expectations over the 14 week period.

It is of interest to note that there were some significant relationships between supervisor interests as measured by the Strong Campbell Interest Inventory and supervisory behavior in terms of model. There was a significant negative relationship between the Skill Development model and the "Artistic" interest category. There was a significant positive relationship between the Skill Development model

and the "Enterprising" interest category. There was a significant positive relationship between the Collaboration model and the "Artistic" interest category and a significant negative relationship between the "Enterprising" interest category and the Collaboration model. There was additionally a significant negative relationship between the Personal Growth model and the "Conventional" interest category.

Though Ciecko found some significant correlations on the theoretical orientation dimension, he concluded that these results were very suspect. The Counselor Orientation Scale (COS) is an instrument which measures a therapist's theoretical orientation by way of his/her beliefs about the nature of man, the therapeutic process and how an individual grows and changes. In Ciecko's study, internal and test-retest reliability measurements over the 14 week supervisory period yielded very low consistency on the part of supervisors in selecting and maintaining a clear position relative to theoretical orientation beliefs. In particular, the "Gestalt" category yielded a mean internal consistency over the period of -.58 and an average test-retest reliability of .44. Thus, the positive significant correlation found between the "Gestalt" and Skill Development model was of questionable meaning.

The data yielded by the AID scale reflected a similar situation with regard to the COS scale; only one of the three categories (psychoanalytic) yielded high enough internal and test-retest reliability scores to warrant serious consideration. Thus, only the significant negative correlation between the Personal Growth model and the "Psychoanalytic" theoretical technique category warranted serious

consideration.

Ciecko concluded that the inability of the COS and the AID scales to yield significant relationships between a therapist's behaviors, beliefs and supervisory model may have been the result of several factors. He cited Wagner and Smith's (1978) suggestion that a doctoral student does not become firm in his/her theoretical beliefs for at least 3 to 5 years after completing his/her degree. Since Ciecko's subjects were second year doctoral students, their inconsistency in identifying theoretical orientation beliefs may have been reflective of their evolving beliefs. Ciecko also noted that the students had a general discomfort with the COS scale that may have influenced the care and thoughtfulness of their responses to this instrument. (He did not provide details.) Additionally, Chieko wondered if it were possible to convert theoretical orientation beliefs into clear relationships with supervisory models using present instrumentation. His rationale for this position was that the two supervisors (of the student supervisors) were only able to agree on the predominant supervisory model they thought the student supervisor would use in supervision (based on the supervisor's observation of the student as a therapist) in only 4 of the 10 cases. Ciecko felt this brought into question Liddle's (1978) assertion that "one's therapeutic orientation is also one's supervisory orientation". Although Ciecko did not mention the possibility, this finding may have also reflected that the student supervisor's were as unclear about their preference for and utilization of supervision models as they were about their theoretical orientation.

Ciecko concluded that, based on the results of his study, some

basic notion of the relationship between supervisory model and theoretical orientation beliefs could not be ascribed. His recommendations pertinent to the present study were that his study should be replicated with a larger sample of subjects, preferably, subjects from two or more different mental health agencies or academic programs so that comparisons between individuals and groups could be made; and that continued research on the impact of the theoretical orientation of student supervisors should not be undertaken.

Summary

Studies investigating the impact of a supervisor's theoretical orientations on his/her supervision offer inconclusive evidence regarding a relationship between these two variables. The results of the studies have been confounded by limitations in the size or composition of the sample. When the variable of supervision model is added increased complexity occurs and the impact of theoretical orientation becomes more difficult to assess.

Chapter III

METHOD

The importance of clinical supervision in the training and performance of psychotherapists is widely accepted. Yet, until recently, the field of supervision and, particularly, the person of the supervisor has received little attention from the researcher. The present study was designed to investigate: (a) the relationship between a supervisor's theoretical orientation and preference for a model of supervision, (b) the nature of the relationship investigated in (a), and (c) the influence of the supervisor variable of professional discipline on preference for a model of supervision.

This study was a descriptive survey and all data were gathered through mailed questionnaires.

The Independent and Dependent Variables Used in the Study

The independent variables There were two major independent variables under investigation in this study: theoretical orientation and professional discipline. Based on the review of the literature, it was assumed that theoretical orientation and practice orientation are

closely related and, at least partially, emerge out of the educational and practice experiences obtained during clinical training within each of the professional disciplines.

Other incidental independent variables utilized in this study included various demographic variables that may have yielded interesting or significant data when measured for possible impact upon a supervisor's preference for a model of supervision. (See Appendix D for a listing of these demographic variables.)

The dependent variables The dependent variable under investigation in this study was supervisor preference for a model of supervision.

Operational Definitions-Instrumentation

For purposes of this study the operational definition of theoretical orientation, derived from the review of the literature, referred to a supervisor's philosophical beliefs and attitudes regarding the nature of man, of personality constructs, of anxiety, and of desirable psychotherapeutic goals and techniques.

The Counseling Orientation Scale One of the instruments utilized in this study to measure a supervisor's theoretical orientation was the Counseling Orientation Scale (COS). Loesch and McDavis (1978) developed the Counseling Orientation Scale to assess the relative preferences of therapists for seven major counseling theoretical orientations: behavioral, client-centered, existential, gestalt, freudian, rational-emotive, and trait-factor. The 35 COS items were chosen to reflect five characteristics for each of the seven

orientations: nature of man, of personality constructs, of anxiety, and of counseling goals and techniques. The COS respondent is asked to select one of four response choices on a Likert scale: strongly agree, agree, disagree, or strongly disagree. (See Appendix F for a listing of items in the Counseling Orientation Scale and for additional data regarding the development of this questionnaire.)

For purposes of the present study the seven counseling theoretical orientations were subsumed, after scoring, into the three major theoretical orientations outlined in the review of the literature as follows: Respondents scoring highest on the freudian orientation-related items were placed in the psychoanalytic/psychodynamic category; respondents scoring highest on the rational-emotive orientation-related items, behavioral orientation-related items or trait-factor orientation-related items were placed in the behavioral category; and respondents scoring highest on the client-centered orientation-related items, existential orientation-related items or gestalt orientation-related items were placed in the humanistic/existential category.

For purposes of this study the operational definition of practice orientation (as a component of theoretical orientation), derived from the review of the literature, referred to a supervisor's preferences regarding the role and function of the therapist, the use of specific therapeutic behaviors or techniques and the focus of the therapeutic session within three categories: psychoanalytic-non-psychoanalytic, directive-non-directive, and personal-impersonal.

AID Scale The other instrument utilized in this study to

measure theoretical orientation was the AID Scale. McNair and Lorr (1964) developed the AID Scale to measure a therapist's theoretical orientation in terms of his/her therapeutic behaviors. The scale is made up of 57 items and measures three scales which, according to McNair and Lorr, adequately characterize practice orientation: a psychoanalytically-oriented versus a non-psychoanalytically-oriented approach to the client, the therapist's affective response to clients: personal versus impersonal, and a directive, active versus a non-directive approach to treatment.

High scoring therapists on the psychoanalytically-oriented vs. non-psychoanalytically oriented scale believe professional training and therapeutic technique have more effect on treatment outcome than the therapist's personality or the affective relationship with the client and appear to practice psychoanalytic psychotherapy.

Low scoring therapists on the impersonal vs. personal oriented scale stress the curative aspects of the therapist's personality and the therapeutic relationship and appear to practice, most essentially, a humanistic/ existential psychotherapy.

High scoring therapists on the directive, active vs. non-directive scale set goals for treatment and are active during the hour and appear to practice behavioral psychotherapy.

Respondents to the items on the AID Scale mark their level of agreement or disagreement on an 8-point Likert scale. (See Appendix E for a listing of items in the AID Scale and for additional data regarding development of this questionnaire.)

In the present study the operational definition of professional discipline was the various mental health disciplines to which psychotherapists belong. These disciplines include: psychiatrists, psychologists, social workers, marriage family therapists, pastoral counselors, occupational therapists, psychiatric nurses and others. For purposes of this study, membership in the various categories of professional discipline will be measured by the self-report of the respondent.

For purposes of this study the operational definition of preference for a supervision model, derived from the review of the literature, was preference for one of Hart's (1978, 1982) three models of supervision: skill development, personal growth, and collaboration. Components of each of these models include the functional relationship and hierarchical distance between the supervisor and the trainee and the focus of the supervision session.

Expectations About Supervision Test The instrument used in this study to measure a supervisor's preference for a supervision model was the Expectations About Supervision Test (EAST). The EAST was adapted from an existing instrument by Ciecko (1981) for the purpose of assessing a supervisor's expectations about his/her behavior in the supervisory session with his/her trainees and locating these expectations within one of Hart's three supervision models. Ciecko developed his instrument by reviewing the items in Smith's (1975) Expectation About Supervision instrument and the supervisory behaviors identified as important in Worthington's and Roehlke's (1979) study on

effective supervision.

In developing Ciecko's instrument two experienced supervisors from an APA approved Counseling Psychology Program and a doctoral student (who had supervisory experience) compiled a list of supervisory behaviors from Smith's and Worthington and Roehlke's instruments and from their experience, and developed the items so that they would reflect the preferences and expectations of a supervisor rather than those of a trainee. A 53 item instrument with a 5-point Likert scale was the result. These experts and the investigator established scoring categories for the revised instrument reflecting preferences for one of Hart's (1978, 1982) three supervisory models: skill development, personal growth, and collaboration.

The skill development supervisory model items reflect a supervisor's preference for a teacher-student type of relationship between the supervisor and the trainee with a large hierarchical distance between them and a supervision focus on the trainee's skills with and understanding of the case.

The personal growth supervisory model items reflect a supervisor's preference for a therapist-client type of relationship between the supervisor and the trainee with a moderate hierarchical distance between them and a supervision focus on the trainee's self-insight and affective sensitivity.

The collaboration supervisory model items reflect a supervisor's preference for a collaborative relationship with a low hierarchical distance between the supervisor and the trainee and a supervision focus on the trainee's integration of skills and personal awareness as

demonstrated in the trainee-client-supervisor interaction. (See Appendix G for a listing of items in the Expectations About Supervision Test and for additional data regarding the development of this questionnaire.)

Responses to the instruments produced nominal and interval level independent variables and interval level dependent variables. The range of possible scores on the Counseling Orientation Scale was 0 to 140. The range of possible scores on the AID Scale was 0 to 456. The range of possible scores on the Expectations About Supervision Test was 0 to 256. Scoring on each of the instruments utilized in this study retained the scoring and classification systems utilized by the original authors of each of the instruments to re-examine the usefulness of these major instruments with a new population.

Sample Selection

The sample for this study was selected from the subscription list of The Clinical Supervisor-the Journal of Supervision in Psychotherapy and Mental Health.[1] This resource was selected as a sampling frame because of the enhanced likelihood that subscribers to such a journal would both perform supervision and have sufficient interest in the field to participate in a study about supervision.

The journal has a subscription list of approximately 950 although some of the subscribers are libraries or individuals from countries other than the United States. The sampling frame for this study included only individual subscribers residing in the United

States, and questionnaires were mailed to the 641 professional individuals meeting this criterion. The possible range of professional disciplines included in the subscription list of the journal included: psychiatrists, psychologists, social workers, marriage, family, and child therapists, pastoral counselors, occupational therapists, psychiatric nurses, and others.

Data Collection

Sources of data for this study included responses by the individual subscribers living in the United States to The Clinical Supervisor. Data collection was accomplished through the use of mailed questionnaires containing the following instruments: the AID Scale, the Counseling Orientation Scale, the Expectations About Supervision test and various demographic items. This sampling frame and the survey questionnaire method of investigation were selected because the population of all clinicians providing supervision is far too large to observe directly and the universe of the total population is unknown.

