THE RELATIONSHIP BETWEEN SUPERVISORY WORKING ALLIANCE AND SUPERVISEES' CLIENT OUTCOMES

by

Hanna Laneuskaya Lainas

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Approved by:

_____
Dr. John R. Culbreth

_____
Dr. Phyllis Post

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Dr. Lyndon Abrams

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Dr. Claudia Flowers

_____
Dr. George Demakis

ABSTRACT

HANNA LANEUSKAYA LAINAS. The relationship between supervisory working alliance and supervisees' client outcomes. (Under the direction of DR. JOHN R. CULBRETH)

This study investigated the relationship between supervisory working alliance and clients' outcomes. The purpose of the study was to establish the existence of that relationship. The importance of this study was supported by the limited research on supervision and client outcomes that was available at the time of the study (Ellis & Ladany, 1997; Freitas, 2002; Goodyear & Bernard, 1998; Inman & Ladany, 2008) Additionally, there was limited research in the supervision literature on the topic of the relationship between therapeutic working alliance and supervisory working alliance (Patton & Kivligan, 1997), and no research thus far that explored the relationship between supervisory working alliance and client outcomes, which provided solid support for the need of the current study. Taking into consideration available research that provided evidence of the connection between therapeutic and supervisory working alliances, the researcher made the inference that the supervisory working alliance had a relationship with therapeutic working alliance and, therefore, had a relationship with client outcomes.

The researcher recruited participants from three different sources: (a) e-mail lists of counselors who were working under supervision towards their full license from three different states whose licensing boards agreed to provide the researcher with contact information, (b) counselor supervisor lists received from the licensing boards from two of the states, and (c) the list of subscribers to Counselor Education and Supervision Network

(CESNET). The study had specific inclusion criteria, which consisted of education and license status of the counselor, standards for supervision requirements, and that counselors had to have at least one adult client who had received a minimum of six therapy sessions and who agreed to participate in the study. Using the inclusion criteria, the final count of the participants consisted of 16 counselor-client pairs. Participant pairs were asked to complete their respective surveys, which consisted of demographic questionnaires for both counselors and their clients, Supervisory Working Alliance Inventory Trainee Form (SAWI-T; Bahrick, 1990) for counselors, and Client Perception of Improvement Survey for clients.

Due to the small sample size the researcher had to adjust data analysis from the originally planned multiple regression to bivariate correlation analysis with one-tailed test of significance in order to determine the relationship between Task, Bond and Goal variables and Health and Functioning, Social and Economic, Psychological/Spiritual, Family and Total Quality of Life variables. Based on the results of the bivariate correlation analysis conducted between variables, significant moderate positive relationships were found between Task and Family (r=.635, p<.01), Bond and Health and Functioning (r=.436, p<.05), Bond and Family (r=.624, p<.01), Goal and Health and Functioning (r=.427, p<.05) and Goal and Family (r=.559, p<.05). While several significant relationships were found between the variables, due to the small sample size the results must be interpreted with caution.

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DEDICATION

I would like to dedicate my dissertation to my family in Belarus and my loved ones here in United States. First to my parents Sergei and Natasha. I want to say thank you for your unconditional love and support throughout my life which allowed me to become the person who I am and taught me how to follow my dreams. Thank you for encouraging me to study hard and learn a foreign language from early childhood. Thank you for helping me to discover the world of psychology and for not letting me quit my college in the first semester in order to become a lawyer. I love you guys so much!

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CHAPTER 1: INTRODUCTION

Supervision is an important part of therapist preparation. It is vital to the process of counselor development (Watkins, 1997). Supervision provides therapists with a chance to practice skills, receive guidance and clinical support from a more senior professional (Bernard & Goodyear, 2009), and plays a fundamental role in counselor training, as well as assures client welfare (Borders, 2001).

Clinical supervision is a new phenomenon that has only been empirically examined in the past 30 years (Watkins, 2011). Bernard and Goodyear (2009) define clinical supervision as an intervention provided by a more senior member of a profession to a junior member of the profession. The crucial part of the definition states that supervision assumes an evaluative and hierarchical relationship, extends over time, enhances professional functioning of supervisee, monitors quality of the service offered to clients and fulfills a gatekeeping function for the profession (Bernard & Goodyear, 2009). Similarly, Maki (1995) argues that clinical supervision consists of two main parts. The first part focuses on the skills, knowledge, and attitudes that are passed from experienced professional to a trainee. The second part includes focus on development and enhancement of professional competencies after completion of the training program (Maki, 1995). Sirola-Karvinen and Hyrkäs (2008) define clinical supervision in the healthcare field as goal-oriented and intentionally planned analysis of work-related issues that is a product of interaction between the supervisor and supervisee. Based on the

presented definitions, the goals of supervision include, but are not limited to, the support of the supervisee's development, formation of the professional identity, and enhancement of the quality of care for clients (Bernard & Goodyear, 2009; Sirola-Karvinen & Hyrkäs, 2008).

According to Bernard and Goodyear (2009), supervision is "viewed as an isomorph of therapy" (p. 154). Furthermore, Liddle, Breunlin, Schwartz, and Constantine (1984) suggest that therapy and supervision are interrelated in their nature and share similar principles of change, patterns, effects, and content. While continuing to explore parallels between therapy and supervision, it is important to identify the main factors that contribute to outcomes of both, and examine them to identify similarities.

According to Bordin (1979), the therapeutic working alliance includes goals, tasks, and bonds between the client and the counselor. The results of several meta-analysis studies conducted in the past 20 years were consistent and suggested that regardless of the type of theoretical orientation used in the session, working alliance was constantly related to the therapeutic outcomes (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Furthermore, therapeutic working alliance is considered the main factor that affects client outcomes and produces change in clients (Bordin, 1979; Castonguay, Constantino, & Holtforth, 2006; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

A fundamental aspect of clinical supervision is the relationship between the supervisor and supervisee. The supervisory working relationship can also be known as the supervisory working alliance (Bordin, 1983). According to Bordin (1983), clear expectations for clinical supervision and supervisor-supervisee agreement on supervision

goals are the main factors that contribute to a strong and positive supervisory working alliance. Additionally, trust between the supervisor and supervisee has an impact on the strength of the supervisory working alliance. Supervision research indicates that greater alliance between supervisor and supervisee will produce greater supervision outcomes (Bernard & Goodyear, 2009; Kauderer & Herron, 1990).

Little information is known about the direct influence of the supervisory working alliance on client outcome. According to Patton and Kivlighan(1997), there is a significant relationship between supervisory working alliance and counseling working alliance. Week-to-week changes of supervisory working alliance predicted week-to-week fluctuations in therapeutic working alliance (Patton & Kivlighan, 1997). Similarly, Bernard and Goodyear (2009) make an inferential connection between supervisory working alliance and clients' therapy outcomes. Consequently, supervisory working alliance seems to affect more than just the supervisor-supervisee dyad. In other words, the relationship that exists between a supervisor and a supervisee has an effect on the relationship between counselors and their clients. Based on established link between therapeutic working alliance and client outcomes (Horvath & Bedi, 2002; Horvath, Del Re, Flukiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin et al., 2000) and established link between supervisory working alliance and therapeutic working alliance (Patton & Kivlighan, 1997) we can make an inference that supervisory working alliance indirectly affects client outcomes through therapeutic working alliance (Bernard & Goodyear, 2009).

Martin, Garske, and Davis (2000) identified 58 published studies on the relationship between therapeutic working alliance and client outcome, however very

limited research is available on the relationship between supervisory working alliance and client outcome (Patton & Kivlighan, 1997). While most supervision studies have relied on supervisee satisfaction (Goodyear & Bernard, 1998), or have focused on the impact of supervision on values, microcounseling skills, and attitudes of supervisees (Patton & Kivlighan, 1997), one of the primary goals of supervision is to ensure client welfare (Bernard & Goodyear, 2009). According to Patton and Kivlighan(1997), there is still very little empirical evidence of the effects of supervision on the counseling process and outcome. Considering that client welfare is one of the most important goals of psychotherapy supervision, it is crucial to measure client outcomes while conducting supervision research. Similar to Seligman (1995) and his argument about measuring psychotherapy treatment outcomes, Goodyear and Bernard (1998) discuss the need for efficacy studies in supervision. Literature reviews of supervision outcome studies provide limited contribution to clarification of the influence of supervision on client outcomes (Ellis & Ladany, 1997; Freitas, 2002; Goodyear & Bernard, 1998; Inman & Ladany, 2008; Watkins, 2011). The controversial nature of the results of supervision outcome studies that currently exist in the body of literature call for more methodologically sound and well-designed studies.

Client therapy outcome is one of the outcome variables that are utilized in efficacy studies of psychotherapy. According to Seligman (1995), effectiveness studies can provide information about success or failure of treatment. Worthen and Lambert (2007) highlight the importance of tracking client treatment outcomes in order to provide effective and successful treatment. Similarly, Reese, Northworthy, and Rowlands (2009)

reported that continuous use of outcome data in measuring treatment progress is an empirically supported way of enhancing outcomes of therapeutic treatments.

According to Ellis and Ladany (1997), only nine studies conducted between 1981 and 1993 meet the criteria of a client outcome study and are referred as "acid tests" of quality supervision (p.485). Similarly, Freitas (2002) chose only 10 studies from 1981 to 1997 that met the criteria of supervision research studies based on client outcomes. According to Inman and Ladany (2008), there have been only 18 empirical studies conducted since the 1980's that have examined supervision and client outcomes. Watkins (2011) argues that after thorough review of the identified articles from the Inman and Ladany (2008) meta-analysis, there are only three studies that truly provide a contribution to the body of knowledge on the influence of supervision on client outcomes.

Multiple authors that have conducted extensive reviews of the empirical literature on supervision outcomes provide practical recommendations that could benefit further research and allow elimination of previous methodological flaws (Ellis & Ladany, 1997; Freitas, 2002; Goodyear & Bernard, 1998; Inman and Ladany, 2008). Goodyear and Bernard (1998) discuss the need for effectiveness and efficacy studies in supervision and identify three main reasons that become barriers in conducting effectiveness studies in supervision. The identified barriers are caused by little theory-driven research in supervision, lack of supervision manuals or protocols, and difficulties with designing a study that protects clients (Goodyear & Bernard, 1998). Similarly, Inman and Ladany (2008) discussed the complexity of conducting supervision research and pointed out difficulties that are caused by lack of reliable measures in assessment of experiences of supervisors, supervisees and clients, as well as problems with sampling.

Based on the abovementioned reviews, there is a gap in the supervision literature that examines clinical supervision and client outcomes. With the help of the methodological critiques that have been provided by authors of meta-analysis studies (Ellis & Ladany, 1997; Freitas, 2002), the author attempted to conduct a more methodologically sound outcome study to determine if supervisory working alliance predicts clients' outcomes.

Purpose and Significance of the Study

The purpose of this study was to investigate whether the relationship between supervisory working alliance and clients' outcomes exist. Supervision is a requirement for all novice clinicians. Clinical supervision serves several purposes: assuring client welfare, providing further skill training and support of therapist development. This study fills the gap in the supervision literature by answering the question whether supervisory working alliance has a relationship with client outcome. While the importance of supervisory working alliance for counselor training and development has been previously established (Bordin, 1983), there is a gap in the literature discussing the relationship between supervisory working alliance and client outcomes.

Research Question

Is there a relationship between supervisory working alliance, as measured by the constructs of bond, task and goals on the Supervisory Working Alliance Inventory Trainee Form (SAWI-T) and treatment outcomes, as measured by clients' perception of improvement of symptoms, relationships with significant people, ability to make decisions, school/work performance, and overall quality of life?

Research Design

In order to answer the research question, this study used a non-experimental correlational research design in order to examine the relationship between variables. The first three variables: bond, goal, and task variables were defined as therapists' self-report rating on three subscales of the Supervisory Working Alliance Inventory Trainee Form (SAWI-T) (Bahrick, 1990). Other five variables were symptoms, relationships with significant people, ability to make decisions, school/work performance, and overall quality of life, all of which were measured by clients' self-report on Client Perception of Improvement Survey.

Delimitations

The proposed study was delimited to:

- Clients who received supervised therapy services
- Therapists who received one hour of clinical supervision for every 40 hours of work from approved clinical supervisors
- Clients who completed the outcome measure
- Clients who received at least six therapy sessions from the clinician

Limitations

The limitations not under control of the researcher may include:

- Different skill levels of the therapists
- Different skill levels of the supervisors
- The therapists and clients who chose not to respond to the surveys
- The severity of the symptoms that clients had at the beginning of the therapy

Assumptions

The proposed study declared the following assumptions:

- The therapists received supervision
- The clients answered the questionnaire honestly
- The therapists answered the questionnaire honestly

Limitations of Survey Research

Due to conducting survey research, several limitations were considered. Response bias and social desirability are common due to using self-report measures. In order to control for this limitations the researcher conducted the survey online and ensured anonymity by asking the participants to create their unique code before they start responding to their surveys.

Additionally, the researcher considered the instrumentation validity threat. In order to minimize this threat, the researcher used the SAWI-T (Bahrick, 1990), a highly valid and reliable instrument. Moreover, the Client Perception of Improvement Survey (CPIS) that was used in the study to collect data from the client participants was developed based on the scales of a highly valid and reliable instrument, the QLI (Ferrans & Powers, 1985). To ensure that the CPIS effectively measures the constructs that were created based on the QLI subscales, the researcher asked three doctoral level licensed professional counselors to serve as experts and provide the researcher feedback about the survey questions to make sure they parallel QLI questions.

The researcher considered limitations to generalizability of the results of this study. In order to be able to minimize this limitation, the researcher used a sample of counselor-client pairs from several states that have licensed professional counselors who

provide counseling to their clients while under supervision. The sample was drawn from the licensed professional counselors who vary by their race, gender, age, education, and years of experience.

Operational Definitions

- Therapists were operationally defined as minimum master's level professionals with a degree in counseling, and were approved by the LPC board as LPC Associates to provide therapy under clinical supervision at a rate of one hour of supervision for every 40 hours of work from a board approved supervisor.
- Supervision was operationally defined as therapists engaging in weekly intervention that is provided by a board approved clinical supervisor to an LPC Associate who is providing therapy.
- Supervisory Working Alliance was operationally defined as the trainee's perception of the agreement on goals and tasks of supervision and the emotional bond between supervisee and supervisor.
- Clients' outcomes were operationally defined as clients' perceptions of improvement in (a) original symptoms that led them to counseling, (b) relationships with significant people in their life, (c) ability to make their own decisions in life based on what they want, (d) their performance at work/school, and (e) their overall quality of life.

Summary

Chapter One provided an overview of clinical supervision, supervisory working alliance, and clients' therapy outcomes. Additionally, the chapter focused on the inconsistency between goals of supervision and the focus of the research conducted in the

field of supervision in the past 30 years. Furthermore, the current chapter pointed out a gap in the supervision literature that examines client outcomes by reviewing supervision research studies that focused on clients' therapy outcomes. Summary of the current research in the field of supervision outcome reflects the gap in the literature and lack of agreement about the influence of supervision on client outcome. Moreover, this chapter pointed out the gap in the literature discussing the relationship between supervisory working alliance and its effects on the clients' therapy outcome.

The importance of determining treatment progress, successes and failures, is one of the ways of assuring client welfare, which corresponds with one of the main goals of supervision. Limited empirical evidence that is available to therapists and supervisors about the relationship between supervision and supervisory working alliance and clients' therapy outcomes increases the need for the research in this specific area. Therefore, the purpose of this study is to investigate the relationship between supervisee perceptions of the supervisory working alliance and clients' therapy outcomes in order to contribute to the body of knowledge in supervision.

CHAPTER 2: REVIEW OF THE LITERATURE

The purpose of this study was to investigate whether the relationship between supervisory working alliance and clients' outcomes exist. Recent research in the clinical supervision field yields several meta-analysis studies that all agree that there has been limited research on supervision and client outcomes (Ellis & Ladany, 1997; Freitas, 2002; Goodyear & Bernard, 1998; Inman & Ladany, 2008). Even though some authors list between 10 to 18 outcome studies that have been conducted from 1981 to 1996 (Ellis & Ladany, 1997; Freitas, 2002; Goodyear & Bernard, 1998; Inman and Ladany, 2008), Watkins (2011) disagrees with these results. The research conducted by Watkins (2011) provides an overview and critique of the so-called "supervision-patient outcome" (p. 247) studies and points out that after thorough review of previously evaluated studies and additional search of the newly published literature, there are only three studies that provide clear information on the effects of supervision on client outcomes. Due to the controversial nature of the reviews of the influence of supervision on client outcomes, this literature review focused on all of the studies conducted and published from 1981 to 2013 that discuss the contribution of supervision to client symptom improvement.