Jenkins (Polansky, 1969) and Babbie (1979) cite both advantages and disadvantages to the survey method of investigation. Utilization of the survey method allows coverage of wide geographic areas at less of a cost than the interview method. Also, a far greater number of potential respondents can be reached in vastly less time. Standardization of responses allows for precoding so that scoring reliability is enhanced. The survey method protects the anonymity of the respondent.

The major disadvantage of the survey method is the high number of not returned questionnaires. The present study addressed this

problem by utilizing a sampling frame with a high interest in the field as evidenced by their willingness to make the financial committment of subscribing to a journal on supervision.

Questionnaires were mailed with prepaid return envelopes addressed to the investigator. The following methods were used to assure respondents' anonymity: a) the investigator was the only person with access to identifying information; b) respondents' names were not utilized in the computation or discussion of the findings of this study, nor were their responses identified in any way, and; c) future presentation of this material in any way will exclude the identification by name of any of the participants in this study. (See Appendix E for the Consent Form signed by participants in this study.) Respondents were requested to return the completed questionnaires as soon as possible.

Data Analysis

Because of the correlational nature of this study, data analysis was accomplished through the use of Multiple Regression and Multivariate Analysis of Variance statistics. The description of possible relationships between demographic variables was presented through the use of correlation coefficients. Frequency tabulations and percentages were utilized to describe the sample.

Both the independent and dependent variables in this study were continuous, interval level variables. Multiple Regression analyses were computed on the relationship of the dependent variable (preference for supervision model as measured by the Expectations About Supervision Test) to the two independent variables (theoretical orientation, as

measured by the Counseling Orientation Scale and the AID Scale, and professional discipline).

Multiple Regression was selected for statistical analysis of these variables because it can determine the degree of relationship between a continuous criterion measure (dependent variable) and an optimally weighted combination of two or more independent variables that are usually continuous (Isaac & Michael, 1981). With this analysis numerous procedures are available for selection of predictor variables to maximize the degree of relationship between the criterion measure and a weighted composite of predictors and correspondingly to minimize the errors of prediction (Isaac & Michael, 1981, p. 200). In this study, Multiple Regression was utilized as a univariate statistic using a general linear model for regression.

Multivariate Analysis of Variance (MANOVA) was selected for statistical analysis to examine the correlation between the demographic variable of stated theoretical orientation and theoretical orientation as indicated by preferences on the COS and AID Scales. MANOVA was chosen because of its ability to ascertain whether each of the three levels of the indpendent variable (stated theoretical orientation) differed on both of the dependent variables (the COS and AID Scales) taken together. Each of the stated theoretical orientations, psychoanalytic/psychodynamic, behavioral, and humanistic/existential, were utilized as independent variables, and preferences for theoretical orientation, as indicated on the COS and AID Scales, were utilized as dependent variables. Step down analyses were performed to determine the univariate contributions of the two dependent variables to

variations in each of the independent variables.[2]

Analysis was performed using SPSS Regression (Nie, Hull, Jenkins, Steinbrenner, Bent, 1975).[3]

The alpha level accepted as significant for all comparisons in this study was p =.05.

Limitations of the Study

The potential limitations of this study concerned problems with sampling, instrumentation and conceptualization.

Sampling problems concerned the potential differences between those who complete and return questionnaires and those who do not. Since nothing can be known about those who did not choose to participate in this study, this limitation could not be overcome. There may also be differences between those clinical supervisors who subscribe to The Clinical Supervisor and those who do not. Again, since nothing will be known about those clinical supervisors who do not subscribe to The Clinical Supervisor, this limitation could not be overcome.

Since this study utilized existing instruments that had been tested in other studies, problems of instrument reliability and validity have been addressed to reduce bias as much as possible. However, since quantitative examination of the field of supervision, and, particularly, of the person of the supervisor is in its infancy, it is difficult to know if the Expectations About Supervision test is actually measuring what it is intended to measure, i.e. a supervisor's theoretical orientation to supervision. A meaningful contribution of this study was the addition of further information regarding the validity of all

utilized instruments to the growing body of research on supervision.

Another possible limitation of this study was that forced-choice responses to questionnaire items may present a distorted or limited view of respondents' attitudes. Respondents are forced to make what may feel like artificial choices among available options. However, the survey method does require respondents to take positions which, assuming the reliability and validity of the instruments, may reveal a discrete and clear picture of the relationship between variables which cannot be achieved with less structured methods of data collection.

A final limitation of this study is that it measured attitudes rather than actual behaviors. Future research will have to determine the nature, if any, of the relationship between a supervisor's theoretical and practice orientation, preference for a supervision model, and actual behaviors in the supervision session.

Chapter IV

PRESENTATION OF FINDINGS

This study was designed to investigate the relationship between the variables of supervisor's theoretical orientation as measured by the Counseling Orientation Scale and the AID questionnaire and preference for a model of supervision as measured by the Expectations About Supervision Test. The nature of this relationship was also examined. Also investigated was the influence of professional discipline on preference for a model of supervision.

Of the original sample of 641 subjects, 210 responses were utilized (33%). An additional 19 responses were received but were not used in the analysis as they were returned after the cut-off date for data collection. Some of the subjects left a few blank questionnaire items. As the returns were counted for items marked and not counted for items left blank sample size differed for different items. Data was error checked by taking 20 cases at random (approximately 10% of the sample) and checking scores against the computer print-outs. No errors were found.

Subjects

Subjects were 210 individual subscribers, residing throughout the United States, to The Clinical Supervisor-the Journal of Supervision in Psychotherapy and Mental Health.

The mean age of the subjects was approximately 41 years. The age distribution of the sample is shown in Table 2. Eighty-three (41%) of the subjects were male and 124 (60%) were female (missing cases=3). Eighty-eight (42%) of the subjects indicated the MSW as the highest degree received while 64 (31%) indicated the M.A. and 44 (21%) the Ph.D. Thirteen (6%) of the subjects indicated the B.A. as the highest degree received (missing cases=1). One hundred twenty-four (59%) of the subjects had 8 or more years of post-degree experience as a therapist. Fifty-one (24%) had 4-7 years of post-degree experience, and 27 (13%) had 0-3 years (missing cases=8). Seventy-seven (37%) of the subjects had 8 or more years of post-degree experience as a clinical supervisor; 66 (31%) had 4-7 years, and 61 (29%) had 0-3 years (missing cases=6). Eighty-six (46%) of the subjects has received 4-7 years of individual supervision; 65 (31%) had 8 or more years, and 56 (27%) had 0-3 years (missing cases=3). Table 4 shows the distribution of the subjects according to the settings in which they provide supervision. Settings represented by the category "Other" include university training centers, drug and alcohol agencies, hospitals, Department of Public Social Service and Probation, church counseling centers, and shelters for victims of abuse and rape. The category "0" indicated subjects who provide supervision in more than one setting.

The largest group represented by licensure or certification were

Table 2

Distribution of Subjects by Age

Age	21-30 years	%	31-40 years	%	41-49 years	%	50+ years	%
Subjects	15	7%	96	46%	52	25%	45	22%

Missing Cases = 2

Table 3

Distribution of Subjects by Licensure Categories

Licensure Category	Number of Subjects	%
L.C.S.W. or A.C.S.W.	88	43
M.F.C.C.	11	6
Licensed Clinical Psychologist	26	13
Registered Nurse	7	3
Other (Art Therapist, Pastoral Counselor, Speech Pathologist)	27	13
No licensure or certification	48	23

Missing Cases = 3

Table 4

Distribution of Subjects by Settings in Which Supervision is Provided

Setting	Number of Subjects	%
University Counseling Center	6	3%
Private Practice Institute	2	1%
Community Mental Health Agency	28	13%
Psychiatric Inpatient Setting	25	12%
Private Practice	17	8%
Family Service Agency	21	10%
Other	80	38%
"O"	31	15%

Missing Cases = 0

clinical social workers (88 or 42%). See Table 3 for the distribution of subjects by licensure or certification.

Ninety-five (48%) of the subjects identified their theoretical orientation as psychoanalytic/psychodynamic. 72 (36%) of the subjects identified their theoretical orientation as humanistic/existential, and 31 (16%) identified their theoretical orientation as behavioral (missing cases=12).

Tables 5, 6, and 7 demonstrated the mean scores (maximum possible, minimum possible, theoretical and sample) of the Counseling Orientation Scale, AID Scale, and Expectations About Supervision Test, the instruments constituting the independent and dependent variables in this study.

Statements of Research Questions and Results

Question 1: Is there a relationship between a supervisor's theoretical orientation and preference for a model of supervision?

The results of the analysis indicate that there are significant relationships between the independent variable, theoretical orientation, as measured by the Counseling Orientation Scale (COS) and the AID Scale, and the dependent variable, preference for supervision model, as measured by the Expectations About Supervision Test (EAST).

Responses to items indicating preference for or rejection of the personal growth model of supervision (DDI) were significantly predicted by responses to the COS and AID Scales ($F(6,203)=9.142$, $P=.001$)(See Table 8). Preference for the personal growth supervision model (DDI) was significantly endorsed by those indicating preference for the

Table 5 - Counseling Orientation Scale - Means

Maximum and Minimum Possible,
Theoretical and Sample

Category	Maximum	Minimum	Theoretical	Sample
CC1 (psychoanalytic)	20	5	12.5	13.6
CC2 (behavioral)	60	16	38	35.8
CC3 (humanistic)	60	15	37.5	43

Table 6 - AID Scale - Means

Maximum and Minimum Possible,
Theoretical and Sample

Category	Maximum	Minimum	Theoretical	Sample
BB1 (psychoanalytic)	79	2	38	42
BB2 (behavioral)	44	-26	9	23
BB3 (humanistic)	66	-39	13.5	12.8

Table 7 - Expectations About Supervision Test - Means

Maximum and Minimum Possible,
Theoretical and Sample

Category	Maximum	Minimum	Theoretical	Sample
DD1 (personal growth)	30	6	18	17.6
DD2 (skill development)	80	16	48	51.6
DD3 (collaborative)	55	11	33	41

Table 8 - Standard Multiple Regression of Therapy and Therapeutic Orientation Models on Personal Growth Supervision Model (DDI)

Variables	DD1	BB1	BB2	BB3	CC1	CC2	CC3	B	Beta	Sr^2
BB1	.09							.020	.060	.000
BB2	-.10	.06						-.070*	-.152	.021
BB3	-.28	.25	-.06					-.121***	-.332	.102
CC1	.24	.50	.03	.16				.303	.163	.015
CC2	.13	.12	.31	.09	.35			.048	.064	.000
CC3	.30	.18	.02	-.03	.51	.44	1	.140*	.169	.019
Means	17.65	41.98	23.04	12.80	13.68	35.81	43.80			
Standard Deviation	4.06	12.01	8.78	11.13	2.19	5.42	4.87			
								R^2 = .2127		
								Adj. R^2 = .19		
								Multiple R = .461***		

*P $\leq$ .05
**P $\leq$ .01
***P $\leq$ .001

personal (humanistic/existential) dimension of the Counseling Orientation Scale (CC3) and by those indicating preference for the personal-oriented dimension of the AID Scale (BB3). There was a significant negative relationship between endorsement of the directive, active-oriented (behavioral) scale (BB2) dimension of the AID Scale and preference for the personal growth model of supervision. Thus, those identified as humanistic/existential on both instruments constituting the independent variable of theoretical orientation significantly endorsed the personal growth model of supervision, and those identified as behavioral on one of the instruments constituting the independent variable of theoretical orientation significantly did not endorse the personal growth model of supervision. Those indicating preference for the psychoanalytic dimensions of both the COS and AID Scales neither significantly endorsed nor significantly rejected the personal growth model of supervision.

Table 8 demonstrates the multiple regression of each of the independent variables measuring theoretical orientation on the personal growth model of supervision. Note that the apparent negative correlation between BB3, preference for the personal-oriented category of the AID Scale, and DDI, the personal growth supervision model, is deceptive. In scoring the AID Scale, a high score on the impersonal-personal category reflects an impersonal stance (non-humanistic/-existential). Therefore, what appears to be a negative correlation is actually a negative correlation between an impersonal or non-humanistic/existential stance and preference for the personal growth supervision model and is, in fact, a positive one for the personal or

humanistic/existential stance. On the directive continuum of the AID Scale, a high score reflects preference for the directive stance of the directive/non-directive category. Therefore, the negative correlation between BB2 and DDI is, in fact, negative.

Responses to the items indicating preference for the skill development model of supervision (DDII) were significantly predicted by responses to the Counseling Orientation Scale and the AID Scale ($F(6,203)=5.636$, $p=.001$)(See Table 9). Preference for this model correlated significantly at a minimum of .05 with the directive, active-oriented or behavioral category (BB2) of the AID Scale and with the personal-oriented or humanistic/existential category (CC3) of the COS. Those endorsing the behavioral and personal categories of the AID Scale and the psychoanalytic categories of the COS and AID Scales neither significantly endorsed nor significantly rejected the skill development model of supervision.

Table 9 indicates the multiple regression of each of the therapy orientation models on the skill development supervision model.

Responses to items indicating preference for the collaboration model of supervision (DDIII) were significantly predicted by responses to the COS and AID Scales ($F(6,203)=6.44$, $p=.001$)(See Table 10). Preference for the collaboration supervision model was significantly correlated with preference for the personal-oriented dimension of the Counseling Orientation Scale (CC3) and with preference for the personal-impersonal dimension of the AID Scale (BB3). Those preferring the directive (behavioral) and the psychoanalytic dimensions of the COS and

Table 9 - Standard Multiple Regression of Therapy and Therapeutic Orientation Models on Skill Development Supervision Model (DDII)

Variables	DDII	BB1	BB2	BB3	CC1	CC2	CC3	B	Beta	Sr^2
BB1	.15							.407	.057	.002
BB2	.26	.06						.222***	.227	.046
BB3	.07	.25	-.06					.429	.056	.003
CC1	.21	.49	.03	.16				.214	.054	.002
CC2	.26	.12	.31	.09	.35			.130	.082	.005
CC3	.24	.18	.02	-.03	.51	.44	1	.289*	.164	.018
Means	51.60	41.98	23.04	12.80	13.68	35.81	43.80			
Standard Deviations	8.58	12.01	8.78	11.13	2.19	5.41	4.87			

R^2 = .143
Adj. R^2 = .117
Multiple R = .378***

*p ≤ .05
**p ≤ .01
***p ≤ .001

Table 10- Standard Multiple Regression of Therapy and Therapeutic Orientation Models on Collaboration Supervision Model (DDIII)

Variables	DDIII	BB1	BB2	BB3	CC1	CC2	CC3	B	Beta	Sr^2
BB1	-.01							-.571	-.013	.000
BB2	.06	.06						.360	.061	.003
BB3	-.20	.25	-.06					-.778*	-.170	.027
CC1	.10	.49	.26	.16				-.935	-.040	.000
CC2	.11	.12	.31	.09	.35			-.474	-.050	.002
CC3	.34	.18	.02	-.03	.51	.44	1	.401***	.382	.100
Means	41.09	41.98	23.04	12.80	13.68	35.81	43.80			
Standard Deviations	5.10	12.01	8.78	11.13	2.19	5.41	4.87			

R^2 = .16
Adj. R^2 = .14
Multiple R = .399***

*P $\leq$ .05
**P $\leq$ .01
***P $\leq$ .001

AID Scales neither significantly preferred nor rejected this supervision model.

Table 10 indicates the multiple regression of each of the therapy orientation models on the collaboration supervision model. Again, note that the apparent negative correlation between BB3 (personal-oriented or humanistic/existential category) of the AID Scale and preference for DDIII (collaboration supervision model) is, in fact, positive.

A MANOVA was performed to investigate the correlation between theoretical orientation as stated by the respondent in the demographic section of the questionnaire and theoretical orientation as indicated by preferences on the Counseling Orientation Scale and the AID Scale. The relationships between these variables were highly significant in the expected directions.

The overall effect of the difference in levels of combined BB1 (psychoanalytically-oriented category of the AID Scale) and CC1 (psychoanalytic-non-psychoanalytic category of the COS) as a function of stated theoretical orientation was highly significant (Wilkes=.858, approx. $F(4,388) = 7.67$, $p=.0001$). Using a stepdown analysis, BB1 and CC1 each contributed significantly to this overall effect with the means being greater and in the expected direction (See Table 11).

The overall effect of the difference in levels of combined BB2 (directive, active-oriented or behavioral category of the AID Scale) and CC2 (directive - non-directive category of the COS) as a function of stated theoretical orientation was highly significant (Wilkes=.893,

Table 11 - Roy-Bargman Stepdown of Theoretical Orientations and Variables BB1 through CC3

Multivariate Effect	Stepdown	df	F	P
Psychoanalytic Theoretical Orientation (BB1 & CC1)		(4,388)	7.67	<.0001
BB1	11.90	(2,195)	11.90	<.0001
CC1	3.67	(2,194)	3.67	<.03
Behavioral Theoretical Orientation (BB2 & CC2)		(4,388)	5.66	<.0002
BB2	6.65	(2,195)	6.65	<.003
CC2	4.72	(2,194)	4.72	<.01
Humanistic Theoretical Orientation (BB3 & CC3)		(4,388)	4.22	<.003
BB3	5.38	(2,195)	5.38	<.006
CC3	3.10	(2,194)	3.10	<.05

approx. F(4,388)= 5.66, p=.0002). Using a stepdown analysis, BB2 and CC2 each contributed significantly to this overall effect with means being greater and in the expected direction (See Table 12).

The overall effect of the difference in levels of combined BB3 (impersonal - personal category of the AID Scale) and CC3 (personal - impersonal category of the COS) as a function of stated theoretical orientation was highly significant (Wilks=.918, approx. F(4.388)=4.22, p=.002). Using a stepdown analysis, BB3 and CC3 each contributed significantly to this overall effect with means being in the expected direction (See Table 13).

See Tables 12, 13, and 14 for demonstrations of the means and standard deviations of the theoretical inventory scores (BB1 through CC3) as a function of each of the stated theoretical orientations.

Question 2: Is there a relationship between professional discipline, defined as the various mental health disciplines to which clinical supervisors belong and measured by the self-report of the respondent, and preference for a model of supervision?

The results of the analysis indicated that there was no significant correlation between the mental health discipline to which the respondent belongs and preference for a model of supervision (F (1.764), p = 1.55).

Multiple regression analyses were performed to investigate possible correlations between each of the other demographic items and preference for a model of supervision. None of these analyses produced

Table 12 - Means and Standard Deviations of Theoretical Inventory Scores (BB1 & CC1) as a Function of Stated Theoretical Orientations

BB1 (AID Scale)	Mean	Standard Deviation	# of Subjects
Entire Sample	42.172	11.78	198
Psychoanalytic	46.08	10.85	95
Behavioral	36.55	11.57	31
Humanistic	39.43	11.44	72
CC1 (COS)	**Mean**	**Standard Deviation**	**# of Subjects**
Entire Sample	13.73	2.10	198
Psychoanalytic	14.37	2.09	95
Behavioral	12.68	1.62	31
Humanistic	13.33	2.04	72

Table 13 - Means and Standard Deviations of Theoretical Inventory Scores (BB2 & CC2) as a Function of Stated Theoretical Orientation

BB2 (AID Scale)	Mean	Standard Deviation	# of Subjects
Entire Sample	23.08	8.43	198
Psychoanalytic	22.25	9.05	95
Behavioral	28.00	4.56	31
Humanistic	22.04	8.20	72
CC2 (COS)	**Mean**	**Standard Deviation**	**# of Subjects**
Entire Sample	35.87	5.26	198
Psychoanalytic	34.84	5.86	95
Behavioral	38.97	3.42	31
Humanistic	35.90	4.56	72

Table 14 - Means and Standard Deviations of Theoretical Inventory Scores (BB3 & CC3) as a Function of Stated Theoretical Orientation

BB3 (AID Scale)	Mean	Standard Deviation	# of Subjects
Entire Sample	12.78	11.23	198
Psychoanalytic	15.24	11.79	95
Behavioral	12.58	10.66	31
* Humanistic	9.61	9.99	72

* Note that BB3 is reflexed on the AID scale with low means indicating humanistic preference.

CC3 (COS)	Mean	Standard Deviation	# of Subjects
Entire Sample	43.92	4.84	198
Psychoanalytic	43.68	5.43	95
Behavioral	42.39	3.67	31
Humanistic	44.90	4.25	72

significant data.

Of all the variables investigated in this study, only theoretical orientation correlated significantly with preference for supervision model.

CHAPTER V

DISCUSSION

Summary

Purposes

The purpose of this study was to gain a basic understanding of the relationship between the variables of supervisor theoretical orientation, professional discipline, and preference for a model of supervision. Theoretical orientation was viewed within the framework of philosophical beliefs and attitudes regarding the nature of man, of personality constructs, of anxiety, and of desirable psychotherapeutic focus, roles, goals and techniques. Professional discipline was viewed within the framework of the various mental health disciplines to which psychotherapists belong. The supervisory process was viewed within the framework of three particular models of supervision: skill development, personal growth, and collaboration as delineated by Hart (1978, 1982).

Previous research in supervision has been sparse and has generally focused on the supervisor-trainee interaction or on the

trainee's satisfaction with the supervision experience. Particularly in the field of social work, while the relevance of sound supervision for responsible clinical practice has been lauded, supervision research has been largely of an impressionistic, editorial, and/or descriptive nature. There has been little research into the person of the supervisor--his/her values, attitudes and beliefs. One reflection of these values, attitudes and beliefs is the theoretical orientation of the supervisor, but there has been scant information on how, or if, the component of the supervisor's theoretical orientation influences the supervisory relationship. This study is intended to provide systematic research data on the supervisor as a unit of study for clinical social workers and for those interested in the supervision process.

Procedures

Subjects in the investigation were 210 clinical supervisors, residing throughout the United States, subscribing to The Clinical Supervisor - the Journal of Supervision in Psychotherapy and Mental Health.

The subjects were contacted by mail and requested to complete and return a personal data form, the Counseling Orientation Scale (COS), the AID Scale and the Expectations About Supervision Test (EAST).

Data was coded and data analysis accomplished through the use of regression statistics.

Findings

Two research questions were identified and examined.

Question 1. Is there a relationship between a supervisor's theoretical orientation and preference for a model of supervision?

Analysis of the sample responses indicates that there are significant relationships between some of the theoretical orientations and some of the models of supervision as measured by the instruments utilized in this study.

Supervisors with a humanistic/existential theoretical orientation, as measured by both the COS and AID Scales, tend to prefer a personal growth model or a collaborative model of supervision. Both models were significantly correlated with the humanistic/existential approach to psychotherapeutic theory and practice. In addition, a humanistic/existential theoretical orientation as measured on the COS Scale has a statistically significant correlation with preference for the skill development model of supervision. On the contrary, a humanistic/existential theoretical orientation as measured by the AID Scale has an inverse (negative) relationship to a skill development model of supervision to a statistically significant degree.

A behavioral theoretical orientation correlates significantly with preference for a skill development model of supervision when measured by the AID Scale. However, the same theoretical orientation (on the AID measurement) has an inverse (negative) statistical relationship with a personal growth model of supervision and no correlation with a collaboration supervision model. Supervisors classified as having a behavioral theoretical orientation on the COS Scale preferred none of the three models of supervision to a statistically significant degree.

Those supervisors who endorsed a psychoanalytic/psychodynamic theoretical orientation, as measured by both the COS and AID Scale, had no statistically significant preference for any of the three models of supervision.