Detailed examination of search results across databases produced a list of articles that examined supervision and client outcomes published between 1981 and 2013. Ultimately, the author was able to identify and retrieve 21 articles that described the research conducted on supervision and client outcomes, which were pertinent to the topic

of this literature review. The final literature list excluded meta-analysis studies that have been conducted on the topic of interest.

The author will start this chapter with defining supervision and outlining the purpose and goals of supervision. The next part of the chapter will highlight the importance of the outcome studies in monitoring effectiveness of the therapy. Further, the author will provide an overview of the research that discusses factors that contribute to client outcomes. Moreover, the author will discuss the relationship between therapeutic working alliance and supervisory working alliance. Next, the author will provide the description of research articles on supervision and client outcomes based on the critique of the relevance of the selected articles to the topic of the study. Finally, the author will provide a critical assessment of the relevant studies to illuminate possible implications to the field of supervision.

Supervision

In the past three decades supervision has been one of the main focuses of counseling research. Since the 1980's, the number of articles addressing supervision has increased by approximately 65 percent. While in 1980's the main focus of supervision research was on theoretical and conceptual issues in supervision, in the past two decades, research focus has shifted to development of supervision models, researching supervisor and supervisee variables, understanding parallel process, and studying the effects of supervision on client outcome (Inman & Ladany, 2008) .

Bernard and Goodyear (2009) define clinical supervision as an intervention provided by a more senior member of the profession to a junior member of the profession. Supervision assumes both an evaluative and hierarchical relationship, which

extends over time and enhances professional functioning of the supervisee. The supervisor is responsible for monitoring the quality of the service offered to clients and fulfilling the gatekeeping function for the profession (Bernard & Goodyear, 2009).

Similarly, Loganbill, Hardy, and Delworth (1982) identify four primary functions of supervision and highlight that one of the functions focuses on the client while the other three focus on the supervisee. The first and principal function of supervision relies on the supervisor's ethical and professional responsibility to ensure client welfare. The second function ensures supervisees' progress within each stage of their development, while the third promotes the transition from one stage to another. Finally the forth function of supervision is evaluation of supervisees. According to Loganbill et al. (1982), the function of ensuring client welfare takes precedence over the rest of the functions of supervision.

Furthermore, clinical supervision is often commonly discussed from two viewpoints based on the purpose and timing of the interventions (Maki, 1995). The first perspective usually describes supervision as a way of transferring the skills, knowledge, and values of the profession to the next generation of counselors with the help of educational programs. This type of supervision is usually provided to counseling trainees while they are still in the process of attending their counselor-training programs. At this point supervisees are still in the lower stages of their professional identity development, are often referred to as entry level counselors (Stoltenberg, 1981), and require more structure and direction. The second viewpoint on supervision usually refers to supervision as a way of assisting new professionals with sustaining and improving their competencies after completion of their training programs. This type of supervision is usually provided

to counselors who have completed their programs and, according to Stoltenberg (1981), are becoming Level Three counselors with increased levels of professional self-identity and ability to work more independently with clients, accept more constructive criticism, and respond more positively and objectively to confrontation from their supervisor.

Even though the above-mentioned definitions agree that the main goals of supervision are therapist professional development and client welfare, it is important to acknowledge other purposes of supervision. Sirola-Karvinen and Hyrkäs (2008) identify clinical supervision in the healthcare field as goal-oriented and intentionally planned analysis of work-related issues that are a product of interaction between supervisor and supervisee. Similarly, Atkins (1981) highlights an essential role of clinical supervision in assisting with transition of the counselors from their training programs to the work setting and becoming new professionals. This function of supervision is especially pertinent given that counselor skills may decrease over time without continuing clinical supervision (Meyer, 1978).

Proctor (1986) outlines three other functions of supervision: formative, normative, and restorative. The first two functions are very similar to the goals of supervision proposed by Bernard and Goodyear (2009) and Loganbill et al. (1982). The formative purpose is to assist the new therapist or trainee with developing necessary skills and competences. The normative function focuses on assuring client welfare. The third, restorative function of supervision, proposed by Proctor (1986) is different from previously suggested goals. The restorative purpose of supervision is assistance given to supervisees for practicing self-care, avoiding burnout and meeting their needs. This function resonates with the definition of supervision suggested by Frick, McCartney and

Lazarus (1995) which states that supervision may be utilized as a method to assist with rehabilitation of impaired professionals.

To summarize, it is important to highlight that in the past three decades supervision has been attracting increased interest of researchers. While the definitions and goals of supervision differ based on the author, the majority of researchers reach consensus on the main functions of supervision. Based on the abovementioned reviews, supervision goals include, but are not limited to, assurance of no harm and enhancement of the quality of care for clients, support of the supervisee's development and formation of professional identity, gatekeeping, and rehabilitation (Bernard & Goodyer, 2009; Frick, McCartney & Lazarus, 1995; Maki, 1995; Proctor, 1986; Sirola-Karvinen & Hyrkäs, 2008). Prior to evaluating supervision outcome research, we should begin with a brief understanding of counseling outcome research, particularly in interventions, instruments and research variables. Counseling outcome research has been conducted significantly longer, is more extensive than the body of supervision outcome research, and can illuminate important findings that might be informative for the supervision outcome research efforts

Counseling Outcome Studies

In order to continue providing quality services to clients, it is important to collect data on therapy outcomes. There are several ways of collecting outcome data. According to Seligman (1995), efficacy and effectiveness studies of psychotherapy can provide researchers with answers to questions of whether treatment worked. Efficacy studies contrast a therapy group to a control group and provide empirical support to various treatment modalities (Seligman, 1995). Efficacy studies are very time-consuming and

expensive. On the other hand, effectiveness studies look at client change with the help of treatment and provide valuable information to practitioners, all at a lower cost (Seligman, 1995).

According to Shueman, Troy, and Mayhugh (1994), changes in a patient's rating of the severity of symptoms has been shown to be an effective outcome measure. In medical settings, doctors often rely on patients' self-report in order to determine whether patients are getting better. A counseling client's perception of progress in addressing a presenting problem and developing coping strategies is as valuable as the judgment of the patient about the improvement of a medical problem. Buetler (1981) highlighted two main types of client self-measurement of treatment gains: improvement rating and measurement of change.

Improvement rating is defined as an evaluation of the amount of progress based on the client's perception. The rating is usually measured on a scale from no improvement to very significant improvement. Furthermore, these types of self-measures are designed to determine clients' perception of progress due to therapy (Buetler, 1981).

In contrast, measurement of change is assessed by subtracting the initial evaluation of the presenting problem from post-treatment ratings. Unfortunately, these measures are often susceptible to confounding variables. According to Green, Gleser, Stone, and Siefert (1975), change is always greater among clients who present with more severe disturbances. Subsequently, clients who have little initial psychological disturbance will show less progress based on the measurement of change assessments, and yet they still have a good chance of reporting perceived progress when using improvement rating instruments.

Factors that Contribute to Client Outcomes

Extensive research has been conducted to investigate variables that contribute to client improvement. According to Nelson and Neufeldt (1996), there are several key factors that need to be considered by counselors who are working towards increasing successful client outcomes. Among the key contributors to successful therapy outcomes are client factors, matching between client and counselor, and the therapeutic relationship between counselor and client. Similarly, Lambert and Cattani-Thompson (1996) conclude that client variables and counselor-client relationship have the strongest effects on client outcomes. The most commonly examined client variables include, but are not limited to, symptom severity, locus of control, social support available to the client, motivation, readiness, ability to relate to the therapist, the strengths of character, and ability to identify the main focus of treatment (Lambert & Anderson, 1996; Nelson & Neufeldt, 1996).

Furthermore, most researchers agree that the counselor-client relationship is one of the most important factors that contribute to client outcomes across therapies. The counselor-client relationship is often referred to as the therapeutic working alliance, and defined as a collaborative counseling relationship between client and counselor. Therapeutic working alliance is considered to have the largest contribution to client outcomes (Horvath & Bedi, 2002; Horvath, Del Re, Flukiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin et al., 2000).

Working Alliance and Client Outcomes

Working alliance is currently the most extensively examined areas and one of the oldest themes in psychotherapy research (Horvath, Del Re, Flukiger, & Symonds, 2011;

Horvath & Symmonds, 1991). One of the main reasons of the research focus on the alliance is the continuous finding that the strength of the alliance is connected to client therapy outcomes. According to meta-analysis results of Horvath and Symmonds (1991) and Horvath et al. (2011), over 190 research studies have examined the leading factors that affect client change and improvement in therapy. The meta-analysis results suggest that reviewed studies provide evidence that the therapeutic working alliance is related to client outcomes.

Furthermore, multiple attempts to find the most effective treatment approach among different types of existing psychotherapies have led researchers to the conclusion that most therapeutic approaches are effective (Lambert & Bergin, 1994; Smith, Glass, & Miller, 1980; Stiles, Shapiro, & Elliot, 1986). While concluding that therapy works, further research has identified that there are specific factors that can provide an explanation to therapeutic outcomes. Consequently, researchers have begun to agree that the therapeutic alliance is a pantheoretical factor and a key component of the change process that exists across all therapeutic orientations and contributes the most to client outcomes (Bordin, 1979; Safran & Muran, 1995).

Since 1991, four meta-analysis studies were conducted in order to synthesize the research that has been done to investigate the relationship between therapeutic working alliance and its connection to client outcomes (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000). While the strengths of the relationship between working alliance and therapy outcomes differs across meta-analyses, most studies found effect sizes that were within a similar range. Horvath and Symonds (1991) report a combined effect size of $r = .26$, $p < .001$. Martin et al. (2000)

and Horvath and Bedi (2002) report similar values of effect size, r =.22, and, r = .21 respectively. The most recent meta-analysis that examined 190 independent effect sizes, conducted by Horvath et al. (2011), reports an overall effect size of r=.275, p< .0001. In other words, seven and a half percent of the client treatment outcomes can be explained by the strength of the working alliance between counselors and their clients.

It is important to highlight that decades of research in the field of client outcomes strongly support the major contribution of therapeutic working alliance to client outcomes. Consequently, this positive correlation between the strength of the therapeutic working alliance and various counseling outcomes across multiple therapeutic modalities is confirmed by the results of the abovementioned meta-analyses. While the overall effect size, ranging from r = .21 to r=.275 is considered to be moderate and accounts for a modest percentage of the total variance in counseling outcome, this correlation is one of the strongest predictors of successful therapy that has been discovered by the research thus far (Castonguay, Constantino, & Holtforth, 2006).

Similar to the need for continuous research on psychotherapy outcomes, the field of supervision needs more methodologically sound and well-designed studies. Although one of the primary goals of supervision is to ensure client welfare, the majority of supervision outcomes have been measured by supervisee competencies, supervisee satisfaction with supervision, the working alliance between supervisee and supervisor, and supervisee self-report of the effectiveness of supervision (Goodyear & Bernard, 1998; Worthen & Lambert, 2007). Goodyear and Bernard (1998) discuss the need for effectiveness and efficacy studies in supervision, but identify three main barriers to conducting this research. The identified barriers are caused by minimal theory-driven

research in supervision, lack of supervision manuals or protocols, and difficulties with designing a study that protects clients. Based on the main goal of supervision (i.e., providing for client welfare), outcome studies need to focus on tracking client changes as a result of therapy. Supervision outcome studies can provide evidence of the effectiveness of supervision by focusing on symptom improvement as an outcome measure.

Supervision and Client Outcomes

In the past decade, several meta-analysis studies were conducted to examine the body of empirical literature on supervision and client outcomes (Ellis & Ladany, 1997; Freitas, 2002; Inman & Ladany, 2008; Watkins, 2011). These studies provide different conclusions. According to Ellis and Ladany (1997), there were only nine studies conducted between 1981 and 1993 that met the criteria of a client outcome study. Similarly, Freitas (2002) selected and reviewed only 10 studies from 1981 to 1997 that met the criteria of supervision research studies based on client outcomes. According to Inman and Ladany (2008) there have been a total of 18 empirical studies conducted since the 1980's that have examined supervision and client outcomes, while Watkins (2011) argues that after a thorough review, only three studies truly meet the criteria of the study of the effects of supervision on client outcomes.

A literature search conducted by the author produced 21 studies that meet the search criteria of supervision and client outcome (Alpher, 1991, Bambling, King, Raue, Schweitzer, & Lambert, 2006; Bradshaw, Butterworth, & Mairs 2007; Callahan, Almstrom, Swift,Borja & Heath, 2009; Couchon & Bernard, 1984; Dodenhoff, 1981; Friedlander, Siegel, & Brenock, 1989; Harkness & Hensley, 1991; Harkness, 1995;

Harkness, 1997; Iberg, 1991; Kivlighan, Angelone, & Swafford,1991; Mallinckrodt & Nelson, 1991; Milne, Pilkington, Gracie, & James, 2003; Nyman, Nafziger & Smith, 2011; Sandell,1985; Steinhelber, Patterson, Cliffe, & LeGoullon,1984; Schoenwald, Sheidow, & Chapman, 2009; Tanner, Gray, & Haaga, 2012; Triantafillou, 1997; Vallance, 2005; White, & Winstanley, 2010). Of the 21 selected studies, 10 did not appear to be true outcome studies. For example, some of the articles in this group did not provide any relevant information to how supervision was conducted, while others did not focus on client outcome measures. Additionally, some of the articles in this group did not have the goal of examining the influence of supervision on client outcomes, but rather were interested in examining other therapeutic and supervision variables and their relationships. For the purpose of this research, these studies will be called assumed supervision outcome studies. In other words, the studies in assumed supervision outcome lack various elements that would make them qualify as real outcome studies. Nevertheless these studies provide important methodological information as well as essential results for the field of supervision, therefore they will be reviewed in this chapter. The remaining 11 studies provided more detailed information about supervision conducted with the therapist and utilized client outcome measures in the research. These studies will be called real supervision outcome studies. Of the 11 real supervision outcome studies, eight studies utilize client symptom reduction or improvement as an outcome measure.

Assumed Supervision Outcome Studies

This section discusses studies that are relevant to the current literature review on supervision and client outcome studies, however do not truly meet the supervision and

client outcome criteria. Some of the studies in this section do not provide information about the supervision that was provided to the therapists. Others discuss connections between supervision and client outcomes, but do not collect any client outcome data. Furthermore, several studies in this section only focus on therapeutic processes and their connection to client outcomes and suggest important topics that need to be discussed in supervision. Lastly, a few studies examined the parallel process phenomenon and provided evidence of the existence of parallels between supervision and therapy.

Two of the studies that were originally identified as supervision outcome studies actually focus on parallel process that happens in supervision. Alpher (1991) conducted a qualitative study that explored parallel process from the perspectives of supervisor, therapist, and the client. Structural Behavior Analysis procedure was chosen as the key focus of the article. The data about client improvement was collected with the Symptom Checklist-90-Revised (Derogatis, 1983). While there was evidence of symptom improvement from pre- to post questionnaire, the evidence of symptom reduction was not explained by any of the phenomena that were explored in the article. Similarly, Friedlander et al. (1989) conducted a case study examining parallel process between supervision and therapy. The researchers collected pre- and post-treatment data from supervisee, supervisor, and the client with the purpose of comparing behaviors and reactions between the supervision and therapy dyads. Additionally, researchers collected data during the treatment process. Even though the study used outcome measures both for supervision and therapy, the researchers were not looking to answer the question of the influences of supervision on client outcomes, but rather find evidence in support of the

parallel process model. Friedlander et al. (1989) does not provide any concrete information of whether supervision had an effect on client outcomes.

Couchon and Bernard's (1984) study was identified as one of the outcome studies in the Freitas (2002) meta-analysis. However, after review of the goals and outcomes of the study, no clear connection between supervision and client satisfaction as an outcome criterion was identified. The purpose of the study was to identify the best time for conducting supervision. While the authors collected client outcome data by asking the client to rate satisfaction with the therapy, the main focus of the study seemed to be on therapist behaviors in the sessions. Couchon and Bernard's (1984) hypothesized that supervision that is provided within four hours before a counseling session will result in greater satisfaction with counseling for clients. The analysis of the data did not yield statistically significant differences in either client or counselor satisfaction in connection to the timing of the supervision. The authors, however, did find that counselors were more likely to follow through with the behaviors discussed in supervision if supervision took place four hours before the counseling session. While the results of the study contribute important information to the field of supervision, unfortunately this study does not provide any information on how supervision and post-supervision counseling behaviors affect client outcomes.