Discussion

The findings in this study largely differed from those of Ciecko (1981). He found a negative correlation between the skill development supervisory model and the "gestalt" (Ciecko utilized all seven categories of theoretical orientation on the COS) theoretical orientation of the COS, and a negative correlation between the personal growth supervisory model and the psychoanalytic theoretical orientation of the COS. This study did not find a negative correlation between the skill development supervision model and the humanistic/existential category of the COS or between the personal growth supervisory model and the psychoanalytic category of the COS. In agreement with the findings of this study, Ciecko found a positive correlation between the personal growth model of supervision and the personal (humanistic/existential) category of AID Scale. Ciecko critiqued his findings and concluded that they were highly suspect due to the newness of his subjects to the profession (second year doctoral students) which, he speculated, along with Wagner and Smith (1978), resulted in their inconsistency in identifying and maintaining theoretical orientation beliefs. Based on the results of his study, he also questioned Liddle's (1978) assertions that one's therapeutic orientation is also one's supervisory orientation. He concluded that his findings did not allow for an

ascription of some basic notion of the relationship between supervisory model and theoretical orientation beliefs and recommended that further research in this area should utilize a larger, multi-disciplined and more professionally experienced sample.

The present study utilized a larger, multi-disciplined and more professionally experienced sample. The sample, consisting of 210 subjects, reflected the preferences of five professional discipline categories. While Ciecko's subjects were all doctoral students in psychology, 43% of the subjects in this sample were licensed or certified as clinical social workers, 13% were licensed as clinical psychologists, 6% were licensed as Marriage, Family, Child Therapists, 16% had some other practice license or certification, and 23% were neither licensed nor certified as mental health practitioners. There were no psychiatrists in this sample. 59% of the sample have had 8 or more years post-degree experience as therapists, 24% have had 4-7 years post-degree experience as therapists, and 37% and 31% have had 8 or more, or 4-7 years post-degree experience, respectively, as clinical supervisors. While Ciecko concluded that his subjects, being new to the mental health field, were likely to not be firm in their theoretical orientations, the stated theoretical orientations of the subjects in this sample were confirmed by their scores on the instruments utilized to measure theoretical orientation, the COS and AID Scale. 48% of the subjects identified their theoretical orientation as psychoanalytic/-psychodynamic, 36% identified their theoretical orientation as humanistic/existential, and 16% identified their theoretical orientation as behavioral.

The findings of the present study, based on a sample highly experienced in the provision of psychotherapeutic and supervisory services, underscore a definite relationship between preference for supervisory model and theoretical orientation for those endorsing behavioral and humanistic/existential theoretical orientations.

The significant correlation between those preferring a behavioral theoretical orientation on the AID Scale and the skill development model of supervision seems consistent with both the assumptions of the behavioral theoretical orientation and the skill development supervision model. The behavioral therapist defines the therapeutic task as the direct teaching and learning of new behavioral associations. The role of the supervisor in the skill development model is that of the teacher who imparts new technical skills and techniques to the trainee and the focus of the supervision is on the transmission of these skills and techniques. Thus the positive correlation between those endorsing a behavioral theoretical orientation on the AID Scale and endorsement of the skill development model of supervision is to be expected.

The lack of significant correlation between those preferring a behavioral orientation on the COS and the skill development model of supervision may be accounted for by the small size of the sample in the behavioral category (16%) and/or by the fact that the Counseling Orientation Scale (COS) measures theoretical orientation (views of human nature and behavior) and the AID Scale measures practice (method) orientation. Obviously, there may be a difference between endorsement of these two sets of constructs relative to endorsement of a model of

supervision. A behaviorist may base his/her practice methods on behavioral tenets and yet may utilize a broader theory of human nature and behavior which incorporates perspectives not tied to practice methods. In this instance, at least, this would imply that one's theoretical orientation may not be inevitably consistent with one's practice (method) orientation, as the latter may more often be tied to the settings in which one practices and to particular client groups than is the former. It is, of course, also possible that the COS does not adequately measure the views of those with a behavioral theoretical orientation. Further research will be needed to answer these questions.

While the behaviorists in this study were not consistent in the relationship between their responses to the COS and AID Scales and their preferences for supervision model, those with a humanistic/existential theoretical orientation were. Using both the COS and AID Scales, those preferring a humanistic/existential theoretical orientation endorsed both the personal growth and collaborative supervision models. However, those preferring a humanistic/existential theoretical orientation as measured by the Counseling Orientation Scale (COS) also endorsed the skill development model of supervision.

The significant correlation between those preferring a humanistic/existential theoretical orientation and the personal growth and collaboration models of supervision seems consistent with the assumptions of the theoretical orientation and with some of the assumptions of these models of supervision. The humanistic/existential therapist focuses on experiencing in the immediate present and on the

spontaneous expression of this experiencing. The goal of treatment is maximal awareness and a higher state of consciousness. This orientation aspires to an egalitarian treatment model, human-to-human. In the personal growth supervision model the focus is on helping the trainee to understand his/her feelings, attitudes and behaviors. The goal of this model is to assist the trainee in becoming more psychologically secure and integrated, the assumption being that the acquisition and enhancement of these attributes will render the trainee a more effective clinician. In this model the supervision session includes little or no emphasis on any particular client. The functional relationship between the supervisor and the trainee is that of therapist and client, and the nature of the hierarchical distance between the supervisor and trainee is considerable; the trainee is seen as needing to change. This tenet seems contrary to those of the egalitarian, human-to-human therapist-client relationship of the humanistic/existential theoretical orientation.

The collaboration supervision model's collaborative functional relationship and low hierarchical distance between supervisor and trainee are compatible with the egalitarian, human-to-human therapist-client relationship of the humanistic/existential theoretical orientation. Also compatible with this theoretical orientation is the collaborative supervision model's focus on the trainee's verbal and non-verbal behavior in the here-and-now of the supervisory session. However, the collaborative model's investigation of the parallels between the trainee's behavior toward the supervisor and his/her behavior toward clients would not be in pure adherence to

humanistic/existential tenets as it deviates from the humanistic/existential focus on the here-and-now.

The endorsement of the skill development model of supervision by those preferring a humanistic/existential theoretical orientation on the Counseling Orientation Scale (COS) is also not in pure adherence to humanistic/existential tenets regarding the nature of man and his behavior.

These discrepancies may be accounted for by deficiencies in the instruments utilized in this study to measure the humanistic/existential theoretical orientation, by deficiencies in the humanistic/existential theoretical model, by some discrepancy between what those preferring the humanistic/existential theoretical orientation do in psychotherapy versus what they do in supervision or by discrepancies between the humanistic/existential theoretical orientation and practice orientation.

Although the humanistic/existential categories of the COS and AID Scales correlated significantly with the personal growth and collaborative models of supervision and with preference for the humanistic/existential theoretical orientation as stated in the demographic section of the questionnaire, their correlation with one another in the multiple regression matrix was very low (BB3, CC3 = .03). This appears to indicate that while the COS and the AID Scales both measure some features of the humanistic/existential theoretical orientation, they may be measuring different attributes. As the COS measures theoretical orientation (world view) and the AID Scale measures practice orientation (methods), their low correlation implies the possibility of extremely wide variations between humanistic/existential

theoretical and practice views. In addition, since the correlation between these two instruments was only .03 (3%) this leaves a possible 97% of the features of this orientation unaccounted for by these two instruments. This implies that there may be insufficiencies in the COS and AID Scales relative to measuring humanistic/existential theory and practice beliefs.

While it is possible that the humanistic/existentialists have different theoretical views regarding human nature and behavior and the appropriate methods for implementing change in psychotherapy, it is also possible that the humanists represented in this study are not firm in either their theoretical, practice or supervision views and that they may, in fact, be utilizing an eclectic or "kitchen sink" approach to supervision. When taking into account the fact that 23% of this sample has no licensure or certification, the impact of this in terms of possible lack of formal training may explain the low correlation between theory and practice beliefs in this group and their endorsement of constructs that appear to contradict their theoretical tenets such as endorsements of the skill development model of supervision by those preferring the humanistic/existential continuum of the Counseling Orientation Scale (COS). Further research will be needed to answer these questions.

Those subjects indicating preference for the psychoanalytic/-psychodynamic theoretical orientation had a high correlation between their theoretical orientation as stated in the demographic section of the questionnaire and their theoretical preferences as measured by the COS and AID Scales. While these subjects were more extreme in their

responses on all instruments constituting the independent and dependent variables (tending to agree or disagree strongly with each item and thus indicating strong convictions about these issues) than those preferring the behavioral or humanistic/existential theoretical orientations, these subjects neither significantly endorsed nor rejected any of the three supervision models. There are several possible reasons for this finding, including the possibility that none of these supervision models adequately reflect the beliefs of the psychoanalytic/psychodynamic theoretical orientation.

The focus of the skill development model is on imparting technical skills and techniques to the trainee. This appears to be contrary to the goal or task of psychoanalytic/psychodynamic practice, which is to make conscious the unconscious through the attainment of insight. Yet, those preferring a psychoanalytic/psychodynamic theoretical orientation endorsed some of the items in this supervision model. Item analysis of responses to the Expectations About Supervision questionnaire revealed that one-third to one-half of those respondents prefering a psychoanalytic/psychodynamic theoretical orientation strongly agreed with those items in the skill development model focusing on the teaching role of the supervisor (such as making reading materials available, selecting appropriate clients for the trainee in order to broaden his/her experience, and giving feedback to the trainee regarding his/her "positive" therapeutic behaviors). One-quarter of the psychoanalytic/psychodynamically oriented respondents strongly agreed with the skill development concept that the focus of supervision should be on the trainee's clients' thoughts and conceptualizations. However,

one-fifth to one-fourth of those respondents preferring a psychoanalytic/psychodynamic theoretical orientation strongly disagreed with those items in the skill development supervision model implying that overt direction of trainees is appropriate (such as telling them what to do with clients, taking over with the client in the event of an emergency, or sitting in on the trainee's sessions with clients).

Although the focus of the personal growth supervision model on the trainee's insight and affective sensitivity seems compatible with psychoanalytic/psychodynamic theory, the personal growth supervisory approach requires a direct emotional involvement and identification on the part of the supervisor with the affective world of the trainee, and this is contrary to the traditionally distant, emotionally detached, somewhat passive (to avoid distracting the client) stance of the psychoanalytic perspective. Item analyses of responses to the Expectations About Supervision questionnaire revealed that only one-fifth of those respondents preferring a psychoanalytic/psychodynamic theoretical orientation strongly agreed with personal growth supervision items implying that supervision should be concerned with the trainee's emotional reactions while almost one-half agreed with those items indicating that the trainee would be helped with his/her "defensiveness" which may occur as he/she does psychotherapy. One-third of these respondents strongly disagreed that the supervisor should work from an emotional frame of reference. This seems to further support the psychoanalytic/psychodynamic notion that supervision will focus on the trainee's functioning with his/her clients and that the supervisor will not emotionally engage with the trainee.

The collaboration supervision model has features that would seem to complement the psychoanalytic/psychodynamic orientation: 1) its focus on process; 2) the goal of heightened awareness for the trainee of his/her feelings and attitudes toward clients; and, 3) advocacy of a metatherapeutic relationship between the supervisor and a trainee's therapeutic relationship with his/her client. Yet, again, the collaborative, intimate relationship between the supervisor and trainee is not in adherence to the proscribed stance of the psychoanalytic/psychodynamic clinician. Item analysis of responses to the Expectations About Supervision questionnaire indicated that approximately one-half of those respondents preferring a psychoanalytic/psychodynamic theoretical orientation strongly agreed with those collaboration supervision model items focused on supporting the trainee as he/she develops skills, confidence, and autonomy as a psychotherapist. These respondents want to be aware of trainees' expectations and to establish supervision goals with them. However, approximately one-quarter of those respondents preferring a psychoanalytic/psychodynamic orientation strongly disagreed with those items in the collaborative supervision model focusing on the supervisor's active emotional use or him or herself or of the supervisory relationship to illuminate or demonstrate psychotherapeutic principles. Thus the lack of either significant endorsement or rejection of the collaborative model by those preferring the psychoanalytic/psychodynamic theoretical orientation appears to again be explained by their strong support and strong rejection of some of the features of this supervision model which cancel each other out

statistically.