Similarly, in the meta-analysis by Ellis and Ladany (1997), Mallinckrodt and Nelson's (1991) study was indicated to be a supervision and client outcomes study. The purpose of the study was to investigate the relationship between counselors' ability to develop therapeutic working alliances and their training levels. The authors collected both clients' and therapists' working alliance data as an outcome measure. Unfortunately,

the focus of the study was mainly on the relationship between the ability to develop therapeutic working alliance across counselors' training levels. While this research can provide valuable information to supervisors about the areas of focus at each training level, this study does not really meet the criteria for a supervision and client outcome study, because no information about supervision that was provided to the therapists was collected and analyzed in this study.

Iberg (1991) was also interested in examining therapist variables and their effects on clients. The purpose of the study was to understand how specific therapist techniques or events of the sessions can affect client outcomes and how certain therapist behaviors need to be addressed in supervision in order to improve client outcomes. Even though, based on the purpose of the study, this research seemed suitable as a supervision and client outcome study, after detailed examination of this article, no indication of the provided supervision was found. The results of the study suggest that high frequency of therapist empathic responses and empathic suggestions lead to better therapy outcomes. Additionally, the author suggests that supervision can assist therapists with correcting their in-session behaviors and, consequently, improve client outcomes. The author indicates that the results of the study could be useful in supervision of therapists.

Milne et al. (2003) and Vallance (2005) seem to have similar findings. While both studies established that therapists exhibit transference of feelings (Milne et al., 2003) and behaviors (Vallance, 2005) from supervision sessions to therapy sessions, neither of the studies collected outcome data from the clients. Milne et al. (2003) conducted a mixed-method study to investigate effectiveness of supervision as measured by observed impacts on supervisee and the client. Based on the results of the quantitative content

analysis, there is evidence of the thematic transference from supervision to therapy. In other words, structure of supervision session, materials discussed, and skills that were practiced by the therapist during supervision were utilized by the therapist in session with the client. The purpose of the study seems to match the criteria for the supervision outcome study; however, after detailed review of the study, it is evident that no measures of client outcomes were used and therefore no outcome data were collected.

Similarly, Vallance (2005) found that higher levels of therapist congruence and confidence in the supervisory relationship leads to higher congruence and competence of therapists in their relationship with clients. Vallance (2005) conducted a qualitative study to examine the influence of supervision on client outcomes based on perceptions of the therapists. The researcher collected data from therapists with the help of semi-structured interviews and open-ended questions. While the results of the study contribute to the field of supervision, and support the need to explore effects of supervision on client outcomes, actual clients did not participate in the study. Additionally, this study does not provide any information on the type of supervision provided to the therapists and does not have any data from the clients about the effects of supervised and non-supervised therapy.

Sandell (1985) conducted a study to test the effects of supervision, therapist competency, and patient ego-level on time-limited psychodynamic psychotherapy outcomes. Therapists received peer group supervision once a week and were responsible for presenting one case weekly. This study seems to have serious methodological flaws, including a very small sample size, nesting of the data and lack of formal instruments to collect supervision and therapy outcome data. Based on the results of the study, both supervision and therapist competence have a negative influence on client outcomes. The

author does not provide any detailed descriptions of the measurement of therapist competency. These results contradict the body of literature that states that therapist competence, together with other factors, such as strong self-efficacy, contribute to therapist's ability to build therapeutic relationships with clients, which in turn positively correlated to client therapy outcomes (Gard & Lewis, 2008). Due to the methodological flaws, the results of this study need to be interpreted with caution.

Triantafillou (1997) conducted a pilot study in order to test a solution-focused supervision training program. The study was conducted with direct care staff who were working with children and youth in a residential treatment facility. Based on the description of the participants, the author was not clear about the education and training level of the staff who were providing direct care to the clients. The author mentioned that only a few direct care staff had social work backgrounds and all of them met a requirement of a minimum of a three-year degree as child and youth workers. The client outcome measures were collected with a "subjective measure" (i.e., Client Satisfaction Survey [CSS]) and an "objective measure" (i.e., frequency of using restraints and the need for psychotropic medication treatments) (Triantafillou, 1997, p.316).

The results of the study (Triantafillou, 1997) indicate that while both treatment and control groups showed a decrease of severe behaviors after treatment, treatment group clients showed a significant decrease in the frequency of needing restraints and use of psychotropic medications throughout the length of the study in comparison with the control group. Both direct care workers and supervisors of the treatment group received solution-focused training, while only supervisors of the control group received solution-focused training. Based on the design of the study, supervisors of both treatment and

control groups received the same type of training, which makes it hard to determine whether supervision had any effect on client outcomes.

Similar to Triantafillou (1997), the study design of Nyman et al. (2011) does not have any different supervision conditions for therapist participants. In this longitudinal study, clients of a university counseling center received services from therapists that were at different professional levels, such as professional staff, interns, and practicum students. All of the therapists received ongoing supervision. Client outcomes were measured by two instruments: College Adjustment Scales (CAS; Anton & Reed, 1991) and The Outcome Questionnaire (OQ-45; Lambert et al., 1996). Both of the measures were administered before the beginning of therapy. The OQ was administered after every third session and the CAS was administered after every sixth session. Therapists received multi-tiered supervision; pre-doctoral students were supervised by the professional staff and practicum students were supervised by pre-doctoral students. The results of the study found client psychological improvements regardless of the counselor level. The findings provide valuable information to the counseling field, however shed no light on how the supervisor of the therapist effects client outcomes.

To summarize, it is important to highlight that while assumed supervision outcome studies lack various elements that would make them qualify as real outcome studies, they provide important methodological information as well as essential results for the field of supervision. Several studies in this section support and explain the phenomenon of parallel process (Alpher, 1991; Friedlander et al., 1989; Milne et al., 2003; Vallance, 2005). Moreover the results of several studies can be used in counselor education and training of therapists (Couchon & Bernard, 1984; Iberg, 1991;

Mallinckrodt & Nelson, 1991; Nyman et al., 2011). Lastly, two studies in this section provided valuable information on how methodological flaws of the research can affect the findings (Sandell, 1985; Triantafillou, 1997).

Real Supervision Outcome Studies

This section of the literature review provides discussion of the studies that meet the criteria for supervision and client outcome studies. These research studies provide detailed information on the supervision that was provided to the therapists and outcome data that was collected during the course of therapy. This section contains studies that examined the influence of supervision variables, types of supervision, and supervision and no supervision conditions on client outcomes. Additionally, these studies utilized various client outcome measures: therapist and client perceived session outcomes, client perceived therapeutic working alliance, symptom reduction measures.

While Dodenhoff (1981) and Kivlighan et al. (1991) differed in goals and outcomes, they were similar in their research design. Both studies fall under the category of effectiveness studies (Seligman, 1995). Effectiveness studies do not have a control group, but rather look at clients' change due to treatment and provide valuable information to practitioners.

Dodenhoff (1981) conducted a study that examined the process of supervision. The study focused on the supervision style and the interpersonal attractiveness of the supervisee to the supervisor. The researcher investigated the effect of the abovementioned independent variables on the effectiveness of the therapists as measured by client outcomes, and therapist effectiveness as measured by the supervisor. The Rating Scale for Outcome (RSO; Storrow, 1960) was utilized to collect data from clients and

supervisors in order to measure therapist effectiveness. The therapists that were exposed to a direct supervision style (i.e. constructive feedback, directions, criticism, answering questions, and encouragement) were found to be more effective as evidenced by higher RSO scores reported by supervisors in comparison to those who received an indirect style of supervision (i.e. emotional and cognitive clarification and acceptance, supervisor questions). Additionally, the author found that a strong positive emotional reaction of the therapist towards the supervisor was connected to a better client outcome as rated by the supervisors. While client outcome data was collected during the investigation process, client outcome ratings did not provide any statistically significant explanation of therapist effectiveness.

Kivlighan et al. (1991) conducted a quasi-experimental study with two groups of therapists: therapists who received live supervision and those who received supervision of the videotaped counseling sessions. During live supervision, supervisors were observing therapists from behind a one-way mirror and gave therapists immediate feedback. Therapists in the videotape review condition met with their supervisor and two of their class peers to review a recording of the therapist's session. The supervisor and peers provided feedback to the therapist regarding the reviewed session. They made suggestions about the skills and techniques utilized in the session, discussed the helpfulness of the interventions, and made recommendations for future therapy sessions. Client outcomes were measured with the Working Alliance Questionnaire and the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984), each completed by the clients. The results of the study indicate that the clients working with therapists who received live supervision had higher working alliance scores in comparison with the

clients working with therapists who received supervision of videotaped counseling sessions. Additionally therapists receiving live supervision seemed to show more intention in setting limits with their clients.

White and Winstanley (2010) conducted an experimental randomized control study to examine the effects of supervision on client care and client outcomes. This study is different from Dodenhoff (1981) and Kivlighan et al. (1991) because, based on the research design, it is considered an efficacy study. Efficacy studies contrast a treatment group to a control group and provide empirical support to outcome data (Seligman, 1995).

In this study (White & Winstanley, 2010), nine adult mental health facilities were randomly assigned to treatment and control group conditions. Facilities that were assigned to the treatment condition were implementing clinical supervision of all mental health nurses into the daily practice. Facilities that were assigned to the control group did not implement clinical supervision. Twenty nine mental health nurses from facilities that were assigned to the treatment group condition were selected to receive four days of training in clinical supervision and became supervisor trainees. Mental health nurses who were in the treatment group condition received clinical supervision from the supervisor trainees on a consistent basis as a part of their routine practice. The mental health nurses in the control group did not receive any supervision. The authors collected qualitative and quantitative data. The Service Attachment Questionnaire (SAQ; Goodwin, Holmes, Cochrane, & Mason, 2003) and Psychiatric Care Satisfaction Questionnaire (PCSQ; Barker & Orrell, 1999) were utilized to collect outcome data from clients. Patient data was collected at baseline and after six and twelve months of treatment. Based on the

results of the statistical analysis no statistically significant differences were found in client care and patient satisfaction between the treatment and control groups.

The next studies reviewed are grouped by two common factors. First, all of the studies met the criteria for real supervision and client outcome studies, and second, all of the studies utilized client symptom reduction measures to collect data on client improvements after supervised therapy. While the studies in this section provide more precise information about the effects of supervision on client outcome, some studies in this section only manipulate therapist variables. Other studies in this section focus on specific supervision variables (i.e. supervisory working alliance), supervision focus, and compare different types of supervision (i.e. live vs. review of tapes, co-therapy supervision vs. cognitive-behavior supervision conducted on a weekly basis). Even though all these studies still fit the criteria of real supervision and client outcomes studies, methodological flaws of some of the studies increase a risk of being criticized for not having enough evidence that supervision, and not just therapist variables, had an effect on client outcome.

Steinhelber et al. (1984) investigated the influence of the amount of supervision and the congruence of the theoretical orientation between supervisor and supervisee had on client outcome. The change in client functioning level was measured by differences in the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976) between the beginning of the treatment and after an average of 22.8 visits over an average of 8.4 months. The GAS was completed by treating therapists. Based on the results of statistical analysis, the clients who received therapy from supervised therapists with congruent therapeutic style (both therapist and supervisor have the same therapeutic orientation) had

a statistically significant increase in their overall functioning level. No support was found for the hypotheses that specific amounts of supervision were related to a client's GAS change. In other words, the amount of supervision provided to the therapist did not have a significant relationship with GAS score change of the clients after an average of 22 sessions.

Bambling et al. (2006) conducted an experimental study that explored the influence of supervision on the symptom reduction and working alliance of clients undergoing depression treatment. All supervisors received manualized training in problem-solving therapy and in one of two foci: alliance skill or alliance process supervision. Therapists were randomly assigned to supervision and no supervision conditions. Clients completed The Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996). The BDI results were used to assess symptom reduction. Based on the results, clients who were assigned to therapists receiving supervision had statistically significant lower BDI scores in comparison with the clients assigned to therapists who received no supervision.

Bradshaw et al. (2007) conducted a quasi-experimental study that examined the influence of clinical supervision on improvement of the knowledge and attitudes of qualified mental health nurses and symptom reduction of their clients. The nurses in the study provided psychological interventions, family interventions, and case management to their clients. The symptom reduction was measured by the modified version of the Krawiecka, Goldberg and Vaughan symptom scale (KGV (M); Krawiecka, Goldberg & Vaughan, 1977) and the Social Functioning Scale (SFS; Birchwood, Smith, Cochrane, et al., 1990). The results of the study showed a significant improvement in clients who were

assigned to both experimental and control groups in comparison with baseline measures. Additionally, the clients assigned to the experimental group showed statistically significant greater reduction in their symptoms in comparison to the control group.

Harkness and Hensley (1991) conducted an experimental study examining the influence of two types of supervision, client-focused and mixed-focused, on client outcome. Client outcomes were measured with two assessments, the Generalized Contentment Scale (GCS; Hudson, 1982) assessed client depression level and the Client Satisfaction Scale (CSS; Poertner, 1986). Lower scores on GCS mean higher contentment, which means less depression. The authors obtained mixed results on the decrease of depression in clients receiving client-focused or mixed-focused types of supervision. Some clients who were treated by therapists supervised using a mixed-focused approach to supervision showed evidence of a decrease in depression, while others showed an increase in depression. Furthermore, clients who were treated by therapists receiving client-focused supervision showed both increases and decreases in depression. After visual inspection of the trends, it seems that depression levels in clients were more related to the therapists who provided the treatment, rather than to the type of supervision received. To summarize, there was no significant support that client-focused supervision reduced client depression.

Additionally, according to Harkness and Hensley (1991), clients who were treated by therapists using a client-focused approach to supervision showed evidence of an increase in satisfaction with goal attainment and the worker-client partnership. As evidenced by this study, supervision had an effect on client outcome, yet the results were not consistent with the hypothesis offered by the researchers. The authors provide

practical suggestions of the utilization of the client-focused supervision based on the fact that client satisfaction increased, however, the important outcome of therapy is client symptom reduction, which was shown to be improved when the supervisor used a mixed-focus supervision.

A study conducted by Harkness (1995) involved data duplication from an original study by Harkness and Hensley (1991). The use of correlational design to analyze the same data used in Harkness and Hensley (1991) allowed the researcher to answer the question of whether supervision is connected to client outcomes. Harkness (1995) found that both problem-solving in supervision and supervisor empathy led to better therapy outcomes. Additionally, the therapists' ratings of the supervisory relationship were associated with clients' ratings of contentment and goal attainment. In other words, higher therapist ratings of the supervisory relationship were associated with higher client ratings of contentment, which means less depression (the direction of the scoring for GCS was reversed to simplify interpretation). Additionally, there was a positive correlation between therapists' ratings of the supervisory relationship and clients' goal attainment. This means that when therapists' ratings of the supervisory relationship increased, then clients' goal attainment increased.

Schoenwald et al. (2009) conducted a non-experimental study to examine the relationship between adherence to supervision protocol, adherence to a therapy model, and changes in behavior and overall functioning of clients. Client outcomes were measured with the help of the Child Behavior Checklist (CBCL; Achenbach, 1991) and Vanderbilt Functioning Inventory (VFI; Bickman, Lambert, Karver, & Andrade, 1998). Based on the three level mixed-effects regression analysis, clients' behavior changes and

increase of overall functioning were predicted by supervisor adherence to the structure and process of the supervision protocol and supervisor focus on clinical development. Additionally, therapist adherence to the treatment model was predicted by supervisor adherence to the supervision model.

Callahan et al. (2009) conducted a study to investigate the effect of clinical supervision on client treatment outcomes. The authors analyzed archival data from 74 clients who received supervised therapy from 40 doctoral level clinical psychologists. Therapists received one hour of individual and two hours of weekly group supervision from nine tenure-track doctoral level clinical faculty. Clients completed the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) at the beginning and at the end of treatment and the Symptom Checklist-90, Revised (Derogatis, 1992) only during the intake session. Additionally, researchers used the Counselor Rating Form Short (CRF-S; Corrigan & Schmidt, 1983) to collect data from clients about their therapists and used that information in the statistical analysis to control for therapists effects. The results of the data analysis revealed no significant differences in intake BDI-II scores among clients. Additionally, analysis yielded no statistically significant correlations of BDI-II scores from intake and termination with CRF-S scores. This means that change in depression levels measured by BDI-II were not connected to therapist attributes measured by the CRF-S. Furthermore, logistical regression analysis was conducted to examine the amount of variance accounted for by three variables: therapists' qualities measured by a total score on CRF-S, clients' symptom severity at intake, and supervision. The results of the logistic regression suggested that 44.5% of the outcome variance was explained by severity of the depression at the intake. Additionally, supervision interventions explained

16% of the variance in client outcomes, while therapist qualities did not produce any significant main effects. In other words, the results of the study suggest that the severity of the client symptoms at intake and supervision provided to the treating therapists significantly predict client outcomes.

The purpose of the Tanner et al. (2012) research was to examine whether co-therapy supervision can enhance client therapy outcomes. Client outcomes were measured by the Outcome Questionnaire (OQ-45; Lambert et al., 1996) at the beginning of each session. The clients were randomly assigned to either the co-therapy supervision condition or the single therapist condition. Co-therapy supervision in this study is defined as therapy provided to the client by a team of the therapist and his or her supervisor. It is unclear whether therapists in the single therapist condition were receiving ongoing supervision or if that condition was a control group with no supervision at all. However, in the discussion section the authors do state that there was no statistically significant difference between the two conditions and suggest that both co-therapy supervision and regular cognitive-behavior supervision that involves tape reviews and case discussions contribute to client improvements over time.

The results of the reviewed studies suggest that strong emotional reaction of a supervisee to a supervisor (Dodenhoff , 1981), supervision that focuses on the client (Harkness and Hensley, 1991), supervisor empathy and a problem-solving focus of supervision (Harkness,1995), adherence to a supervision protocol (Schoenwald et al., 2009), and live supervision (Kivlighan et al., 1991) contribute to improved client outcomes. Furthermore, several studies provide evidence that supervised therapy is more effective for client symptom reduction than unsupervised therapy (Bambling et al., 2006;

Bradshaw et al., 2007). Additionally, after detailed examination of the current supervision and client outcome research, it is evident that supervision outcome studies do not include research investigating the relationship between supervisory working alliance and client outcomes. Knowing that the therapeutic working alliance is considered the most robust predictor of client outcomes, and that the therapeutic working alliance has a relationship with supervisory working alliance, it becomes critical to examine the relationship between the supervisory working alliance and client outcomes. Due to lack of research on the relationship between supervisory working alliance and client outcomes, it is important to establish a connection between the supervisory working alliance and client outcomes through a therapeutic working alliance.

Relationship between Therapeutic Working Alliance and Supervisory Working Alliance

Therapeutic alliance of supervisees with their clients is considered one of the supervisory working alliance outcomes (Bernard & Goodyear, 2009). Currently there is only limited research that exists in the supervision literature on the topic of the relationship between therapeutic working alliance and supervisory working alliance. Based on the available research that provides evidence of the connection between therapeutic and supervisory working alliances, it is possible to infer that the supervisory working alliance has an effect on the therapeutic working alliance and, therefore, has an effect on client outcomes.

Patton and Kivligan (1997) established a link between supervisory working alliance and therapeutic working alliance. In their study with 75 counselor-client pairs, the authors investigated whether there was a strong positive relationship between supervisory working alliance perceived by supervisees and therapeutic working alliance

perceived by clients. Each client in the study received four 50-minute counseling sessions from a therapist trainee. Every therapist received a 50-minute supervision session from an assigned supervisor right after completion of the therapy session with the client. As hypothesized, the research results revealed a strong positive relationship between supervisory working alliance and therapeutic working alliance. Additionally, researchers found significant week-to-week fluctuations in both therapeutic alliance and supervisory working alliance. Patton and Kivligan (1997) concluded that therapist trainees were learning how to build relationships from their supervision sessions and were applying that to their therapy sessions with clients.

Similar to the findings of Patton and Kivligan (1997) that suggest that supervisory working alliance can serve as a model for the therapist on how to build therapeutic working alliance, Gard and Lewis (2008) argue that the relationship-building process can be modeled by the supervisor to the supervisee while developing supervisory working alliance in supervision. Furthermore, the authors suggest that the supervisor contributes to the supervisee's perceptions of self as a therapist and can either assist therapist trainees with decreasing self-judgment and anxiety or contribute to increasing negative feelings. These findings are especially true for therapist trainees who are entry-level counselors (Stoltenberg, 1981) and who perceive the therapeutic process as new and difficult. Novice therapists often have a hard time focusing on all the dimensions of therapy, such as content, context, client's emotional reactions and therapist's own reactions to the client, therefore they often need help with learning how to effectively focus on building therapeutic working alliance in the session.

As mentioned earlier, the supervisor can play a crucial role in assisting the therapist trainee with alleviating anxiety, self-doubt, and in turn increasing the supervisee's focus on relationship building with the client. In other words, the way the supervisor focuses on establishment of a genuine and important supervisory working alliance parallels supervisees' capabilities to build the therapeutic working alliance with their clients. Even though there is no evidence thus far about the relationship between supervisory working alliance and client outcomes, based on the available research that proves a connection between therapeutic alliance and supervisory alliance, we can make an inference that supervisory working alliance indirectly affects client outcomes through therapeutic working alliance.

Summary

The importance of this study is strongly supported by the limited research on supervision and client outcomes that is available to date (Ellis & Ladany, 1997; Freitas, 2002; Goodyear & Bernard, 1998; Inman & Ladany, 2008). A thorough search across databases produced a list of 21 articles which examined supervision and client outcome studies published between 1981 and 2013. Due to the limited number of studies, the examination of the existing research presented controversial results of the influence of supervision on client outcome.

While conducting supervision outcome research, it is important to review counseling outcome research. Counseling outcome research has been established to have similarities with supervision in interventions, instruments, and research variables supporting the importance of conducting supervision outcome research. Furthermore, counseling outcome research has been conducted significantly longer and can illuminate

important findings that might be informative for supervision outcome research. Additionally, Goodyear and Bernard (1998) identify barriers to conducting supervision and client outcome research and highlight the importance of addressing previous methodological flaws in order to eliminate difficulties with designing a good research study that protects clients and provides unbiased results. Based on the suggested implications of the reviewed literature, supervision outcome studies need to focus on tracking client changes and symptom improvement as client outcome measures.

From reviewing decades of research on counseling outcomes, we can find strong support of the contribution of therapeutic working alliance to client outcomes. While therapeutic working alliance accounts for a modest percentage of the total variance in counseling outcome, this correlation is one of the strongest predictors of successful therapy that has been discovered by researchers thus far (Castonguay, Constantino, & Holtforth, 2006). After examining research conducted on supervision outcomes, there is evidence of similarities between the variables that have an effect of client outcomes that have been previously examined by counseling outcomes studies. The results of the reviewed supervision outcome studies suggest that strong emotional reaction of supervisee to supervisor (Dodenhoff , 1981), supervision that focuses on the client (Harkness and Hensley, 1991), supervisor empathy and a problem-solving focus of supervision (Harkness,1995), adherence to a supervision protocol (Schoenwald et al., 2009) and live supervision (Kivlighan et al., 1991) contribute to improved client outcomes.

Currently there is only limited research that exists in the supervision literature on the topic of the relationship between therapeutic working alliance and supervisory

working alliance and no research has been found thus far that explores the relationship between supervisory working alliance and client outcomes. Nevertheless, based on the available research that provides evidence of the connection between therapeutic and supervisory working alliances, it is possible to infer that the supervisory working alliance has a relationship with therapeutic working alliance and, therefore, has a relationship with client outcomes.

Inconsistent results of the previous research on supervision and client outcomes, limited research on the connection between therapeutic working alliance and supervisory working alliance, and lack of research on supervisory working alliance and client outcomes grants support for the need of the current study. While the importance of supervisory working alliance for counselor training and development has been previously established (Bordin, 1983), there is a gap in the literature discussing the relationship between supervisory working alliance and client outcomes. The purpose of this study to fill the gap in the supervision literature by answering the question of whether the supervisory working alliance has a relationship with client outcome.

CHAPTER 3: METHODOLOGY

Currently there is limited research on the relationship between the supervisory working alliance and client outcomes. The purpose of this study was to address this gap in the literature. This chapter will focus on the methodology of the research study. The chapter will include a description of the research design, review of the research question, description of the participants and recruitment procedures, data collection procedures, instrumentation section, and data analysis description. The summary will conclude this chapter.

Research Design

This study used a non-experimental correlational research design in order to examine the relationship between three independent variables and five dependent variables. The independent variables of the study are bond, goal, and task, which are defined as therapists' self-report rating on three subscales of the Supervisory Working Alliance Inventory Trainee Form (SAWI-T) (Bahrick, 1990). The dependent variables are symptoms, relationships with significant people, ability to make decisions, school/work performance, and overall quality of life, all of which are measured by client's self-report on Client Perception of Improvement Survey.

Research Question

Is there a relationship between supervisory working alliance, as measured by the constructs of bond, task and goals on the Supervisory Working Alliance Inventory

Trainee Form (SAWI-T) and treatment outcomes, as measured by clients' perception of improvement of symptoms, relationships with significant people, ability to make decisions, school/work performance, and overall quality of life?

Participants

The sample consisted of counselor-client pairs. The researcher used a sample of counselors from several states who were licensed professional counselor associates or provisionally licensed counselors and receiving supervision from a professional clinical supervisor or other qualified professional supervisors approved by the counseling board. The professional counselors in the sample have obtained a master's or doctoral degree in counseling from an accredited educational institution and passed an examination administered by the board. As part of their licensure process, they were required to receive one hour of supervision for every 40 hours of work from a board approved clinical supervisor.

The counselors who agreed to participate in the study recruited client participants. In order for the counselor to select a client, the counselor asked the next client that came in for counseling and who had received a minimum of six therapy sessions to participate in the study. The counselor did that successively until a client agreed to participate. The researcher was only able to use data from the counselor-client pair if both the counselor and his or her identified client completed the questionnaires.

In order to use multiple regression analysis, the minimum sample size for the study was calculated with the help of a priori power analysis (Faul, Erdfelder, Lang & Buchner, 2007). According to Cohen (1988), the calculation of the sample size for the study is based on Type I error probability level. This is set by the researcher using

estimated effect size based on the reviewed literature and the level of power that is preferred by the researcher. According to Ellis, Ladany, Krengel and Schult (1996), estimated large effect size for supervision research is at $\eta^2 = .50$. For this study, the significance will be set at α =.05, which means that there will be 5% chance of error that the effect will be determined, while in reality there will be no effect. Based on the review of the articles provided in Ellis et al. (1996), the average power for supervision research is set at .08. The researcher will use the G-Power3 statistical program (Faul, Erdfelder, Lang & Buchner, 2007) to calculate sample size for the current research with a medium effect size $\eta^2 = .30$, α =.05, and power set at .80. Based on the power analysis, the researcher needed to recruit a minimum of 107 participant pairs.

Because the minimum sample size for regression analysis was not met, the researcher had to adjust data analysis procedures to be appropriate for the small sample size. Bivariate correlation analysis was therefore used as the statistical analysis procedure to investigate relationships between variables.

Data Collection Procedures

After receiving IRB approval to conduct the study, the researcher began data collection procedures. The researcher requested e-mail lists from the counseling boards of all 50 states and received positive response from only three states. Upon receipt of the e-mail lists, the researcher created a database that included counselors who were working under supervision towards their full license, which consisted of 5290 e-mail addresses. For the study the researcher only recruited counselors who met the inclusion criteria:

- counselor was a master's or Ph. D level therapist who was currently working towards full counselor license;

- counselor was receiving one hour of supervision for every 40 hours of work from a board approved supervisor;
- counselor had at least one adult client who received a minimum of six therapy sessions and agreed to participate in the study.

The researcher used Dillman, Smyth and Christian (2009) Tailored Design Method for data collection in order to ensure the receipt of a minimum of 107 responses from counselor-client pairs. Tailored Design Method has been proven to assist with minimizing survey errors and increasing the quality and quantity of survey responses (Dillman et al., 2009). Based on the Tailored Design Method, the researcher followed a specific timing sequence for the e-mail contacts. On Day 1, the researcher sent an initial e-mail to all the addresses from the compiled database with a brief description of the study, inclusion criteria, instructions for the counselor, and links to the questionnaires for the counselor and the client (Appendix A). The counselors were asked to give a link to the questionnaire to the next client that comes in for counseling and who has received a minimum of six therapy sessions. The counselor was asked to do that successively until a client dagreed to participate. Each questionnaire began with the informed consent and IRB approval information.

When the participants entered their respective questionnaires, they were presented with the informed consent and IRB approval information. The purpose of the study, estimated time required completing the questionnaire, and benefits and risks to participating in thethe study were explained to the participants in the informed consent (Appendix B). The participants were informed that they had the right to quit the questionnaire at any time without any penalties. Additionally, the counselor informed

consent had inclusion criteria questions. If participants agreed to participate in the study, and if counselors met inclusion criteria, they were redirected to the page where they were asked to create a unique code that allowed the researcher to match the counselor-client pair without using any personal information. The participants were asked to enter the first two letters of the counselor's first name, the first two letters of the client's first name, the first two letters of the town where the counseling was taking place, and the last two digits of the client's birth year. After successful creation of the unique codes, participants were directed to fill out a brief demographic questionnaire. Lastly, the participants were asked to complete the instruments.

Further, according to the timing sequence of Dillman et al. (2009) Tailored Design Method, the first reminder e-mail was sent on Day 8, seven days after the initial solicitation e-mail (Appendix C). Due to the low response rate, a second e-mail reminder was sent on Day 15, a week after the first reminder e-mail (Appendix D). In addition, at two different occasions in data collection period, the researcher requested and received updated lists of counselors who became licensed throughout the calendar year in order to add those counselors to the potential participant pool. These two updates occurred approximately three months and five months after beginning the data collection process.

In order to increase the low sample size after completion of the steps listed above, the researcher added counselor supervisor lists consisting of 2830 e-mails to the database. The researcher sent recruitment e-mails to the list of supervisors from two large southeastern states asking for their help with recruiting counselors and their clients for this study. The researcher followed the same timing sequence for the counselor supervisors as was used with the counselors.

After sending two e-mail reminders to the counselors and two e-mail reminders to the supervisors, and still not meeting the desired number of participants, the researcher decided to continue data collection and sent the study participation request to the Counselor Education and Supervision Network (CESNET) listserv. CESNET is an unmediated listserv consisting of 2,850 subscribers. CESNET listserv consists of counselor educators, counselor supervisors, counselors in training is often used to exchange different research ideas, post research participation requests, and job openings in counseling and counselor education fields. Based on the etiquette of the research participation requests for CESNET, the researcher sent an initial participation request and one more follow up request to the subscribers.

Additionally, the researcher used snowball sampling to recruit extra participants through those who had already responded to recruitment. Furthermore, the researcher contacted counselors who responded to their respective surveys but did not have a client match. The researcher asked the counselors to remind their clients about their part of the survey.

Extra measures were taken to increase the sample size and to assure that participation requests were delivered to the intended recipients. The researcher employed Constant Contact e-mail delivery service. This service tracked the rate of opened e-mails, marked e-mails as secure to recipients and eliminated chances of the e-mail going to spam folders.

Instrumentation

Participants were asked to complete two instruments. Both the counselors and their clients were asked to fill out a brief demographic questionnaire. Counselors were

asked to complete the Supervisory Working Alliance Inventory Trainee Form (SAWI-T) and clients were requested to fill out the Client Perception of Improvement Survey. The next sections will provide an overview of these instruments.

Demographic Questionnaire

Counselors were asked to complete 11 questions in order to provide the researcher with descriptive data about the counselors (Appendix F). The questions were both multiple choice and short answer and consisted of gender, race or ethnicity, age, education level, length of receiving supervision, theoretical orientation, counselor's credentials, and credentials of the supervisor, area of study, work setting, and symptom severity of the chosen client. This information was used to describe the sample of counselors.

Clients were requested to complete a four question demographic questionnaire (Appendix G). The questionnaire included multiple-choice questions about gender, race or ethnicity, age, and education level. This information was collected to provide a description of the client sample.

Supervisory Working Alliance Inventory Trainee Form

The Supervisory Working Alliance – Trainee (SAWI-T) (Bahrick, 1990; Appendix H) is a modified version of the Working Alliance Inventory (WAI) developed by Horvath and Greenberg (1989). Horvath and Greenberg (1989) developed the WAI based on the pantheoretical model of working alliance proposed by Bordin (1979). According to Bordin (1979), the therapeutic relationship between the client and the counselor is a key component of the change process that exists across all therapeutic orientations. The therapeutic relationship consists of three main components: a consensus

on goals, assignment of tasks, and development of bonds between the client and the counselor (Bordin, 1979). Tasks of the working alliance are defined as behaviors and cognitions that form the essence of the therapy session. The agreement of the client and the counselor on the goals of therapy constitutes the second component of the therapeutic working alliance. Lastly, the concept of bond is defined as mutual acceptance, respect, and trust between the client and the counselor (Horvath & Greenberg, 1989).