Those respondents with a psychoanalytic/psychodynamic theoretical orientation appear to prefer a supervision model that would be consistent with the tenets of their theoretical orientation but that is not represented as a discrete model in the Expectations About Supervision Test. Such a model would endorse and reject features of the skill development, personal growth and collaborative supervision models as outlined by Hart (1976, 1982). Support is indicated for those features of the skill development model that emphasize the teaching function of the supervisor, however those features of this model that emphasize overt direction of trainees are rejected. Those features of the personal growth model that emphasize direct emotional involvement by the supervisor with the trainee's affective or personal world are rejected. Strong support is given to those features of the collaborative supervision model which suggest respectful support of the trainee as he/she practices and learns to become a more competent psychotherapist, yet those features of this model that suggest a metatherapeutic relationship between the supervisor and trainee are rejected.

Based on the above evaluation, an outline of a supervision model that more adequately represents the supervision preferences of those having a psychoanalytic/psychodynamic theoretical orientation suggests a respectful, responsible, supportive, and emotionally-distant supervisor who sees his or her task as helping trainees to acquire insight and certain skills with their clients. Kersey's (1982) finding that those supervisor's professing a psychoanalytic/psychodynamic theoretical

orientation focused their supervision on the trainee's clients, rather than on the trainee, lends support to this interpretation.

It is also possible that the lack of significant rejection or endorsement of any of the supervision models by those preferring a psychoanalytic/psychodynamic theoretical orientation reflects the psychoanalytic/psychodynamic emphasis on differential diagnosis of clients (and, by implication, of trainees) and that this group is eclectic in its application of supervision models. Perhaps the psychoanalytic/psychodynamic perspective on supervision is inherently developmental in nature and varies depending on the supervisor's diagnosis of the professional developmental level of the trainee. Thus, the psychoanalytic/psychodynamic supervisor may draw from each of these models at various times, ignoring other of the stated tenets of his/her chosen theoretical orientation, in response to the varying needs of the trainee. The results of the item analyses of the Expectations About Supervision questionnaire suggest that this is not the case, but further empirical research is needed to illuminate this issue.

It also appears that the instrument utilized to measure preference for supervision model (the EAST) may fail to adequately measure the supervision preferences of those with a psychoanalytic/-psychodynamic theoretical orientation.

Question 2. Is there a relationship between professional discipline and preference for a supervision model?

In the present study, no correlation was found between the mental health discipline to which the respondent belongs and preference

for a supervision model.

Discussion

The results of the analysis indicated that there was no significant correlation between respondents' mental health disciplines as stated in the demographics and their preferences for supervision model as measured by the Expectations About Supervision Test (EAST).

This finding contrasted with McNair and Lorr's (1964) finding that preference for psychotherapeutic technique was associated with professional discipline. It is possible that preference for psychotherapeutic technique may be associated with professional discipline while preference for supervision model is not. In any case, as 43% of the sample were clinical social workers and 23% of the sample were unlicensed, the distribution of subjects throughout the mental health disciplines was not adequate to conclusively address this question. Clearly, further research will be required to address this issue.

It is noteworthy that such a large percentage of the respondents in this study were clinical social workers. It is possible that this reflects the large number of social workers subscribing to the Clinical Supervisor journal or that the fact that this author is a clinical social worker encouraged other social workers to lend their support to this research project by completing and returning the questionnaire. As the professional discipline of those who did not respond to this study cannot be known, this question cannot be answered.

Instrumentation

The results of this study indicate that the instruments utilized have strengths and weaknesses. This author believes that, overall, the instruments have value and recommends their continued utilization for research purposes.

Among experienced clinicians and supervisors, there is a high correlation between their stated theoretical orientation and their preference for theoretical orientation as measured by the Counseling Orientation Scale (COS) and the AID Scale. Thus it appears both that experienced clinicians are clear in their theoretical beliefs and that the items constituting these two instruments adequately describe the components of many of these beliefs. However, while the COS and AID Scales measure many features of the psychoanalytic/psychodynamic, behavioral, and humanistic theoretical orientations, it is not all inclusive. The high correlation matrixes of the psychoanalytic/-psychodynamic and behavioral categories of the COS and AID Scales indicate that these instruments measure most of the features of these two theoretical orientations. The low correlation matrixes of the humanistic/existential categories of the COS and AID Scales may indicate either that these instruments fail to measure many of the features of this theoretical orientation or that one of these instruments adequately measures many of the features of this orientation while the other does not. It is also possible that humanistic/existential theoretical tenets are not specific enough to allow for adequate quantification and/or that "humanistic" and "existential" are too dissimilar to be grouped together as the same orientation. Therefore, the low matrixes may be reflective

of these issues rather than of weaknesses in the instruments.

Further research should investigate whether the low correlation matrixes of the humanistic/existential categories of the COS and AID Scales indicate weaknesses in the instruments or lack of specificity humanistic/existential theoretical postulates. If the weaknesses are in the instruments they should be revised and expanded to measure more features of the humanistic/existential theoretical orientation.

While both the COS and AID Scales produced significant results, it appears that the results produced by utilizing the AID Scale were consistently more significant in their correlation to preference for supervision model. It is possible that the efficacy of the COS was diminished by this author's reduction of the original seven categories of theoretical orientation into three. It is also possible that the AID Scale is more useful that the COS because it deals with more measureable behaviors. In any case, the COS should be examined and revised with reference to its measurement of the behavioral orientation, as it is less adequate as a predictor than the AID Scale. Based on the results obtained by these two instruments in this study, it appears that future investigators would do well to utilize the AID Scale in preference to the Counseling Orientation Scale (COS), in its present form, for research purposes.

Based on the results of this study it appears possible to quantify and measure the beliefs that constitute theoretical orientation and those constituting supervision model preferences and to investigate correlations between them. The Expectations About Supervision Test (EAST) quantifies and measures preferences for supervision model to some

extent but is not totally successful. The EAST appears to adequately measure the supervisory preferences of those preferring humanistic/-existential and behavioral practice theoretical orientations, but it fails to adequately measure the supervisory preferences of those preferring a psychoanalytic/psychodynamic theoretical orientation. This author feels that this scale is useful but should be refined and expanded to more adequately measure supervisory preferences for those with a psychodynamic/psychoanalytic theoretical orientation. Further research will be required to determine more about the relationship between theoretical orientation and supervision model for those having a psychoanalytic/psychodynamic theoretical orientation.

As this study focused on attitudes rather than behaviors, differences may exist between supervisors' attitudes toward supervision and their actual behaviors in supervision sessions. This is an important area for future research, but the instruments utilized by this researcher are not adequate to investigate this issue. Audio and video recordings of both sessions in which the trainee is being supervised and of the supervision sessions appear to be an invaluable research aid to description and quantification of the supervision process and, particularly, of the relationship between attitudes and behaviors. Further research is recommended to determine additional useful types of instrumentation for investigating preference for and use of supervision models.

Clinical Importance

This study identified three statistically distinct groups of

supervisors who did not differ in their preference for supervision model by attributes of professional discipline, age, sex, number of years experience as a therapist or supervisor, practice setting, number of years of personal therapy or supervision received. As theoretical orientation is the only attribute examined in this study that influenced preference for supervision model, it appears that supervision practices may be largely influenced by the values and attitudes of the supervisor. It seems that values and attitudes, as manifested in this study by theoretical orientation, may be the critical factor influencing how a supervisor provides supervision. This conclusion raises thought-provoking and disturbing dilemmas both for trainees and for the education and preparation of supervisors for supervision.

The findings of this study suggest that supervisors, like psychotherapists (Lowe, Grayson, & Lowe, 1975; LaCrosse & Barak, 1976; Lazarus, 1978), are drawn to a style of supervision that fits their character structures as manisfested in their values and attitudes and that this influence is an important source of their behavior in supervision. This finding adds support to Liddle's (1979) suggestion of a parallel relationship between one's theoretical approach to psychotherapy and to supervision and to Leddick & Bernard's (1980) conclusion, based on a review of the history of supervision, that, due to a lack of a theoretical base for supervision, supervision is closely linked to the theoretical assumptions of psychotherapeutic practice.

Many writers in the field of supervision (Szurek, 1949; Towle, 1954; Kadushin, 1976) have suggested that the factors essential to effective clinical learning include active involvement of the learner in

the learning process, arrangement and presentation of content into some comprehensive, internally consistent framework which satisfactorily explains human behavior, and regard for the learner's uniqueness. The results of this study suggest that supervisors supervising out of a clear and consistent theoretical orientation to psychotherapy may accomplish at least the second of these objectives. However, these same writers stress the need for learning to proceed from the familiar to the unfamiliar so that the learner's coping mechanisms are not overwhelmed. The apparent reliance of the supervisors in this study on their theoretical orientation as a basis for their supervision practices may preclude a developmental supervision focus and, therefore, make accomplishment of this objective unlikely.

Some researchers in the supervision field (Pierce & Schauble, 1970; Elsenberg & Delany, 1970; Ronnestad, 1973; Silverman & Quinn, 1974) have concurred on the effectiveness of modeling as a training device and cited it as a crucial variable in supervision. This implies that, with or without his/her intent or awareness, the focus and behaviors of the supervisor will be emulated by the trainee. Therefore, whatever the nature of the supervision experience, the impact on the trainee will be profound. Steiner's research (1978) supported the notion that the biases of supervisors are perpetuated onto the next generation of psychotherapists. These authors imply that supervision serves as an apprenticeship for trainees and that this is an inevitable and legitimate supervision model. However, since reliance on theoretical orientation as a sole basis for supervision probably limits the range of the supervisor, these limitations will undoubtedly be

mirrored and reflected in the trainee's work with his/her clients.

Nelson (1978) found that trainees preferred supervisors who allowed and encouraged them to develop their own style, offered feedback and helpful therapeutic techniques and who were actively practicing psychotherapy on a regular basis. The beliefs of the supervisors surveyed in this study appear to be consistent with these criteria. Therefore, their reliance on theoretical orientation as a basis for supervision, while not ensuring that the developmental learning needs of their trainees are met, also may not be preventing them from satisfying many of the stated desires of their trainees. However, as the goal of supervision is not merely to please the trainee but to improve his/her competence as a clinician, accomplishment of this objective, while certainly important, is an insufficient task or goal of supervision.

If, as the findings of this study imply and as Miars, Tracey, Ray, Cornfeld, O'Farrell and Gelso (1983) speculated, supervision models are implicit in and arise out of the various theoretical orientations, then the recent supervision models as delineated and promulgated in the supervision literature may be having little real impact or influence on their intended audience of supervisors. The way in which the supervisor engages the trainee, the content and focus of the supervision session, and the ways in which the trainee is encouraged to function with his/her clients appear to be largely determined by the theoretical world view of the supervisor regarding the dynamics of human behavior and the methods of intervention and treatment to effect change. Some researchers (Kersey, 1982; Miars, Tracey, Cornfeld, O'Farrell, & Gelso, 1983) concluded that the supervisors they studied, in fact, did not vary their

supervision according to the developmental learning needs of their trainees. A grave misfortune of this limitation is that, unless the supervisor is consciously aware of the subjectivity of his/her world view and conveys this to the trainee, the trainee may leave the supervision experience believing that he/she has received the view, rather than one person's view, of human nature and methods of effecting change. This narrowness of perspective hardly seems compatible with the goal of social work supervision, which is to prepare the trainee to function with optimal effectiveness and independence in agency and private practice settings (Kadushin, 1976; Vargus, 1977).