The current study used the Supervisory Working Alliance – Trainee (SAWI-T) (Bahrick, 1990), which is a modified version of the Working Alliance Inventory (WAI) developed by Horvath and Greenberg (1989). Bahrick (1990) made only minor changes to the WAI instrument by changing the terms "therapist" and "client" to "supervisor" and "supervisee". Additionally, the phrase, "client problems", was modified to "supervisee issues" and "supervisee concerns".

The Supervisory Working Alliance – Trainee (SAWI-T) (Bahrick, 1990) consists of 36 item stems. The answers range from 1-7, with "never" corresponding with 1, "rarely" corresponding with 2, "occasionally" corresponding with 3, "sometimes" corresponding with 4, "often" corresponding with 5, "very often" corresponding with 6, and "always" corresponding with 7. The SWAI-T includes three subscales: Goal, Task, Bond. Each subscale, containing 12 questions, has positively and negatively scored items. For example, questions 2, 4, 13, 16, 18, 24, and 35 are positively scored and correspond with the Task subscale, while questions 7, 11, 15, 31, and 33 are negatively scored on the same subscale. The Bond subscale includes nine positively scored questions (5, 8, 17, 19, 21, 23, 26, 28, and 36) and three negatively scored questions (1, 20, and 29). Finally, the Goal subscale contains six positively scored questions (6, 14, 22, 25, 30, and 32) and six

negatively scored questions (3, 9, 10, 12, 27, and 34). The scores for each subscale are calculated by obtaining the mean score for all 12 items on a subscale. Higher mean scores indicate a higher level of agreement between the counselor and supervisor on the goals and tasks of supervision and stronger emotional connection, or bond, between the counselor and supervisor.

The validity of the SWAI-T is supported by its negative relationship with supervisee role conflict and role ambiguity (Ladany & Friedlander, 1995), positive relationship with supervisory racial identity interactions (Ladany, Brittan-Powell, & Pannu, 1997) and with supervisee satisfaction (Ladany, Ellis, & Friedlander, 1999). Additionally, Ladany, Lehrman-Waterman, Molinaro, and Wolgast (1999) report inverse relationship of SWAI-T with perceived unethical behaviors of supervisors. Reliability and internal consistency estimates have exceeded alpha = .91 for all the subscales (Ladany et al., 1997; Ladany & Friedlander, 1995).

Client Perception of Improvement Survey

According to Shueman, Troy, and Mayhugh (1994), changes in a patient's rating of the severity of symptoms has been shown to be an effective outcome measure. In medical settings, doctors often rely on patients' self-report in order to determine whether the patients are getting better. A counseling client's perception of the progress in dealing with a presenting problem and developing coping strategies is as valuable as the judgment of the patient about the improvement of a medical problem. Buetler (1981) highlighted two main types of client self-measurement of treatment gains: improvement rating and measurement of change.

Improvement rating is defined as an evaluation of the amount of progress based on the clients' perception. The rating is usually measured on a scale from no improvement to very significant improvement. Furthermore, these types of self-measures are designed to determine clients' perception of progress due to therapy (Buetler, 1981).

In contrast, measurement of change is assessed by subtracting the initial evaluation of presenting problem from the post-treatment ratings. Unfortunately, these measures are often susceptible to confounding variables. According to Green, Gleser, Stone, and Siefert (1975), change is always greater among clients who present with more severe disturbances. Subsequently, clients who have little initial psychological disturbance will show less progress based on the measurement of change assessments, and yet they still have a good chance of reporting perceived progress when using improvement rating instruments.

Based on the above-mentioned types of self-measures, the researcher used an improvement rating measure in order to capture the progress that clients' perceive that they made from the beginning of counseling. Improvement rating measures are able to minimize confounding variables and provide information about the progress from clients experiencing various levels of psychological disturbance. Contrary to the change assessment, improvement ratings are able to provide the researcher with information from clients who have improved significantly from those who have had minor improvements.

The researcher developed a Client Perception of Improvement Survey (CPIS; Appendix I) based on the subscales of the well-known and widely used Quality of Life Index (QLI) (Ferrans & Powers, 1985). The QLI consists of four main subscales: health and functioning subscale, social and economic subscale, psychological/spiritual subscale,

and family subscale. Additionally the QLI has a total score that is calculated from all the items and represents the total quality of life.

Reliability of the QLI was determined by calculating Cronbach's alpha (Cronbach, 1951). According to Ferrans and Powers (1985), internal consistency reliability for the QLI (total score) was supported by Cronbach's alpha of .93. Additionally, temporal reliability was supported by test-retest intercorrelations with a two-week interval for all five scores: overall quality of life (r = .79), social and economic (r =.68), family (r = .69), health and functioning (r = .72), and psychological/spiritual (r = .76) (Dougherty, Dewhurst, Nichol, & Spertus, 1998).

Convergent validity of the QLI was determined by calculating correlations between the total QLI score and Campbell, Converse, and Rodgers (1976) measure of life satisfaction. Several studies yielded statistically significant strong correlations (r = .61, .65, .75, .77, .80, .83, .93) (Bliley & Ferrans, 1993; Ferrans & Powers, 1985; Ferrans & Powers, 1992; Anderson & Ferrans, 1997; Ferrans, 1990).

The QLI is commonly used in multiple settings to assess overall quality of life in terms of life satisfaction. Even though the QLI is considered a highly valid and reliable instrument, it is not able to address the research question of this study. The current study investigated the relationship between the therapist's perception of supervisory working alliance and the client's perception of improvement after attending therapy. While the QLI is able to measure quality of life based on satisfaction with life, the instrument questions do not specifically target the changes that occurred in the client's life due to specific interventions such as counseling.

Following the QLI format, the researcher developed CPIS survey questions that correspond with the QLI subscales. For example, the CPIS question “my original symptoms that led me to go to counseling (e.g. sadness, feeling overwhelmed, stressed, inability to sleep, relationship issues etc.) have improved” corresponds with psychological/spiritual and health and functioning subscales. Furthermore, the question “my relationships with significant people in my life (e.g. parents, partner/spouse, children, and friends) have improved” matches QLI family subscale. The social and economic QLI subscale aligns with the “my performance at work/school has improved” question from the CPIS. And, the CPIS question “my ability to make my own decisions in life based on what I want has improved” matches the health and functioning QLI subscale. The researcher also added an overall quality of life improvement question to the CPIS in order to be able to collect information from the participant that will correspond with the QLI overall quality of life score, which is calculated by adding the scores from all of the survey items.

Similarly to QLI, CPIS consists of four main subscales: health and functioning subscale, social and economic subscale, psychological/spiritual subscale, and family subscale. First 20 questions of CPIS survey correspond with four subscales. Health and functioning subscale includes questions 1 through 6, 12 and 13. Social and economic subscale consists of questions 9, 11, 14, 15. Psychological/spiritual subscale contains 16 through 20. Family subscale is reprensented by questions 7, 8 and 10. Question number 21 is an overall quality of life improvement question which corresponds with the QLI overall quality of life score. Additionally CPIS has a total score that is calculated from all the items and represents the total quality of life. Answers are measured on a 6-point

Likert scale. Answers range from “not at all”, “very little”, “some”, “moderately”, “significantly” to "completely" and correspond with the numbers 1, 2, 3, 4, 5 and 6 respectively.

Limitations of Survey Research

Due to conducting survey research, several limitations were considered. Response bias and social desirability are common due to using self-report measures. In order to control for this limitation the researcher conducted the survey online and ensured anonymity by asking the participants to create their unique code before they started responding to their surveys.

Additionally, the researcher considered the instrumentation threat. In order to minimize this threat, the researcher was using the SAWI-T (Bahrick, 1990), a highly valid and reliable instrument. Moreover, the Client Perception of Improvement Survey (CPIS) that will be used in the study to collect data from the client participants was developed based on the scales of a highly valid and reliable instrument, the QLI (Ferrans & Powers, 1985). To ensure that the CPIS effectively measured the constructs that were created based on the QLI subscales, the researcher asked three doctoral level licensed professional counselors to serve as experts and provide the researcher feedback about the survey questions.

The researcher considered limitations to generalizability of the results of this study. In order to be able to minimize this threat, the researcher used a sample of counselor-client pairs from several states that have licensed professional counselors who provide counseling to their clients while under supervision. The sample was drawn from

the licensed professional counselors who vary by their race, gender, age, education, and years of experience.

Because an experimental design was not used in this study, causal inferences are limited. Due to employing correlational analysis in this study, we can only report the size and direction of the relationship between variables and cannot make an inference about causal relationship. When interpreting the results of this study we need to be clear that correlations between the variables do not indicate that one variable is the result of occurrence of the other variable, but rather the increase or decrease of the value of one variable, increases or decreases the value of another variable.

Data Analysis

Upon completion of data collection, the minimum requirement of having 107 pairs was not met. After exhaustive data collection attempts only 16 counselor-client pairs were available for data analysis. Due to the small sample size the researcher was not able to conduct the planned multiple regression analysis between supervisory working alliance variables of bond, task and goals and treatment outcomes, as measured by clients' perception of improvement of symptoms, relationships with significant people, ability to make decisions, school/work performance, and overall quality of life. Taking into consideration small sample size and after consultation with the dissertation committee, the researcher had to change data analysis to bivariate correlation procedure. Pearson's product-moment correlation was conducted between Task, Bond and Goal variables of SWAI-T (Bahrick, 1990) and Health and Functioning, Social and Economic, Psychological/Spiritual, Family and Total Quality of Life variables of CPIS. Bivariate

correlation analysis was chosen because it allowed to research relationships between quantitative variables and was appropriate for smaller sample sizes.

Summary

This chapter outlines the methodological framework that will be used in this study. The described methodology is created in order to analyze relationships between three variables of the supervisory working alliance: goal, task, and bond and five variables of client perceptions of improvement of symptoms, relationships with significant people, ability to make decisions, school/work performance, and overall quality of life. The various sections of this chapter offer a detailed description of the research design, data collection procedures, instrumentation, participants, threats to validity and data analysis that will be used in this study.

CHAPTER 4: RESULTS

The purpose of this study was to investigate whether a relationship exists between supervisory working alliance and clients' outcomes. This chapter consists of five sections: (a) descriptive statistics of the sample; (b) instrumentation; (c) data management; (d) data analysis; and (e) summary.

Participants

Participant recruitment pool consisted of 10,970 e-mail addresses. The total number included three different groups. The first group was comprised of 5,290 e-mail addresses of the counselors who were working under supervision towards their full license from three different states. Additionally counselor supervisor lists from two different states consisting of 2,830 e-mails represented the second group in the total pool. Finally, the list of 2,850 subscribers to Counselor Education and Supervision Network (CESNET) was included as the third group of potential participants.

After sending the initial study participation e-mail, 339 e-mails were removed from the original pool of 10,970 due to being undeliverable, leaving 10,631 e-mail addresses. Furthermore, the researcher received and recorded 533 responses from potential participants who responded to the recruitment e-mail stating that they would not participate in the study. The majority of those respondents were counselors who stated that they worked exclusively with children. Others reported their inability to participate in the study due to not meeting the inclusion criteria of providing a minimum of six counseling sessions to their clients due to the specific setting of their of jobs. A small

portion of this group provided alternative responses, which included reluctance to participate due to a perceived lack of trust in confidentiality of the study,, the belief that asking their clients to participate in this study could potentially damage their relationship with their clients, and unwillingness to participate in the study due to negative attitudes towards mandatory supervision. After removing 533 responses from the potential participant, list the final count was 10,098 e-mails.

Upon completion of the data collection period, the researcher received a total of 51 counselor responses and 16 client responses. Out of the 51 counselor responses, 10 counselors did not agree to the informed consent and were removed from the final number of participants, leaving 41 counselors who agreed to participate in the study. Out of 41 remaining counselors, six responded that they had chosen a client participant who was under 18 years old. The inclusion criteria for the study specified that the counselor needed to have at least one client who was at least 18-years old, therefore the responses of those six counselors were also removed from the number of participants, leaving the total number of counselor participants at 36. While the remaining counselors met the criteria for the study, based on the inclusion criteria, only counselor-client pairs were used for the data analysis, totaling 16 pairs. Taking into consideration the small sample size, and after consultation with the dissertation committee, the researcher changed the data analysis to bivariate correlation procedure.

Demographic data was collected from the participants. Counselors responded to the questions about their gender, race or ethnicity, age, education level, length of receiving supervision, theoretical orientation, counselor's credentials, credentials of the supervisor, area of study, work setting, and symptom severity of the chosen client.

Clients answered questions about their age, gender, race or ethnicity, and educational level. This demographic information about counselors and their clients provided the descriptive information about the sample of this study.

Counselor Sample

The counselor sample consisted of six males (37.5%) and 10 females (62.5%). The range of counselor age fell between 20 and 60 years old. Six (37.5%) counselors reported their age in the range of 20 to 30 years old, six counselors (37.5 %) described their age in 41 to 50 year old range, and three counselors (18.7%) checked the 51 to 60 year old range. Only one counselor in the sample (6.3%) reported the age within 31 to 40 years old range. The sample of counselors was divided into two racial categories. Nine counselors (56.3%) reported their race as White and seven counselors (43.8%) reported their race as Black or African American.

The majority of the sample, 15 counselors (93.8%) had a Master's degree and one counselor (6.3%) had a Doctoral degree. Additionally, counselors were asked to report areas of study of their completed degrees. Areas of study reported by the counselors is presented in Table 1. Twelve counselors (75%) stated having a Mental Health Counseling background. Other areas of study included Marriage and Family Therapy (n=1, 6.3%), School Counseling (n=1, 6.3%), and Pastoral Counseling (n=1, 6.3%). One counselor (6.3%) chose Other category and specified the area of study as Professional Counseling.

Table 1: Area of Study Reported by the Counselors

Area of Study	N	%
Mental Health Counselling	12	75.0
Marriage and Family Therapy	1	6.3
School Counseling	1	6.3
Pastoral Counseling	1	6.3
Other (Professional Counseling)	1	6.3
Total	16	100.0

Based on the inclusion criteria of the study all of the counselors received clinical supervision. One of the responses was noted as an outlier due to exceeding licensing board guidelines for the length of the time that a counselor receives supervision before becoming fully licensed. The outlier response of 149 months was replaced with an average value of the length of supervision reported by the sample and equaled 21 months. The length of clinical supervision received by the counselors is listed in Table 2. The length of supervision ranged between nine month and 58 months, with a mean of 21.1 (SD=12.6). The median length of receiving supervision for this sample was 17 months, with a mode of 14 months. Four out of 16 counselors (25%) reported that they had received supervision for 14 months. Two counselors (12.5%) had been in supervision for 24 months. Other lengths of supervision included nine months (n=1, 6.3%), 11 months (n=1, 6.3%), 12 months (n=1, 6.3%), 16 months (n=1, 6.3%), 18 months (n=1, 6.3%), 21 months (n=1, 6.3%), 22 months (n=1, 6.3%), 26 months (n=1, 6.3%), 41 months (n=1, 6.3%), and 58 months (n=1, 6.3%).

Table 2: Length of Supervision Received by the Counselors

Length of Supervision	N	%
9 months	1	6.3
11 months	1	6.3
12 months	1	6.3
14 months	4	25.0
16 months	1	6.3
18 months	1	6.3
21 months	1	6.3
22 months	1	6.3
24 months	2	12.5
26 months	1	6.3
41 months	1	6.3
58 months	1	6.3
Total	16	100.0

The counselors were asked to describe their theoretical orientation, choosing from the following options: Person-Centered, Gestalt or Experiential, Cognitive or Cognitive-Behavioral, Adlerian, Reality, Solution-Focused, and Psychodynamic. The counselors also had an option to fill in their orientation in the blank space if they did not see the choice that they wanted to use. Of the counselor participants, 62.5 % (n=10) reported using Cognitive or Cognitive-Behavioral theoretical orientation, 18.8% (n=3) chose Person-Centered orientation, 12.5 % (n=2) described themselves as Solution-Focused therapists, and 6.3% (n=1) reported using Psychodynamic theoretical orientation.