Literature on supervision discusses the theory and practice of supervision as if there can be a singular approach to it (Mueller & Kell, 1972; Kaslow, 1976; Kuripus & Baker, 1977). Supervision models are built upon a variety of components, including insights into learning processes gleaned from education as well as clinical observation, and are put forward with the intent that they will be learned and applied by supervisors as they are presented. However, the results of this study suggest that if the model taught is not compatible with the supervisor's values and attitudes regarding the role, function, and task of the supervisor and of supervision it is likely that, if the supervisor applies the model at all in work with trainees, it will be altered in the process of application to be compatible with his/her philosophical and functional comfort.

Moreover, if supervision, in fact, emerges out of the supervisor's theoretical orientation to psychotherapy, the question arises as to whether supervisors are actually incorporating any of the

supervision literature or are merely applying the tenets of psychotherapy to supervision. As the tasks and purposes of psychotherapy and supervision are different, this raises serious questions as to how well the task of supervision (i.e. the preparation of the trainee for more effective clinical practice) is actually being accomplished.

The above bodes ill for satisfaction of the learning needs of trainees. Many recent writers (Reynold, 1942; Spice & Spice, 1976; Blake and Mouton, 1978; Littrell, Lee-Borden & Lorenz, 1979; Stoltenberg, 1981; and Loganbill, Hardy & Delworth, 1982) have proposed developmental models for supervision wherein the role, function, and task of the supervisor and of the supervision are to be varied depending upon the developmental needs of the trainee for his/her growth as a clinician. Hart (1978, 1982) also suggests that his models be variably applied to the supervision process in response to the learning needs of trainees. These theoreticians would undoubtedly support an initial and ongoing diagnosis of the trainee and differential application of all supervision procedures depending upon these assessments. Again, the results of this study suggest that, in practice, this is not likely to occur. It appears that what the trainee receives in supervision may not be at all planned or conceptualized according to his/her educational needs and clinical skills as flexibility of supervisors may be strongly limited by their theoretical orientations to clinical practice.

Based on the findings of this study it seems likely that the use of a supervision model by a clinical supervisor may not be influenced by the learning needs or preferences of the trainee. If this is the case

then the goodness of fit between the trainee and supervisor becomes extremely critical for the success of the supervision experience. Therefore, in a private practice situation, clinicians desiring further supervision would do well to select a supervisor who shares his/her theoretical orientation (i.e. world view). This fit would, perhaps unfortunately, appear to offer the best prognosis for the successful preparation of the trainee for more effective, if specialized, clinical practice. Another way for potential trainees to seek effective supervision would be to decide where their clinical skills need strengthening and then find a supervisor possessing a relevant theoretical orientation to meet their learning needs. If they want to learn specific methods and techniques to improve or expand their skills as therapists then they should choose a supervisor with a behavioral orientation to psychotherapy. If they want personal growth as clinicans then they should find a supervisor with a humanistic/existential theoretical orientation. If they prefer to acquire insight and certain diagnostic and treatment skills with their clients then it appears they should find a supervisor with a psychoanalytic/psychodynamic theoretical orientation to psychotherapy. Another possibility would be simultaneous consultation with two or more supervisors so that a wider range of learning needs could be met.

In agencies and field placements where choice of supervisor is not an option and where it is unlikely, due to newness as a clinician, that the trainee has a firm theoretical orientation, it truly behooves the supervisor and the agency to accept responsibility for investigation of the unconscious, subconscious, or preconscious elements of

supervision practices so that they can become more flexible in meeting the learning needs of trainees. Supervisors should examine their supervision in terms of their flexibility relative to roles, hierarchy and focus and evaluate these elements to see if this is really how they want their supervision to be. Agencies and supervisors should also develop quantitative criteria to evaluate the outcomes of supervision in terms of the increased clinical competence of their trainees. Supervised training for supervisors would be an invaluable aid in this process.

The obvious way for trainees to receive the training that literature and research indicate is optimal would be to utilize only supervisors trained in developmental theory and developmental supervision who know when and how to use themselves differently in terms of role, hierarchy, and focus in supervision according to the changing needs of trainees, and who are characterologically able to supervise with this kind of flexibility. The question of how to produce such supervisors is of enormous importance.

While the literature contains extensive discussion of supervision models, at this time it contains no supervision theory. Theoretical orientations to supervision must be articulated and compared to theoretical orientations to psychotherapy so that this data is available for incorporation into the training of supervisors.

At present most supervision training consists of classes on supervision offered by some graduate institutions. Models of supervision are presented to graduate students with the assumption that they will be digested by the learner. The findings of this study

support the hypothesis that the training of supervisors cannot be effective if it is conceptualized and taught only academically. This author agrees with Chien & Appleton (1970) who concluded, based on the results of their research, that greater flexibility was required in psychotherapeutic teaching and that it must address the rigidities arising from the value systems of all participants since the impact of values upon learning is so apparent. Without helping the supervisor to learn to think about what he/she is doing in the supervision session, it seems that presentation of didactic materials has little real impact on supervisors' behavior. This failure has implications for trainees and their clients in that a domino effect is most likely created. If theories are presented to supervisors regardless of their capacity to integrate them, they are likely to perpetuate the same unexamined approach with their trainees, and the trainees are likely to replicate the same process with their clients. Therefore, the importance of studying the process of supervision, instead of merely attempting to apply supervision techniques, becomes apparent.

Establishment of training programs and institutions for training of supervisors seems essential. The primary and fundamental task of these programs would be to help (potential) supervisors learn to think about how and why they supervise and to enhance their capacity to be flexible and open in the process of this task. This undoubtedly requires that the learner engage in characterological exploration regarding his/her attitudes, values, and ways of being and functioning in the world. This author has experience in such an institution, The Institute for Advanced Training in Experiential Psychotherapy/

The Saturday Center in Santa Monica, California, and reported in a previous publication (Davenport, 1984) that this kind of learning requires intense engagement among all participants and that, while unsettling and anxiety-provoking, it is richly rewarding. In this institute, supervisors study and examine their own process in monthly supervision meetings. Tapes of supervision sessions are played and the focus of the group is on the processes generating the supervisors' actions in the supervision sessions with their trainees. This exploration frequently frees up learning blocks in supervisors which then enables them to approach the learning, choosing, and application of the various models of supervision with enhanced flexibility and openness to the real learning needs of their trainees.

Clearly, further research is needed in this area to determine how to best enhance the capacity of supervisors to supervise in ways that truly benefit trainees. Reliance on theoretical orientation to psychotherapy as a basis for supervision is not sufficient for realization of this objective.

Conclusion

This study has offered data confirming the profound influence of supervisors' theoretical orientation to psychotherapy on their preferences for a model of supervision. This influence impinges on supervisors' capacities to be sufficiently flexible to meet the developmental learning needs of trainees. Awareness of and attention to this issue is critical for consideration when planning for the meaningful preparation of supervisors for supervision.

EXPLANATORY NOTES

[1] This journal is published by the Haworth Press, Inc. and is in its third year of publication.

[2] For utilization purposes as Multivariate Analysis of Variance (MANOVA) statistics, the psychoanalytic/psychodynamic, behavioral, and humanistic/existential categories of the Counseling Orientation Scale and the AID Scale were reclassified from interval to continuous level categories.

[3] For coding purposes categories of each of the instruments constituting the independent and dependent variables were given labels. Labels for the three dimensions of the Counseling Orientation Scale (COS) were: CC1 (psychoanalytic-non-psychoanalytic, CC2 (directive-non-directive), and CC3 (personal-impersonal). Labels for the three dimensions of the AID Scale were: BB1 (psychoanalytically-oriented scale), BB2 (directive, active-oriented or behavioral scale), and BB3 (personal-oriented or humanistic/existential). Labels for the three dimensions of the Expectations About Supervision Test (EAST) were: DD1 (personal growth model), DDII (Skill Development Model), and DDIII (collaboration model).

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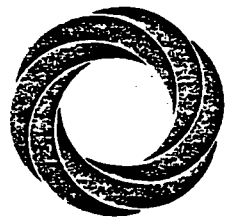
Appendices

Appendix A



Judith M. Davenport, M.S.W.
Licensed Clinical Social Worker (L6682)

Dear Colleague,

I am appealing to you for help in the research I am doing for my doctoral dissertation at the California Institute for Clinical Social Work.

My study investigates the nature of the process of clinical supervision. The staff of the journal, The Clinical Supervisor was sufficiently impressed by the merits of this study to be willing to provide me with the names of its subscribers. As a fellow subscriber to The Clinical Supervisor, I am hoping both that you provide supervision and that this discipline is of interest to you. I am asking that you complete and return to me the enclosed three-part questionnaire. Because the questionnaire requires your first, and most spontaneous response, it is expected that completion of it will require less than thirty minutes of your time. Your cooperation in completing and returning the questionnaire will be invaluable to me and will add further needed data to the body of research on supervision.

Please complete the Respondent's Information Form, the Consent Form, and the Questionnaire and return them to me in the enclosed, stamped envelope. Your anonymity and confidentiality will be protected by the methods outlined on the Consent Form. Following completion of the study, you will receive a summarized statement of the research findings.

I am fully aware that your schedule is busy and realize that my request will be an imposition on your time. Therefore, I want you to know how very much I appreciate your assistance and support! It would help me greatly if you could return the completed materials to me as soon as possible.

If you have any questions, please do not hesitate to phone me collect at (213)829-7407.

Again, thank you for your help.

Judith Davenport

Judith Davenport, M.S.W.

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Appendix B

INSTRUCTIONS FOR COMPLETION OF QUESTIONNAIRE

Please complete the Consent Form and the Respondent Information Form.

Note that the three-part questionnaire is printed on the front and the back of each page. Please do not forget to complete both sides of each page. The questionnaire explores various aspects of the perspectives of clinical supervisors. Please give your first and most spontaneous response to each item. In the first section, each item is followed by a continuum of responses ranging from "disagree very much" to "agree very much". In the second section, each item is followed by a continuum of responses ranging from "strongly disagree" to "strongly agree". In the third section, each item is followed by a continuum of responses ranging from "very little expectation" to "very strong expectation". For all the items please circle the number under the response that most closely reflects the strength of your beliefs about that item. Please answer every question.

Please return this entire stapled packet when completed in the enclosed, stamped envelope.

Again, thank your for your participation in my study.

Appendix C

CONSENT FORM

I consent to participate in the research study, An Investigation of the Relationship Between a Clinical Supervisor's Theoretical Orientation and Preference for a Model of Supervision, the procedures of which have been approved by the dissertation committee of Judith J. Davenport, chaired by Dee Barlow, Ph.D.

I agree to complete this three-part questionnaire. I am assured that my confidentiality and anonymity are being protected by the following methods:

1) The investigator, Judith Davenport, is the only person who will have access to identifying information.

2) My name will not be used in the computation or discussion of the findings of this study not will my responses be identified in any way.

3) The presentation of this material in report or publication will exclude the identification of any of the participants in this study.

I am aware that I am free to refuse to participate in this study.

Name (please print)_____

Signature_____

Mailing Addresss_____

City, State_____

Zip Code_____

Appendix D

RESPONDENT INFORMATION FORM

please complete the following information.