Table 3: Theoretical Orientation of the Counselor

Theoretical Orientation	N	%
Person-Centered	3	18.7
Cognitive/ Cognitive-Behavioral	10	62.5
Solution-Focused	2	12.5
Psychodynamic	1	6.3
Total	16	100.0

In response to the question about their supervisors' certification, counselors chose from Licensed Professional Counselor Supervisor (LPCS), Licensed Marriage and Family Therapy Supervisor (LMFTS), Licensed Clinical Social Worker Supervisor (LCSWS), and Other if their supervisor has another certification that is not listed. Fifteen counselors (93.8%) reported having a supervisor with a counseling background. One participant (9.3%) chose LCSWS as the certification of the supervisor.

Counselor work setting was divided into eight categories: In-Home Outpatient Therapy, Private Practice Office, In-Home Community Support Team, Doctor's Office, Hospital Setting, Substance Abuse Intensive Outpatient Program, School, and "Other". Work settings of the participants is reported in Table 4. Five counselors (31.3%) described their work setting as Private Practice Office. Four participants (25%) shared that they do In-Home Outpatient Therapy. One counselor (6.3%) reported working in the hospital setting. The rest of the counselor sample (n=6, 37.5%) chose to clarify their work setting by selecting the "Other" category and filling in the blank. Among "Other" responses were nonprofit private group practice (n=1); combination of Intensive-in-Home, school and Outpatient Therapy in office (n=1); University (n=1); Outpatient Community Mental Health Facility (n=2); and College Counseling Center (n=1).

Table 4: Work Setting of the Counselor

Work Setting	N	%
In-Home Outpatient Therapy	4	25.0
Private Practice Office	5	31.3
Other	6	37.5
Hospital Setting	1	6.3
Total	16	100.0

Finally, the counselors were asked to report severity of symptoms of the participating clients in the study. Symptoms severity is reported in Table 5. Nine counselors (56.3%) reported that their clients' mental health symptoms fall within the moderate range. Five participants (31.3%) described their clients' symptoms as mild, and two counselors (12.5%) reported their clients' to have severe symptoms.

Table 5: Symptom Severity of the Clients

Severity of the Symptoms	N	%
Mild	5	31.3
Moderate	9	56.3
Severe	2	12.5
Total	16	100.0

Client Sample

The client sample consisted of four males (25%) and 12 females (75%). Their age range is presented in Table 6. Seven participants (43.8%) reported their age falling between 20 and 30 years old. Four (25%) clients chose the 41 to 50 year age range. Two people (12.5%) described their age between 31 and 40 years old and two others (12.5%) selected the 51 to 60 year age category. One participant (6.3%) responded as being in the 61 to 70 year age category. The client sample represented only two racial or ethnic categories: White and Black or African American. The sample contained an equal number of White clients (n=8, 50%) and Black or African American clients (n=8, 50%).

Table 6: Clients' Age

Age Range	N	%
20-30	7	43.7
31-40	2	12.5
41-50	4	25.0
51-60	2	12.5
61-70	1	6.3
Total	16	100.0

Clients' educational levels are presented in Table 7. The majority of participants reported either having or pursuing higher education at that time or stated that they had attended some college in the past. Two clients (12.5%) reported completing grammar school. Four participants (25%) described their educational level as High School or equivalent. Two client participants chose the "Other" category, with one specifying (6.3%) currently pursuing a Bachelor's degree and another (6.3%) having an Associate's Degree in Medical Science. Four clients (25%) shared that they had a Bachelor's degree. Three participants (18.8%) reported attending some college, and one client (6.3%) reported having a Master's degree.

Table 7: Clients' Educational Level

Educational Level	N	%
Grammar School	2	12.5
Bachelor's Degree	4	25.0
Other	2	12.5
High School or Equivalent	4	25.0
Some College	3	18.7
Master's Degree	1	6.3
Total	16	100.0

Instrumentation

For the study, counselors and clients completed their respective online surveys. The counselors who agreed to participate in the study recruited client participants. In order for the counselor to "randomly" select a client, the counselor asked the next client that came in for counseling and who had received a minimum of six therapy sessions to participate in the study. The counselor did that successively until a client agreed to participate. The researcher was only able to use data from the counselor-client pair if both the counselor and his or her identified client completed the questionnaires.

Before conducting data analysis, the researcher transformed raw scores received from the participants and created new variables. Counselor responses to SWAI instrument were scored and combined into three subscales. The researcher had to use reverse scoring for items 1, 3, 7, 9, 10, 11, 12, 15, 20, 27, 29, 31, 33 and 34. Furthermore, variables Task, Bond, Goal were created by obtaining the mean score for all 12 items on a corresponding subscale.

Client responses to the CPIS survey were transformed into five variables matching the subscales. Mean scores were calculated for each of the four variables, Health and Functioning, Social and Economic, Psychological/Spiritual and Family. The final variable, Total Quality of Life, was obtained using the sum of the mean scores to create a total mean score for the client.

Supervisory Working Alliance Inventory Trainee Form

The Supervisory Working Alliance – Trainee (SAWI-T) (Bahrick, 1990) consists of 36 item stems. The answers range from 1-7, with "never" corresponding with 1, "rarely" corresponding with 2, "occasionally" corresponding with 3, "sometimes"

corresponding with 4, “often” corresponding with 5, “very often” corresponding with 6, and “always” corresponding with 7. The SWAI-T includes three subscales: Goal, Task, Bond. Each subscale, containing 12 questions, has positively and negatively scored items. For example, questions 2, 4, 13, 16, 18, 24, and 35 are positively scored and correspond with the Task subscale, while questions 7, 11, 15, 31, and 33 are negatively scored on the same subscale. The Bond subscale includes nine positively scored questions (5, 8, 17, 19, 21, 23, 26, 28, and 36) and three negatively scored questions (1, 20, and 29). Finally, the Goal subscale contains six positively scored questions (6, 14, 22, 25, 30, and 32) and six negatively scored questions (3, 9, 10, 12, 27, and 34). The scores for each subscale are calculated by obtaining the mean score for all 12 items on a subscale. Higher mean scores indicate a higher level of agreement between the counselor and supervisor on the goals and tasks of supervision and stronger emotional connection, or bond, between the counselor and supervisor.

The mean scores and standard deviations for Task, Bond, and Goal subscales of the SWAI are presented in Table 8. Counselor participant scores for the Task subscale ranged between 4 and 5.92, with a mean score of 5.17 (*SD*=.68). Responses for the Bond subscale fell between 4.08 to 6.92 with a mean of 5.93 (*SD*=0.89). The scores for the Goal subscale ranged from 3.5 to 7, with a mean of 5.65 (*SD*=1.05).

Table 8: SWAI Subscale Means, Standard Deviations

SWAI Subscales	M	SD
Task	5.17	.68
Bond	5.93	.89
Goal	5.65	1.05

Client Perception of Improvement Survey

The researcher developed a Client Perception of Improvement Survey (CPIS; Appendix I) based on the subscales of the well-known and widely used Quality of Life Index (QLI) (Ferrans & Powers, 1985). Even though the QLI is considered a highly valid and reliable instrument, it was not able to address the research question of this study. The current study investigated the relationship between the counselor's perception of supervisory working alliance and the client's perception of improvement after attending therapy. While the QLI measures quality of life based on satisfaction with life, the instrument questions do not specifically target changes that occurred in the client's life due to specific interventions such as counseling, therefore the need for development of the CPIS arose.

Similarly to QLI, CPIS consists of four main subscales: health and functioning subscale, social and economic subscale, psychological/spiritual subscale, and family subscale. First 20 questions of CPIS survey correspond with four subscales. Health and functioning subscale includes questions 1 through 6, 12 and 13. Social and economic subscale consists of questions 9, 11, 14, 15. Psychological/spiritual subscale contains 16 through 20. Family subscale is reprensented by questions 7, 8 and 10. Question number 21 is an overall quality of life improvement question which corresponds with the QLI overall quality of life score. Additionally CPIS has a total score that is calculated from all the items and represents the total quality of life. Answers are measured on a 6-point Likert scale. Answers range from "not at all", "very little", "some", "moderately", "significantly" to "completely" and correspond with the numbers 1, 2, 3, 4, 5 and 6 respectively.

The mean scores and standard deviations for the CPIS subscales are presented in Table 9. Participant scores for the Health and Functioning subscale ranged between 2.13 and 4.88, with a subscale mean of 3.72 (*SD*=.90). Responses for the Social and Economic subscale fell between 1.5 to 4.75, with a mean of 3.44 (*SD*=1.03). The scores for Psych subscale fluctuated from 2.4 to 4.8, with a mean of 4.19 (*SD*=.88). The Family subscale included scores between 2.33 and 5.67, with a mean of 3.83 (*SD*=.94). Finally, the Total Quality of Life subscale consisted of the scores ranged from 2.14 to 4.9, with a mean of 3.82 (*SD*=.82).

Table 9: CPIS Subscale Means, Standard Deviations

CPIS Scale	M	SD
Health	3.72	.90
SES	3.44	1.03
Psych	4.19	.88
Family	3.83	.94
Total	3.82	.82

Data Analysis

Before conducting bivariate correlation analysis, the data was screened for normality, missing values, and outliers. The researcher used SPSS in order to screen the data and to produce output containing histograms, scatter diagrams and indices of skewness and kurtosis. Upon review of the SPSS output, the researcher determined that the current data did not have outliers and met the criteria for normality.

Correlation analysis with one-tailed test of significance was conducted in order to determine the relationship between Task, Bond and Goal variables and Health and Functioning, Social and Economic, Psychological/Spiritual, Family and Total Quality of Life variables. Pearson's product-moment coefficient was computed to determine the

direction and the strength of the relationships between variables. The choice of one-tailed test of significance was determined by hypothesized positive relationships between the variables. The correlation matrix is presented in Table 10.

The results have to be interpreted with caution due to lack of representativeness of the small sample of this study. Furthermore, the results cannot be generalized to either counselor or client populations due to potential instability of correlations. According to the results of the Pearson's correlations conducted between variables, significant moderate positive relationships were found between Task and Family (r=.635, p<.01), Bond and Health and Functioning (r=.436, p<.05), Bond and Family (r=.624, p<.01), Goal and Health and Functioning (r=.427, p<.05) and Goal and Family (r=.559, p<.05). The strength and the direction of these relationships indicate that higher scores on the Task, Bond and Goal subscales of the SWAI correspond with higher scores on the Family subscale of the CPIS. Furthermore, higher scores on the Bond and Goal subscales parallel higher scores on the Health and Functioning subscale. In other words, the results suggest that those counselors who have reported stronger relationships with their supervisors and better agreement on the goals and tasks of supervision had clients who self-reported improvement in their family life. Additionally, stronger supervisory relationship and agreement on goals of supervision reported by therapists is related to clients' self-reports of improvements in their health and functioning.

No significant correlations were found between Task variable and Health and Functioning, Social and Economic, Psychological/Spiritual, and Total Quality of Life variables. Furthermore, no significant correlations were found between Bond variable and Social and Economic, Psychological/Spiritual, and Total Quality of Life variables.

Moreover, there were not significant correlations between Goal variable and Social and Economic, Psychological/Spiritual, and Total Quality of Life variables.

Table 10: Correlation Matrix for Variables

	Health	SES	Psych	Family	Total
Task	.373	.054	.172	**.635****	.336
Bond	**.436***	.186	.252	**.624****	.418
Goal	**.427***	.113	.241	**.559***	.380

** Correlation is significant at the 0.01 level (1-tailed).
* Correlation is significant at the 0.05 level (1-tailed).

Client perception of Improvement Survey was developed by the author and was used in this study for the first time; therefore it was important to look at relationships between highly valid and reliable SWAI subscales and newly developed survey questions. In order to further investigate relationships between supervisory working alliance constructs and clients' perception of improvement, Pearson's correlation coefficients between Task, Bond and Goal and individual questions of CPIS survey were computed. The correlation matrix is presented in Table 11. The strength of the relationship between counselors and their supervisors had moderate positive correlations with the clients' perceptions of improvement of control over their lives (r=.551, p<.05), overall family happiness (r=.672, p<.01), the emotional support from their families (r=.439, p<.05), how much they worry (r=.524, p<.05), peace of mind (r=.481, p<.05), and overall quality of life (r=.434, p<.05). Moreover, therapists' and supervisors' agreement on tasks of supervision showed moderate positive relationships with clients' self-reported improvement of control over their lives (r=.451, p<.05), overall family

happiness (r=.569, p<.05), and improved relationship with their spouse, lover, or partner (r=.591, p<.01). Furthermore, the agreement on the goals of supervision between counselors and their supervisors had moderate positive relationship with clients' perception of improvement of control over their lives (r=.544, p<.05), and their overall family happiness (r=.603, p<.01).

Table 11: Correlation Matrix for Task, Bond and Goal and Individual Questions of CPIS Survey

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Task	.130	.282	.222	**.451***	.282	.258	**.569***	**591****	-.050	.317	-.016	.155	.408	.261	-.046	.300	.124	.354	.022	-.043	.348
Bond	.291	.415	.165	**.551***	.301	.205	**672****	.387	.062	**.439***	.139	.145	**.524***	.419	-.060	**.481***	.309	.366	.006	-.061	**.434***
Goal	.242	.373	.341	**.543***	.296	.159	**604****	.363	.038	.371	.057	.156	.408	.348	-.107	.421	.194	.404	-.002	.014	.379

** Correlation is significant at the 0.01 level (1-tailed).

* Correlation is significant at the 0.05 level (1-tailed).

Individual Questions of CPIS Survey corresponding with the table heading

1. My overall health has improved
2. My level of energy has improved
3. My ability to take care of myself without help has improved
4. My control over my life has improved
5. My chances for living as long as I would like to have improved
6. My sex life has improved
7. My overall family happiness has improved
8. My relationship with my spouse, lover, or partner has improved
9. My ability to make friends has improved
10. The emotional support from my family has improved
11. Emotional support from people other than your family has improved
12. My ability to take care of family responsibilities has improved
13. How much I worry has improved
14. My performance at my school/work has improved
15. My ability to take care of my financial needs has improved
16. My peace of mind has improved
17. My ability to achieve personal goals has improved
18. My happiness in general has improved
19. My life satisfaction in general has improved
20. My personal appearance has improved
21. My overall quality of life has improved

Summary

This chapter provided a description of the counselor and client samples, instrument results and data analysis. Statistical analysis procedures were discussed and conclusions were drawn. The sample of the study contained counselors and their clients.

The majority of the counselors were females (62.5%). There were more White (56.3%) than Black or African American (43.8%) counselors in the sample. Predominant reported age fell into two ranges: 20-30 years old (37.5 %) and 41-50 years old (37.5 %). The majority of the counselors reported having Master's degrees (93.8%), and Mental Health Counseling backgrounds (75%) dominated reported areas of study. The average reported length of supervision received was 21.1 months, and majority of the sample (93.8%) reported having supervisors with counseling backgrounds. Sixty two and a half percent of the counselor sample described having a Cognitive or Cognitive-Behavioral theoretical orientation. The most commonly mentioned work setting was a Private Practice office (43.8%). Finally, the majority of the sample (56.3%) reported that their clients' mental health symptoms fell within a moderate range of severity.

The client sample predominantly consisted of females (75%). The most common age range in the sample was between 20 and 30 years old (43.8%). Racial representation of the sample was equally split between White and Black or African American. The majority of participants reported either having or pursuing higher education (56.5%).

Several significant relationships were found between the variables. Moderate correlations were established between strength of counselors' supervisory relationship and clients' improvement of health and functioning, and family relationships. Furthermore, a moderate positive relationship was discovered between counselors'

agreement on the goals of supervision and clients' improvement of health and functioning, and family relationships. Additionally, there was a significant positive relationship found between counselors' agreement on tasks of supervision and clients' perceptions of improvement on family subscale.

After further detailed investigations of correlations between Task, Bond and Goal and individual questions from the CPIS survey, it was established that strength of counselors' supervisory relationship had the most significant correlation with clients' perception of improvement. Stronger supervisory relationships between counselors and supervisors yielded more improvement in clients' control over their lives, overall family happiness, the emotional support from their families, how much they worry, peace of mind, and overall quality of life. Moreover, the agreement on the goals and tasks of supervision between counselors and their supervisors had moderate positive relationships with clients' perception of improvement of control over their lives, and their overall family happiness. Additionally, significant correlation was discovered between counselors' reports of agreement on tasks of supervision and clients' reported improvement in relationships with their spouse, lover, or partner.

No significant correlations were found between Task, Bond and Goal variables with Social and Economic, Psychological/Spiritual, and Total Quality of Life variables. Furthermore, there were no sagnificant correlations between Task and Health and Functioning variables. Moreover, no significant correlations were discovered between Task, Bond and Goal variables and majority of the individual questions of CPIS survey as listed in the Table 11.

CHAPTER 5: DISCUSSION

The purpose of this study was to investigate whether a relationship between supervisory working alliance and clients' outcomes exist. This study attempted to fill the gap in the supervision literature that examines counselor supervision and its effect on client outcomes. The literature review process has revealed previously established evidence of the importance of the supervisory working alliance for counselor training and development (Bordin, 1983). Additionally, the researcher found significant support for the need to investigate the connection between counselor supervision and client outcomes (Ellis & Ladany, 1997; Freitas, 2002; Inman & Ladany, 2008; Watkins, 2011). Furthermore, the researcher discovered that there was a gap in the literature examining the relationship between supervisory working alliance and client outcomes. The current chapter - consists of the following parts: overview of the study, discussion of the study results, limitations, implications for the future research, and conclusion.

Overview

This study investigated the relationship between supervisory working alliance and clients' outcomes. The purpose of the study was to establish the existence of that relationship. The research question of the study was: Is there is a relationship between supervisory working alliance, as measured by the constructs of bond, task and goals on the Supervisory Working Alliance Inventory Trainee Form (SAWI-T) and treatment outcomes, as measured by clients' perception of improvement of symptoms, relationships

with significant people, ability to make decisions, school/work performance, and overall quality of life?

The importance of this study was supported by the limited research on supervision and client outcomes that was available at the time of the study (Ellis & Ladany, 1997; Freitas, 2002; Goodyear & Bernard, 1998; Inman & Ladany, 2008) Additionally, there was limited research in the supervision literature on the topic of the relationship between therapeutic working alliance and supervisory working alliance (Patton & Kivligan, 1997) and no research thus far that explored the relationship between supervisory working alliance and client outcomes provided solid support for the need of the current study. Taking into consideration available research that provided evidence of the connection between therapeutic and supervisory working alliances, the researcher made the inference that supervisory working alliance had a relationship with therapeutic working alliance and, therefore, had a relationship with client outcomes.

The researcher recruited participants from three different sources: (a) e-mail lists of counselors who were working under supervision towards their full license from three different states whose licensing boards agreed to provide the researcher with contact information, (b) counselor supervisor lists received from the licensing boards from two of the states, and (c) the list of subscribers to Counselor Education and Supervision Network (CESNET). The study had specific inclusion criteria which consisted of education and license status of the counselor and standards for supervision requirements. Another important inclusion criterion specified that counselors had to have at least one adult client who had received a minimum of six therapy sessions and who agreed to participate in the

study. All of the inclusion criteria determined the final count of the participants, which consisted of 16 counselor-client pairs.

Participants were asked to complete their respective surveys, which consisted of demographic questionnaires for both counselors and their clients, Supervisory Working Alliance Inventory Trainee Form (SAWI-T; Bahrick, 1990; Appendix H) for counselors, and Client Perception of Improvement Survey (CPIS; Appendix I) for clients. Due to the small sample size the researcher had to adjust data analysis from the originally planned multiple regression to bivariate correlation analysis with one-tailed test of significance in order to determine the relationship between the independent variables (Task, Bond and Goal) and dependent variables (Health and Functioning, Social and Economic, Psychological/Spiritual, Family and Total Quality of Life). Several significant relationships were found between the independent and dependent variables, however due to the small sample size the results must be interpreted with caution.

Discussion of the Results

The results of this study provide the first attempt to inform the field of supervision by suggesting the potential existence of the relationship between supervisory working alliance based on counselors' responses and client outcomes measured by self-reported clients' perceptions of improvement after receiving a minimum of eight counseling sessions. The results have to be interpreted with caution due to lack of representativeness of the sample and the small sample of this study. This section includes discussion of demographic characteristics of the sample, results received from the administration of the SWAI-T (Bahrick, 1990) to the counselors, and clients' perception of improvement based

on the results of CPIS. The discussion about correlations between variables will complete this section.

Demographics

While discussing demographic data it is important to mention the lack of representativeness and the small sample size and highlight that these results have limited generalization to counselor and client populations outside of this study. Demographic data suggested diversity of the counselor sample which was represented by both male (37.5%) and female (62.5%) counselors. Racial composition of the sample was almost equally split between African-American (43.8%) and Caucasian (56.3%) counselors, however, the sample lacked representations of other races and ethnicities. There were two predominant age groups: 20-30 years old (37.5 %) and 41-50 years old (37.5 %). The age of the younger group may suggest that these counselors were traditional students and received their master's degree right after or not too long after their bachelor's degree. The age of the older group may suggest that participants were non-traditional students and might have chosen counseling as a second career.

The majority (93.8%) of counselors in the sample had a Master's degree in Mental Health Counseling and received between 9 and 58 months of supervision from a supervisor with counseling background. These demographic statistics were expected by the researcher and are in line with licensure rules in the states where the sample was drawn from. Additionally, participants on average had over a year of post-master's experience, which according to Stoltenberg, McNeill, and Delworth (1998) suggests that they may fit the category of Level Three counselors. At this point of professional identity development, counselors usually are able to work more independently with clients and

are more likely to accept constructive criticism from their supervisors. Furthermore, Level Three counselors tend to respond more favorably to confrontation from a supervisor (Stoltenberg, McNeill, & Delworth, 1998). At this developmental stage, counselors are more self-aware and able to focus on self in their therapy sessions. These skills might have contributed to the counselors' desire to participate in this study as a way to continue professional development with the help of knowledge about their clients' perceptions of improvement.

The majority of the sample (62.5%) reported using a Cognitive or Cognitive-Behavioral theoretical orientation. These results are in line with the evidence-based practice standards for adult mental health and substance abuse treatments suggested by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). According to SAMHSA (2014), Cognitive-Behavior therapy is one of the suggested evidence-based treatment modalities currently used in illness management and recovery practices.

The most commonly mentioned counselor work setting (56.25 %) included different types of outpatient practice. These results are similar to information provided by Bureau of Labor Statistics (2013). Based on the occupational employment statistics from May 2013, outpatient care centers are considered to have the highest published employment for mental health counselors (Bureau of Labor Statistics, 2013).

Finally, the majority of the sample (56.3%) reported that their selected clients' mental health symptoms fell within a moderate range of severity. These results might be due to social desirability of the counselors (Fisher, 1993). Counselors might be more likely to ask clients with less severe symptoms to participate in the study due to an

expectation of more progress within eight sessions that were specified as inclusion criteria for the study.

The client sample included mostly females (75%) and was evenly split between two races: African-American (50 %) and Caucasian (50 %). The client sample had a wide diversity in age. Participants' age fell in every age category between 20 years old and 70 years old, with the most common age category being 20 to 30 years old (43.8%). Six out of sixteen participants (37.5%) reported either some higher education course work or completed degrees. These results are much higher than the national average. According to American Community Survey (ACS) results, the national average for education attainment among the population of 25 year olds and older is 17.9% for a Bachelor's degree (United States Census Bureau, 2010). This means that the current sample has more people with Bachelor's level education than the overall United States population. Additionally, two participants from the sample (12.5%) reported only completing grammar school. This statistic is higher than the national average of 6% of the people in United States who have less than 9th grade education.

Other educational categories represented in the client sample can be considered in line with the ACS national sample. Three out of sixteen participants (18.7%) reported that they had attended some college, while ACS results suggest a national average of 21.3 %. Furthermore, 25% of the client sample reported having a High School diploma or equivalent, which is close to the ACS national average of 28.2%. Moreover, one client (6.3%) obtained an Associate's Degree in Medical Science, matching the national average of 6%.

Results of Research Question

These results must be interpreted with caution due to small sample size which cannot assure stability of these correlations. Additionally, it is important to interpret results with caution due to the correlational nature of this research. More specifically, there were extraneous factors that might have contributed to the correlation between supervisory working alliance and clients' perception of improvement.

Based on the results of bivariate correlation analysis, significant relationships were found between the independent variables Task, Bond, Goal and the dependent variables Health and Functioning, Social and Economic, Psychological/Spiritual, Family and Total Quality of Life improvement. Moderate correlations were established between the strength of supervisory relationship between counselors and their supervisors, which was measured by Bond variable, and the clients' self-report of the improvement of health and functioning (r=.436, p<.05), and family relationships (r=.624, p<.01). Furthermore, a moderate positive relationship was discovered between counselors' agreement with their supervisors on the goals of supervision and clients' improvement of health and functioning (r=.427, p<.05), and family relationships (r=.559, p<.05). Additionally, there was a significant positive relationship found between counselors' agreement on tasks of supervision and clients' perceptions of improvement on family subscale (r=.635, p<.01). In other words, these findings suggest that stronger bonds with supervisors and better agreement on the goals of supervision correlated with clients who self-reported improvement in their family life and their health and functioning. Additionally, agreement on tasks of supervision reported by therapists is related to clients' self-reports of improvements in family functioning.

No significant correlations were found between Task variable and Health and Functioning, Social and Economic, Psychological/Spiritual, and Total Quality of Life variables. Furthermore, no significant correlations were found between Bond variable and Social and Economic, Psychological/Spiritual, and Total Quality of Life variables. Moreover, there were not significant correlations between Goal variable and Social and Economic, Psychological/Spiritual, and Total Quality of Life variables.

These results were expected by the researcher and supported the inference that the supervisory working alliance has a relationship with client outcomes. While no current literature directly supported these findings nor provided empirical evidence of the relationship between supervisory working alliance and client outcomes, there was significant support in the literature that provided evidence of the relationship between strength of therapeutic working alliance and successful client outcomes (Horvath & Bedi, 2002; Horvath, Del Re, Flukiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin et al., 2000). Moreover, Patton and Kivligan (1997) demonstrated the existence of the relationship between therapeutic working alliance and supervisory working alliance, suggesting that the supervisory working alliance can serve as a model for the therapist on how to build therapeutic working alliance. Furthermore, Gard and Lewis (2008) provided evidence that the relationship-building process can be modeled by the supervisor to the supervisee while developing supervisory working alliance in supervision.

Additionally, the existence of the relationship between supervisory working alliance and some of the self-reported client outcomes might also be supported by previous research studies related to the topic of supervision and client outcomes. For example, strong emotional reaction of a supervisee to a supervisor (Dodenhoff, 1981) and

supervisor empathy (Harkness, 1995) were determined to contribute to positive client outcomes. Even though these studies did not focus on supervisory working alliance, they can be considered parts of the supervisory relationship and have been established to contribute to improved client outcomes.

While further exploring the meaning of the results of correlations, it is important to highlight that the Family variable had the most correlations. The existence of those correlations could be potentially interpreted by the relational nature of both supervisory working alliance subscales of Task, Bond and Goal and the Family subscale of the CPIS. In other words, a stronger supervisory working alliance might create a stronger therapeutic alliance, and in turn model relationship-building skills for the client, who can practice those in personal relationships with significant people. Additionally, significant correlations between the Family variable and the Task, Bond and Goal variables may suggest that clients' self-reported improvements might first take place and be observed in their family environment.

Furthermore, correlations between the Health and Functioning variable and Bond variable might suggest that the counselor's ability to build relationships has a connection to clients' perceptions of improvement in their health and functioning. It is possible that clients feel empowered by attending therapy, therefore symptoms decrease due to active steps toward self-care. Moreover, considering that supervision is an opportunity for counselors to practice and learn how to build a therapeutic alliance through experiencing and building a supervisory working alliance and counselors ability to collaborate on goals of supervision might assist counselors and clients to increase the agreement on the goals of counseling. Agreement on goals of counseling is an indicator of the strength of bond,

and in turn can empower clients to feel more in control over their lives and potentially increase self-perception of improvement in health and functioning.

The lack of significance in other correlations may be related to the limited number of sessions received by the clients at the time of study. Based on the inclusion criteria, the client was supposed to have minimum of six therapy sessions with the counselor. It is possible that six counseling sessions were not enough for clients to observe improvements in other areas of their life as measured by Social and Economic, Psychological/Spiritual, and Total Quality of Life variables. Additonally, it is important to highlight that initial counseling sessions are usually spent on bulding therapeutic working relationships, and therefore might not be sufficient in assisting clients with making improvements in these other areas of their lives.

Contribution of the Study

At the time of the study, there was no empirical evidence supporting the relationship between supervisory working alliance and client outcomes. While results of this study must be interpreted with caution due to the small sample size and cannot be generalized to either counselor or client populations due to potential instability of discovered correlations, this study serves as a first attempt to establish the relationship between supervisory working alliance and client outcomes. This study could be considered as a pilot study for future research in the field of supervision and client outcomes. This study provides a literature review and summarizes the small number of studies that have focused on the connection between supervision of therapists and its effect on client outcomes. Finally, the results of this study provide the first attempt to

inform the field of supervision of the potential existence of the relationship between supervisory working alliance and client outcomes.

Limitations of the Study

The main limitation of this study is the small sample size. The current sample size prevented the researcher from conducting the originally planned multiple regression analysis. Inability to utilize multiple regression prevented the researcher from conducting a more complex examination of the relationships between independent and dependent variables and from making more generalizable inferences about the relationships between supervisory working alliance and client outcomes. Additionally, the small sample size limited the researcher from making inferences about counselor and client populations based on demographic characteristics of the sample of this study. Furthermore, data analysis procedures, which included multiple correlational analysis, had a potential to increase Type I error rate due to calculations of multiple correlation coefficients.

Feasibility of this study was a major contributing factor to the small sample size and can be considered another limitation of this study. More specifically, the recruitment procedures potentially contributed to the low response rate resulting in the small sample size of this study. The researcher utilized e-mail lists received from the licensing boards of several states in order to recruit counselors for this study. Even though the researcher followed Dillman, Smyth and Christian's (2009) Tailored Design Method for data collection and utilized reliable e-mail delivery service – Constant Contact that ensured e-mails were delivered directly to the inbox of the recipients and were marked as "safe" by most of the e-mail servers – the researcher had no control over how many e-mails were opened by the potential participants. Additionally, due to lack of access to the client

information, the researcher had to rely on counselors to recruit their own clients. This procedure may have contributed to the low response rate from the client population due to lack of follow up from the counselor. Furthermore, the inability of the researcher to control whether the counselors provided clients with instructions that outlined confidentiality of the study may have contributed to clients' unwillingness to participate. Finally, the researcher's inability to send a reminder to the clients to complete their survey might have contributed to the low response rate. All the above-mentioned factors might have compromised the feasibility of this study.

Another limitation of this study is the utilization of a questionnaire that did not have established psychometric properties. Due to the lack of existing instruments that could measure the dependent variables of the study, the researcher had to create a questionnaire in order to measure clients' self-reported perception of improvement. Lack of validity and reliability statistics of CPIS can potentially affect the results by creating a measurement error; therefore the results must be interpreted with caution.

The third limitation of this study is a non-response bias. Counselors and clients who did not choose to participate in this study could have been significantly different from those participants who agreed to participate. Additionally, based on the responses that researcher received from the counselors who chose not to participate in the study, it was evident that there were more counselors who met the inclusion criteria for the study but chose not to participate. Responses included not participating due to a perceived lack of trust in confidentiality of the study; the belief that asking their clients to participate in this study could potentially damage their relationship with their clients; and an

unwillingness to participate in the study due to negative attitudes towards mandatory supervision.

The fourth limitation of the study is social desirability. According to Fisher (1993), participants may respond to questionnaires in a way that presents them in the most favorable way. Social desirability may skew results and distort overall findings. Additionally, due to the specific research design that required counselors to recruit their own clients for this study, counselors' social desirability might have contributed to choosing clients who made more significant progress. The researcher created a specific procedure in order for the counselor to "randomly" select a client. The counselor was instructed to ask the next client who came in for counseling and had received a minimum of six therapy sessions to participate in the study. The counselor was asked to do this successively until a client agreed to participate. Even though the procedure was intended to assist with randomization and help with social desirability, the researched had no control of the client selection process for this study.

Another potential limitation of this study could be related to the professional identity development of the counselors who comprised the pool of participants. Based on inclusion criteria, the researcher was looking for counselors who were receiving supervision. Based on the license requirements of the states which agreed to share lists of counselors who receive supervision, only counselors who were still working towards their full license required supervision. According to Stoltenberg, McNeill, and Delworth (1998), novice counselors perceive therapeutic process as new and difficult. They often have a hard time focusing on all the dimensions of therapy, therefore, it may be difficult to build strong therapeutic relationships with their clients. Those counselors may have

increased anxiety related to asking their clients to report their perceived therapy outcomes out of fear of being recognized as incompetent or ineffective.