Age: 21-30___ 31-40___ 41-50___ 50 or over___
(please check ( ) one)

Gender: male___ female___
(Please check ( ) one)

Highest degree received:_____ In what field?_____

If you are licensed or certified to proved counseling or psychotherapy, what kind of license or certificate do you have:

_____

Number of post-degree years of experience as a therapist:
(please check ( ) one) 0-3___ 4-7___ 8 or more___

Number of post-degree years of experience as a supervisor:
(please check ( ) one) 0-3___ 4-7___ 8 or more___

Number of years you have received individual supervision:
(please check ( ) one) 0-3___ 4-7___ 8 or more___

Principal settings in which you provide supervision at this time:
(please check ( ) all that apply)

University Counseling Center___ Private Practice Institute___
Community Mental Health Agency___ Psychiatric Inpatient Setting___
Private Practice___ Family Service Agency___
Other (specify)_____

Which of the following most closely approximates your major theoretical orientation:
(please check only one category)

Behavioral___ Humanistic/Existential___
Psychoanalytic/Psychodynamic___

Appendix E

AID Scale

Appendix E

Developmental Data - AID Scale

49 of the items in McNair and Lorr's AID Scale were based on the Therapist Orientation Questionnaire (TOQ) developed by Sundland and Barker (1962), and NcNair and Lorr developed the other 8 items on their own.

The 17 items on the psychoanalytically oriented scale ("A" scale) represent analytic techniques and were based on the TOQ cluster of Theory of Motivation, Important Topics, Conceptualizations of the Relationship and Cognitive Gains.

The 21 items on the personal oriented scale ("I" scale) represent impersonal versus personal modes of relating to clients and was hypothesized on the basis of relationships among four TOQ scores: Emotional Tenor, Spontaneity, Learning Process and Curative Aspects of the Therapist.

The 19 items on the directive, active approach to treatment scale ("D" scale) were derived from a TOQ cluster comprising Planning, Goals, Type of Activity, Frequency of Activity, and Criteria for Success.

The AID Scale was administered to 192 male and 73 female therapists (social workers, psychologists and psychiatrists) in 44 Veteran Addministration Mental Hygiene Clinics. Results of their study indicated that the three dimensions could reliably differentiate between therapeutic orientations.

AID Scale (AID)

SCORING INSTRUCTIONS

To Obtain Individual Scores

Each item has a value from 1 to 8. An individual's responses to each item are totaled. The person's score indicates his relative position on the three continuums in respect to others who were administered the AID at the same time. The following items have positive values: 5, 8, 20. 30. 44, 47, 48, 51, 56 are impersonal-related. 1, 10, 16, 31, 34, 40 are directive related. 6, 9, 12, 15, 18, 21, 36, 42, 49, 50 are psychoanalytically-related. The following items have negative values: 4, 23, 29, 38, 41, 57 are impersonal-related. 19, 22, 46, 52, are directive-related. 33 is psycho-analytically-related.

	Disagree very much	Disagree quite a bit	Disagree mildly	Disagree a little	Agree a little	Agree mildly	Agree quite a bit	Agree very much
1. A therapist should have long range goals for his clients.	1	2	3	4	5	6	7	8
2. Some emotional involvemement with clients is inevitable.	1	2	3	4	5	6	7	8
3. There may be unconscious motives, but they play a minor role in daily behavior or in shaping a person's life.	1	2	3	4	5	6	7	8
4. The wise therapist advises the client about the best way of coping with a life situation.	1	2	3	4	5	6	7	8
5. A therapist should <u>not</u> "personalize" his office with photos of the family, souvenirs, momentos, etc.	1	2	3	4	5	6	7	8
6. Usually (with proper timing) a therapist should analyze the client's resistance.	1	2	3	4	5	6	7	8
7. It is often good therapy to strongly urge clients to "try out" certain behaviors which are initially frightening to them.	1	2	3	4	5	6	7	8
8. Whatever the intensity of the client's expression, a therapist is most effective when he feels detached, objective and impersonal.	1	2	3	4	5	6	7	8

	Disagree very much	Disagree quite a bit	Disagree mildly	Disagree a little	Agree a little	Agree mildly	Agree quite a bit	Agree very much
9. It is necessary for clients to learn how eraly in childhood experiences have left a mark on them.	1	2	3	4	5	6	7	8
10. Therapists should make an overall treatment plan for each case.	1	2	3	4	5	6	7	8
11. it is all right for a therapist and a client to have coffee or other refreshments together during the therapy hour.	1	2	3	4	5	6	7	8
12. A therapist should ask many of his clients to free associate.	1	2	3	4	5	6	7	8
13. Therapists should introduce topics during the therapy hour whenever they need discussion.	1	2	3	4	5	6	7	8
14. The most important learning in therapy is verbal and conceptual in nature.	1	2	3	4	5	6	7	8
15. The most important results of therapy are the new ideas and ways of thinking about himself/herself that a client achieves.	1	2	3	4	5	6	7	8
16. It is important for a client to be helped to make a social adjustment.	1	2	3	4	5	6	7	8
17. A therapist can help a client more if the therapist has met and mastered problems similar to the client's.	1	2	3	4	5	6	7	8

	Disagree very much	Disagree quite a bit	Disagree mildly	Disagree a little	Agree a little	Agree mildly	Agree quite a bit	Agree very much
18. When a client relates a dream in therapy, the therapist should try to help him understand its meaning.	1	2	3	4	5	6	7	8
19. A treatment plan is <u>not</u> important for successful therapy.	1	2	3	4	5	6	7	8
20. The most important factors in successful therapy are professional training and expert use of therapeutic techniques.	1	2	3	4	5	6	7	8
21. Understanding why one does things is the most effective factor in changing one's behavior.	1	2	3	4	5	6	7	8
22. Whatever direction a client chooses to move (short of murder, suicide, etc.) should be satisfactory to the therapist.	1	2	3	4	5	6	7	8
23. The more effective therapists do things during the therapy hour for which they have no reasoned basis, merely a feeling they are right.	1	2	3	4	5	6	7	8
24. It is rarely helpful for a therapist to formulate for himself/herself the psychodynamics of the therapist-client relationship.	1	2	3	4	5	6	7	8
25. The therapist should point out connections between the client's behaviors and attitudes - both those expressed in therapy and those described from present and past situations.	1	2	3	4	5	6	7	8

	Disagree very much	Disagree quite a bit	Disagree mildly	Disagree a little	Agree a little	Agree mildly	Agree quite a bit	Agree very much
26. A therapist should not have any physical contact with a client (other than an occasional handshake).	1	2	3	4	5	6	7	8
27. The most beneficial outcome of therapy is for a client to learn the reasons for his behavior.	1	2	3	4	5	6	7	8
28. It is quite acceptable to interrupt a client while he/she is talking in order to make a comment.	1	2	3	4	5	6	7	8
29. It is all right to address clients by their first names.	1	2	3	4	5	6	7	8
30. It is sometimes all right to discuss politics, movies, weather, current events, sports or philosophy with a client during the therapy hour.	1	2	3	4	5	6	7	8
31. A therapist should assume different roles with different clients.	1	2	3	4	5	6	7	8
32. The most important results of therapy are the new feelings and emotions clients come to experience.	1	2	3	4	5	6	7	8
33. People can be understood without recourse to the concept "unconscious determinants of behavior."	1	2	3	4	5	6	7	8

	Disagree very much	Disagree quite a bit	Disagree mildly	Disagree a little	Agree a little	Agree mildly	Agree quite a bit	Agree very much
34. A thorough case history and a proper diagnosis are very important to treating a case effectively.	1	2	3	4	5	6	7	8
35. In effective therapy, clients learn mostly through the affective and unverbalized relationship between himself/herself and the therapist.	1	2	3	4	5	6	7	8
36. It is important to interpret symptomativ behavior such as slips of the tongue, mannerisms of the client, etc.	1	2	3	4	5	6	7	8
37. Deliberately expressing approval of desirable client behavior is <u>not</u> a good therapeutic policy.	1	2	3	4	5	6	7	8
38. The therapist's personality is more important to the outcome of therapy than his client.	1	2	3	4	5	6	7	8
39. It is very important for therapists to conceptualize, think-through, how the client is relating to him/her.	1	2	3	4	5	6	7	8
40. With most clients, it is important to lead the interview into fruitful areas of discussion.	1	2	3	4	5	6	7	8
41. A therapist should spontaneously express his thoughts about the relationship during the hour.	1	2	3	4	5	6	7	8

	Disagree very much	Disagree quite a bit	Disagree mildly	Disagree a little	Agree a little	Agree mildly	Agree quite a bit	Agree very much
42. For a client to improve his current way of life, he must come to understand his early childhood relationships.	1	2	3	4	5	6	7	8
43. It is rarely wise to see other members of the client's family.	1	2	3	4	5	6	7	8
44. If a client is very critical or appre ciative of a therapist, it should not change the therapist's feelings toward the client in any way.	1	2	3	4	5	6	7	8
45. It is possible to make sense of a client's behavior without assuming motives of which he/she is unaware.	1	2	3	4	5	6	7	8
46. The overall goals of therapy should be set by the client only.	1	2	3	4	5	6	7	8
47. In the therapy hour, the therapist should act reserved, uninvolved and impersonal.	1	2	3	4	5	6	7	8
48. It is unwise for a therapist's remarks and reactions to a client to be unplanned, spontaneous, not thought through.	1	2	3	4	5	6	7	8
49. A good therapist "interprets" his/her client's behavior - in the sense of telling him its real significance or meanings of which he/she is unaware.	1	2	3	4	5	6	7	8

	Disagree very much	Disagree quite a bit	Disagree mildly	Disagree a little	Agree a little	Agree mildly	Agree quite a bit	Agree very much
50. It is important to analyze the transference reactions to the client.	1	2	3	4	5	6	7	8
51. A therapist who is emotionally involved with a case is defeating his/her own purpose.	1	2	3	4	5	6	7	8
52. The best therapists are fairly passive and silent during the therapy hour	1	2	3	4	5	6	7	8
53. It is usually all right to have a telephone conversation with a client even when there is no pressing need.	1	2	3	4	5	6	7	8
54. A therapist must feel warm toward a client if he/she is to help him/he	1	2	3	4	5	6	7	8
55. A therapist should avoid asking probing questions.	1	2	3	4	5	6	7	8
56. A therapist must never show he/she is angry at the client.	1	2	3	4	5	6	7	8
57. It is all right for the therapist to walk about the room during the therapy hour.	1	2	3	4	5	6	7	8

Appendix F

COUNSELING ORIENTATION SCALE

Appendix F

Developmental Data - COUNSELING ORIENTATION SCALE

Loesch and McDavis (1978) first administered the Counseling Orientation Scale (COS) to a total of 294 students enrolled in graduate-level counselor education programs at seven universities. Additionally, the COS was readministered to 36 students after a two-week interval for test-retest reliability purposes. Pearson product-moment correlations for test-retest reliability produced coefficients of B = .88, CC = .86, E = .90, G = .81, F = .87, RE = .78, and TF = .81. All coefficients were significant at the .001 level.

Twenty doctoral candidates in counselor education participated in the COS content validation. Additionally, four counselor education faculty were asked to sort the COS items into a characteristic by orientation grid. All four faculty members were 100 percent correct in their assignments.

COUNSELING ORIENTATION SCALE (COS)

SCORING INSTRUCTIONS

To Obtain Individual Scores

Each item has a value from 1 to 4. All items have positive values. An individual's responses to each item are totaled. The person's score indicates his relative position on the seven major counseling theoretical orientations in respect to others who were administered the COS at the same time. Items 1, 8, 15, 22, 29 are behavioral orientation-related. Items 2, 9, 16, 23, 30 are client-centered orientation-related. Items 3, 10, 17, 24, 31 are existential orientation-related. Items 4, 11, 18, 25, 32 are gestalt orientation-related. Items 5, 12, 19, 26, 33 are Freudian orientation-related. Items 6, 13, 20, 27, 34 are rational-emotive orientation-related. Items 7, 14, 21, 28, 35 are trait-factor orientation-related. After scoring, the seven theoretical orientations are subsumed into three major theoretical orientations as follows: Subjects scoring highest on the Freudian orientation-related items were placed in the psychoanalytic/-psychodynamic category; subjects scoring highest on the rational-emotive orientation-related items, behavioral orientation-related items, and trait-factor orientation-related items were placed in the behavioral category; and subjects scoring highest on the client-centered orientation-related items, existential orientation-related items and gestalt orientation-related items were placed in the humanistic/-existential category.

COUNSELING ORIENTATION SCALE

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. People are mechanistic in that they are merely responsive to environments over which they have little control.	1	2	3	4
2. People are guided by their perceptions of themselves and their environments.	1	2	3	4
3. People are well adjusted when they experience existence in order to develop commitments and act on potentialities.	1	2	3	4
4. The best way to help people is to provide situations in which they can get closely and intensely in touch with themselves.	1	2	3	4
5. Anxiety is caused by unconscious conflicts in the mind.	1	2	3	4
6. People have the potential to be rational and can rid themselves of emotional difficulties through rational thinking.	1	2	3	4
7. People may be considered well adjusted when their characteristics and their environments are appropriately matched.	1	2	3	4
8. People's behaviors are determined by the antecedent conditions in operation at any given point in time.	1	2	3	4
9. The well-adjusted person is mature, self-directed, congruent, and open to new experiences.	1	2	3	4
10. The best way to help people is to aid them in finding the meanings of their lives.	1	2	3	4

	Strongly Disagree	Disagree	Agree	Strongly Agree
11. Anxiety is the result of unresolved feelings about previous events.	1	2	3	4
12. People are shaped by their needs, instincts and drives.	1	2	3	4
13. Psychological states are the result of either logical or illogical thought processes.	1	2	3	4
14. The best way to help people is to match them to appropriate environments and show them how their skills and attitudes are appropriate for those environments.	1	2	3	4
15. Being well adjusted means having learned behaviors that don't cause problems.	1	2	3	4
16. The best way to help people is to be open, accepting, and understanding of whatever they wish to communicate.	1	2	3	4
17. People become anxious, then they lose sight of the purpose of their lives.	1	2	3	4
18. People are more than the sums of their parts; they are a coordination of the parts working as a whole.	1	2	3	4
19. People's personalities are the composite results of all that has happened previously in their lives.	1	2	3	4
20. People will be well-adjusted when the vast majority of their behaviors are rational.	1	2	3	4
21. Uncertainty about use of personal potential in appropriate situations results in anxiety.	1	2	3	4
22. The best way to help people is to aid them in-learning behaviors that bring about desired reactions.	1	2	3	4
23. Incongruence between self-concept and personal experiences leads to anxiety.	1	2	3	4

	Strongly Disagree	Disagree	Agree	Strongly Agree
24. People are responsible only to themselves and must define their own meanings for their lives.	1	2	3	4
25. A person is a self-regulating system trying to balance between doing and thinking components.	1	2	3	4
26. In order to achieve maximum adjustment, people must reconstruct parts of their personalities.	1	2	3	4
27. The best way to help people is to use teaching and persuasion to help them eliminate irrational ideas from their lives.	1	2	3	4
28. People are not capable of developing autonomously and need the assistance of others effectively to match their potential to their environments.	1	2	3	4
29. People are anxious because they have learned inappropriate reactions to certain stimuli.	1	2	3	4
30. A person is in a constant state of movement toward self-actualization.	1	2	3	4
31. What people are or do is determined by the individual meanings in their lives.	1	2	3	4
32. People are well-adjusted when they take responsibilities for their own lives and are in touch with themselves and the world.	1	2	3	4
33. The best way to help people is to let them verbalize the source(s) of their problems.	1	2	3	4
34. Anxiety is the result of over-generalizing the potentially negative effects of an event.	1	2	3	4
35. People seek to organize and maintain their lives by matching their unique patterns of capabilities and potential to their environments.	1	2	3	4

Appendix G

EXPECTATIONS ABOUT SUPERVISION TEST

Appendix G

Developmental Data - EXPECTATIONS ABOUT SUPERVISION TEST (EAST)

In revising the EAS, in order to maintain Kirchner's experiential/-didactic continuum, Smith constructed a new linear scale using Kirchner's 16 experiential/didactic items. Spearman rank-difference correlation coefficient between Kirchner's 38 subjects on the original 60 items of the EAST and on the 16-items which comprised the new scale was rho = .81. 16 subjects in Kirchner's study also took part in Smith's study. The Pearson product moment correlations coefficient between these 16 subjects on the 16-item EAST for spring of 1974 and spring of 1975 was .85. From these correlations Smith assumed the 16-item EAST attained the validity and reliability levels achieved by Kirchner in his 1974 study.

Smith's Expectation About Supervision instrument identified 40 supervisory behaviors, and the Worthington and Roehlke study identified 42 supervisory behaviors. Worthington and Roehlke's items reflected supervisor's perceptions of the importance of each behavior to good supervision. Both of these instruments were designed to assess trainee preferences and expectations about supervisory behavior. Trainee preferences and expectations were rated on a 5-point Likert scale in each instrument.

EXPECTATIONS ABOUT SUPERVISION TEST (EAST)

SCORING INSTRUCTIONS

To Obtain Individual Scores

Each item has a value from 1 to 5. All items have positive values. An individual's responses to each item are totaled. The person's score indicates his relative position on the three supervisory models in respoect to others who were administered the EAST at the same time. Items 13, 21, 22, 23, 27, 35 are personal growth supervisory model-related. Items 3, 4, 5, 8, 9, 11, 14, 15, 17, 26, 30, 34, 36, 38, 46, 48 are skill development supervisory model-related. Items 2, 7, 16, 32, 33, 39, 41, 42, 44, 50, 52, 53 are collaboration supervisory model-related.

EXPECTATIONS ABOUT SUPERVISION TEST

	Very Little Expectation	Little Expectation	Moderate Expectation	Strong Expectation	Very Strong Expectation
1. As a supervisor, I will help the supervisee recognize his/her strengths as a counselor.	1	2	3	4	5
2. My supervisee and I will sometimes work directly on the relationship he/she and I have in supervision.	1	2	3	4	5
3. As a supervisor, I will suggest certain kinds of clients for my supervisee to broaden his/her experience as a counselor.	1	2	3	4	5
4. As a supervisor, I will be a model for doing counseling.	1	2	3	4	5
5. As supervisor, I will make available appropriate reading materials.	1	2	3	4	5
6. As supervisor, I will assess what my supervisee needs most, at this stage of his/her development, to become a good counselor and orient supervision in that direction.	1	2	3	4	5
7. My supervisee and I will form a personal friendship that may include leisure-social interaction outside of professional activities.	1	2	3	4	5
8. As a supervisor, I will help my supervisee set goals for the outcome of his/her client cases.	1	2	3	4	5
9. As a supervisor, I will assist my supervisee in learning how to write psychological reports.	1	2	3	4	5
10. As a supervisor, I will be confrontative with me supervisee.	1	2	3	4	5

	Very Little Expectation	Little Expectation	Moderate Expectation	Strong Expectation	Very Strong Expectation
11. As a supervisor, I will tell my supervisee what to do with his/her clients.	1	2	3	4	5
12. As a supervisor, I will help my supervisee improve his/her communication skills.	1	2	3	4	5
13. My supervisee and I will concern ourselves with his/her emotional reactions.	1	2	3	4	5
14. As a supervisor, I will choose clients for my supervisee.	1	2	3	4	5
15. As a supervisor, I will step in and take over in the event of an emergency or crisis with a supervisee's client.	1	2	3	4	5
16. As a supervisor, I will want to know my supervisees expectations about supervision.	1	2	3	4	5
17. My supervisee and I will concern ourselves with the patterns of his/her client's thoughts and conceptualizations.	1	2	3	4	5
18. As supervisor, I will sit in occasionally as my supervisee does counseling.	1	2	3	4	5
19. As a supervisor, I will help my supervisee understand the ethical implications of doing counseling.	1	2	3	4	5
20. As a supervisor, I will be respectful of my supervisee as a unique person.	1	2	3	4	5
21. As a supervisor, I will allow my supervisee to choose the content of our supervisory sessions.	1	2	3	4	5
22. As a supervisor, I will help my supervisee deal with personal problems of his/her own.	1	2	3	4	5

	Very Little Expectation	Little Expectation	Moderate Expectation	Strong Expectation	Very Strong Expectation
23. As a supervisor, I will help my supervisee become more mature as a person.	1	2	3	4	5
24. As a supervisor, I will communicate information concerning my supervisee's competence as a counselor to those responsible for his/her progress in the training program.	1	2	3	4	5
25. As a supervisor, I will help my supervisee to recognize alternative ways of dealing with his/her clients.	1	2	3	4	5
26. As a supervisor, I will show my supervisee how to do effective initial (intake) interviews.	1	2	3	4	5
27. My supervisee and I will deal with his/her dynamics.	1	2	3	4	5
28. As a supervisor, I will evaluate my supervisee's competence as a counselor.	1	2	3	4	5
29. As a supervisor, I will help my supervisee deal with his/her defensiveness which may occur as he/she does counseling.	1	2	3	4	5
30. As a supervisor, I will help my supervisee select appropriate psychological tests to be used in conjunction with counseling.	1	2	3	4	5
31. My supervisee and I will do co-therapy with clients.	1	2	3	4	5
32. My supervisee will consult with me on emergencies with his/her clients; but I will, as much as possible, allow my supervisee to handle the situation himself/herself.	1	2	3	4	5

	Very Little Expectation	Little Expectation	Moderate Expectation	Strong Expectation	Very Strong Expectation
33. As a supervisor, I will gain new insights about doing counseling as the result of my relationship with my supervisee.	1	2	3	4	5
34. My supervisee and I will role play different counseling techniques for situations that may occur in counseling.	1	2	3	4	5
35. As a supervisor, I will work, in supervision, from an emotional frame of reference.	1	2	3	4	5
36. As a supervisor, I will work, in supervision, from a conceptual frame of reference.	1	2	3	4	5
37. My supervisee will attend nearly all supervisory sessions that are scheduled.	1	2	3	4	5
38. As a supervisor, I will demonstrate how to administer, score, and interpret psychological reports.	1	2	3	4	5
39. As a supervisor, I will encourage my supervisee to find his/her own style of counseling.	1	2	3	4	5
40. As a supervisor, I will periodically give feedback to my supervisee about my observations concerning his/her competence as a counselor.	1	2	3	4	5
41. As supervisor, I will establish clear goals conjointly with my supervisee against which progress in supervision can be measured.	1	2	3	4	5
42. As supervisor, I will use the relationship between me and my supervisee to demonstrate counseling principles.	1	2	3	4	5

	Very Little Expectation	Little Expectation	Moderate Expectation	Strong Expectation	Very Strong Expectation
43. As supervisor, I will use humor in my supervision sessions.	1	2	3	4	5
44. As supervisor, I will renegotiate goals with my supervisee at mid-semester.	1	2	3	4	5
45. As supervisor, I will provide more structure during the initial sessions than during later sessions.	1	2	3	4	5
46. The focus of most supervision sessions will be on conceptualizing the dynamics of the client's personality.	1	2	3	4	5
47. The focus of most supervission sessions will be on the content of the counseling sessions.	1	2	3	4	5
48. As supervisor, I will give appropriate feedback to my supervisee about his/her positive counseling behaviors.	1	2	3	4	5
49. As a supervisor, I will be sensitive to the difference between how my supervisee talks about his/her actions and how he/she really behaves with clients.	1	2	3	4	5
50. As a supervisor, I will help my supervisee in developing self-confidence as an emerging counselor.	1	2	3	4	5
51. As a supervisor, I will give emotional support to my supervisee when appropriate.	1	2	3	4	5
52. As supervisor, I will help my supervisee realize that trying new skills usually seems awkward at first.	1	2	3	4	5
53. The focus of most supervision sessions will be on the relationship between me and my supervisee.	1	2	3	4	5