Implications and Recommendations for Future Research

The current study attempted to establish a relationship between supervisory working alliance and client outcomes. Even though, due to the small sample size, the results could not be generalized beyond this study's sample, this study can serve as a pilot study for more methodologically sound research with more reliable recruitment procedures. The literature review of the current study included a synthesis of existing literature on supervision and client outcomes as well as established inferential connections between supervisory working alliance and client outcomes. This literature review can serve as a platform for further research in the field of supervision as it shows gaps in the supervision literature in relation to client outcomes. The literature synthesis provides support for the need of further exploration of the relationships between supervision, specifically supervisory alliance, with client outcomes in order to assist counselors and counselor supervisors with client welfare and increase successful client outcomes. With the help of these discussed limitations of this study, future researchers will be able to develop more efficient recruitment and data collection procedures in order to increase sample sizes in future studies of this nature.

Counselors and counselor supervisors can utilize the reviewed literature and results of this study in order to work on improving their supervisory relationship and learning how to build a strong therapeutic working alliance with clients by practicing relationship-building strategies in supervision. Counselor educators can utilize the current study as evidence of the importance of supervision in general and more

specifically the potential importance of a strong supervisory working alliance not only for counselor development but for improvement of client outcomes. Furthermore, counselor educators can utilize the synthesized literature of this study in order to educate counselors in training on the importance of client outcome research and its contribution to continuous attempts to find factors that help increase positive client outcomes.

Research findings together with the study limitations provide multiple opportunities for future research. Due to the small sample size, the current study cannot provide generalizable results, but it does provide support for the need of further investigation. One possibility is implementing different data collection procedures. The researcher can recruit mental health agencies who will be open to implementing data collection procedures for a future study as a part of their company's policies and procedures for counselors under supervision. This research design will allow the researchers to collect ongoing counselor and client data until the participation numbers reach the required minimum based on established power analysis.

Additionally, future researchers can utilize university counseling centers as participant recruitment sites. Counseling centers frequently employ fully licensed counselors and counselors who are still working towards full licensure. Because these centers often provide supervision to all levels of licensure, researchers can explore the difference in client outcomes between fully licensed counselors and those who are still working towards their full license.

Future qualitative research can also focus on analyzing reasons why counselors and clients choose not to participate in client outcome research. For example, the researcher can construct an open ended or semi-structured interview that would provide

qualitative data for better insight as to why counselors chose not to participate in client outcome research. Similarly, the researcher can provide clients with the same opportunity to anonymously respond to qualitative questions in order to identify reasons that prevent them from engaging in research.

Conclusions

Supervision is a vital part of counselor preparation and development (Watkins, 1997). Supervision plays a fundamental role in counselor training, as well as assures client welfare (Borders, 2001). The main focus of supervision research in the past two decades has been on researching supervisor and supervisee variables and exploring effects of supervision on client outcomes (Inman & Ladany, 2008).

There is a gap in the literature exploring a relationship between supervisory working alliance and client outcomes. Limited research exists in the supervision literature on the topic of the relationship between therapeutic working alliance, considered the most robust predictor of client outcomes, and supervisory working alliance. Patton and Kivligan (1997) established that the therapeutic working alliance has a relationship with supervisory working alliance. Despite the inferences that could be made from all available research, there is a lack of empirical evidence. Therefore, it is crucial to examine the relationship between supervisory working alliance and client outcomes. The results of this research provide support for the possible existence of a relationship between supervisory working alliance measured by Task, Bond and Goal scales of SWAI-T and self-reported clients' perceptions of improvement measured by Health and Functioning, Social and Economic, Psychological/Spiritual, Family and Total Quality of Life scales of CPIS. The results of this research cannot be generalized and therefore, must

be interpreted with caution due to lack of representativeness of the small sample of the study. However, this study can be considered as a pilot study for future research.

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APPENDIX A: STUDY RECRUITMENT LETTER TO COUNSELORS

Dear Counselor,
I am currently conducting a study for my dissertation to investigate the relationship between supervisory working alliance and client outcomes. I am looking for participants to engage in an online survey. To be a part of the study, participants should meet the following criteria:

- hold master's or Ph. D level degree
- hold LPCA and currently work towards full counselor license;
- receive weekly supervision from a board approved supervisor;
- have at least one adult client who received a minimum of six therapy sessions and agrees to participate in the study

As an incentive to participate in the study, participants may choose to be entered into a sweepstakes where they can win a $20 gift card to Amazon.com. Ten $20 gift cards will be offered to the counselor participants of this study and 10 $20 gift cards will be offered to the client participants of this study.
The survey is conducted online and will take about 20 minutes to complete. If you are interested in participating in the study and you meet the inclusion criteria please follow the steps:

1. Identify one adult client on your caseload who received a minimum of six therapy sessions and agrees to participate in the study.

2. Provide your client with the link to the survey that you can find in the attachment named CLIENT PARTICIPANT.

3. Please access the study's website (http://surveymonkey.com/) for more details on the study and the research materials and follow the instructions to complete your part of the survey.

You can find instructions on how to enter the $20 gift card sweepstakes at the end of the survey.
Thank you very much.

Hanna Lainas MA, NCC, LPC
University of North Carolina at Charlotte
(hlainas@uncc.edu)

APPENDIX B: STUDY RECRUITMENT LETTER TO CLIENTS

Dear Participant,
I am currently conducting a study for my dissertation to find out if your improvement in therapy is related to the supervision that your counselor is receiving. I am looking for participants to engage in an online survey.
As an incentive to participate in the study, participants may choose to be entered into a sweepstakes where they may win a $20 gift card to Amazon.com. Ten $20 gift cards will be offered to the participants of this study.
To be a part of the study, participants should meet the following criteria

- receive a minimum of six therapy sessions from your counselor

The survey is conducted online and will take about 20 minutes to complete. If you are interested in participating in the study and you meet the inclusion criteria please access the study's website (http://surveymonkey.com/) for more details on the study and the research materials then follow the instructions to complete your part of the survey.
You can find instructions on how to enter the $20 gift card sweepstakes at the end of the survey.
Thank you very much.

Hanna Lainas MA, NCC, LPC
University of North Carolina at Charlotte
(hlainas@uncc.edu)

APPENDIX C: COUNSELOR INFORMED CONSENT

The University of North Carolina at Charlotte
9201 University City Boulevard
Charlotte, NC 28223-001

College of Education
Department of Counseling
704-687-8960

Dear Participant,

You are invited to participate in a study being conducted by me, Hanna Lainas, a Doctoral Candidate from the Department of Counseling in the College of Education at the University of North Carolina at Charlotte. For my dissertation project, I am conducting research on the relationship between supervisory working alliance and client outcomes. My project focuses on the supervisory working alliance between therapists and their supervisors and specifically how the supervisory working alliance is related to the supervisees' client outcomes.

Findings of this study are expected to fill the gap in the supervision literature by answering the question of whether the supervisory working alliance can predict client outcomes. This knowledge will contribute to the training of therapists and enhancement of the therapy outcomes. If you decide to participate, you will complete one research instrument and a short demographic questionnaire at a convenient time and place for you. The completion time for all of the measures should take approximately 20 minutes. The research instrument is designed to gather information about the strength of the supervisory working alliance.

You are a volunteer and are under no obligation to participate. If you do participate, your responses will be completely anonymous and confidential. The questionnaires are coded such that participant identities are never identified. You may choose to terminate participation should you experience emotional discomfort while completing the materials. No adverse actions will be taken against you for opting out. All data collected will be stored in a secure place. Only my dissertation committee and I will have access to it.

If at any point during this study you decide, you would like to opt out, simply exit the survey by closing your web browser's window. There will be no adverse action taken against you for opting out of this study.

I am inviting licensed professional counselor associates who are working towards full counselor license, receive weekly supervision from a board-approved supervisor, and have at least one adult client who received a minimum of six therapy sessions and agreed to participate in the study. I expect to recruit approximately 107 counselor-client pairs.

If you meet the inclusion criteria and wish to participate, simply click on the link titled "continue to survey" and you will be sent to the survey's website (http://uncc.surveyshare.com/s/AYAGBFD). By clicking on the link and agreeing to participate in the study, you are acknowledging that you have read and understand the informed consent document. No additional information will be required from you unless you wish to participate in the drawing for a $20 gift card in which case you will provide your email address at the completion of the online survey.

This study has been approved by IRB (Protocol #13-12-04). No risk or negative consequence is expected from your participation. Your participation may contribute to improvement of the training of therapists and enhancement of the therapy outcomes.

Any information about your participation, including your identity, will be kept confidential. If you have any questions about the study, please contact me at hlainas@uncc.edu or 828-719-0895, or you may contact my dissertation chair, Dr. Jack Culbreth at 704-687-8973 or the Office of Research Compliance at 704-687-1871 and uncc-irb@uncc.edu .
By replying to this recruitment and informed consent document, you acknowledge that:

1. You are at least 18 years old.
2. You meet the participant criteria:
    - hold Master's or Ph. D. level degree
    - provisionally licensed counselor (or equivalent in your state) or licensed professional counselor associate who are working towards full counselor license,
    - receive one hour of supervision from a board-approved supervisor for every 40 hours of work,
    - have at least one adult client who received a minimum of six therapy sessions and agreed to participate in the study.
3. You have read and understood the aforementioned information.
4. Your decision to participate in this study was completely up to you and your information will be kept confidential.
5. You have been given an opportunity to ask the researchers questions concerning this research and your participation.

Sincerely,

Hanna Lainas MA, NCC, LPC
Doctoral Candidate
University of North Carolina at Charlotte
Contact: hlainas@uncc.edu; 828-719-0895

APPENDIX D: CLIENT INFORMED CONSENT

The University of North Carolina at Charlotte
9201 University City Boulevard
Charlotte, NC 28223-001

College of Education
Department of Counseling
704-687-8960

Dear Participant,

You are invited to participate in a study being conducted by me, Hanna Lainas, a Doctoral Candidate from the Department of Counseling in the College of Education at the University of North Carolina at Charlotte. For my dissertation project, I am conducting research to find out whether your improvement in therapy is related to the supervision that your counselor is receiving.

Findings of this study are expected to contribute to the training of therapists and improvement of the therapy outcomes. If you decide to participate, you will complete one research instrument and a short demographic questionnaire at a convenient time and place for you. The completion time for all of the measures should take approximately 15 minutes. The research instrument is designed to gather information about your perception of your improvement after therapy.

You are a volunteer and are under no obligation to participate. If you do participate, your responses will be completely anonymous and confidential. The questionnaires are coded such that participant identities are never identified. You may choose to terminate participation should you experience emotional discomfort while completing the materials. No adverse actions will be taken against you for opting out. All data collected will be stored in a secure place. Only my dissertation committee and I will have access to it.

If at any point during this study you decide, you would like to opt out, simply exit the survey by closing your web browser's window. There will be no adverse action taken against you for opting out of this study.

I am inviting participants who received a minimum of six therapy sessions from the counselor who offered for you to participate in this study. I expect to recruit approximately 107 counselor-client pairs.

If you meet the inclusion criteria and wish to participate, simply proceed with the survey. By agreeing to participate in the study, you are acknowledging that you have read and understood the informed consent document. No additional information will be required

from you unless you wish to participate in the drawing for $20 dollar gift card in which case you will provide your email address at the completion of the online survey.

No risk or negative consequence is expected from your participation. This study has been approved by IRB (Protocol #13-12-04). Your participation may contribute to improvement of the training of therapists and enhancement of the therapy outcomes.

Any information about your participation, including your identity, will be kept confidential. If you have any questions about the study, please contact me at hlainas@uncc.edu or 828-719-0895, or you may contact my dissertation chair, Dr. Jack Culbreth at 704-687-8973 or the Office of Research Compliance at 704-687-1871 and uncc-irb@uncc.edu .

By replying to this recruitment and informed consent document, you acknowledge that:

1. You are at least 18 years old.
2. You received a minimum of six therapy sessions from the counselor who offered for you to participate in this study.
3. You have read and understood the aforementioned information.
4. Your decision to participate in this study was completely up to you and your information will be kept confidential.
5. You have been given an opportunity to ask the researchers questions concerning this research and your participation.

Sincerely,

Hanna Lainas MA, NCC, LPC
Doctoral Candidate
University of North Carolina at Charlotte
Contact: hlainas@uncc.edu; 828-719-0895

APPENDIX E: FIRST REMINDER E-MAIL

Dear Counselor,

Last week I e-mailed you a request to participate in my dissertation study that investigates the relationship between supervisory working alliance and client outcomes. As an incentive to participate in the study, participants may choose to be entered into a sweepstakes where they may win a $20 gift card to Amazon.com.

If you have already completed the survey, please accept my sincere thanks. If not, please do so today. I am especially grateful for your help because with your help we will be able to answer the question of whether the supervisory working alliance can predict client outcomes. This knowledge will contribute to the training of therapists and enhancement of the therapy outcomes.

If you choose to participate, please follow the steps:

1. Identify one adult client on your caseload who received a minimum of six therapy sessions and agrees to participate in the study.

2. Provide your client with the link to the survey that you can find in the attachment named CLIENT PARTICIPANT.

3. Please access the study's website for more details on the study and the research materials and follow the instructions to complete your part of the survey.

You can find instructions on how to enter into $20 gift card sweepstakes at the end of the survey.

Thank you very much.

Hanna Lainas MA, NCC, LPC
University of North Carolina at Charlotte
(hlainas@uncc.edu)

APPENDIX F: SECOND REMINDER E-MAIL

Dear Counselor,

A couple weeks ago, I e-mailed you a request to participate in my dissertation study that investigates the relationship between supervisory working alliance and client outcomes. If you have already completed the survey, please accept my sincere thanks.

If not, please do so today. I am especially grateful for your help because with your help we will be able to answer the question of whether the supervisory working alliance can predict client outcomes. This knowledge will contribute to the training of therapists and enhancement of the therapy outcomes.

If you choose to participate, please follow the steps:

1. Identify one adult client on your caseload who received a minimum of six therapy sessions and agrees to participate in the study.

2. Provide your client with the link to the survey that you can find in the attachment named CLIENT PARTICIPANT.

3. Please access the study's website for more details on the study and the research materials and follow the instructions to complete your part of the survey.

You can find instructions on how to enter into $20 gift card sweepstakes at the end of the survey.

Thank you very much.

Hanna Lainas MA, NCC, LPC
University of North Carolina at Charlotte
(hlainas@uncc.edu)

APPENDIX G: THANK YOU E-MAIL AND FINAL REMINDER

Dear Counselor,

I wanted to thank you of your participation in my project. This is the final e-mail that you will receive from me. I really appreciate the time and effort that you have committed assisting me with this dissertation project. Your help was very valuable and I hope the information that you and your client provided will assist with filling the gap in the supervision literature by answering the question of whether the supervisory working alliance can predict client outcomes. This knowledge will contribute to the training of therapists and enhancement of the therapy outcomes.

If you did not have a chance to participate in the study yet and would like to have an opportunity to be entered into a sweepstakes where you may win a $20 gift card to Amazon.com please follow the steps:

1. Identify one adult client on your caseload who received a minimum of six therapy sessions and agrees to participate in the study.

2. Provide your client with the link to the survey that you can find in the attachment named CLIENT PARTICIPANT.

3. Please access the study's website for more details on the study and the research materials and follow the instructions to complete your part of the survey.

You can find instructions on how to enter into $20 gift card sweepstakes at the end of the survey.

Thank you very much.

Hanna Lainas MA, NCC, LPC
University of North Carolina at Charlotte
(hlainas@uncc.edu)

APPENDIX H: DEMOGRAPHIC QUESTIONAIRE COUNSELORS

Please answer the following questions:

1. Your age (check one): ☐ 20-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80
   ☐ Other (please specify): _____

2. Your gender (check one): ☐ Male ☐ Female ☐ Transgendered ☐ Unspecified

3. Your race/ethnicity (check one):

   ☐ White
   ☐ Black or African American
   ☐ Latino/a
   ☐ Asian or Asian American
   ☐ American Indian/Alaskan Native
   ☐ Pacific Islander or Native Hawaii
   ☐ Biracial/Multiracial
   ☐ Other (please specify): _____

4. Your educational level:

   ☐ Bachelor's Degree
   ☐ Master's Degree
   ☐ Doctorate Degree

5. Area of study

   ☐ Mental Health Counselling
   ☐ Social Work
   ☐ School Counseling
   ☐ Pastoral Counseling
   ☐ Psychology
   ☐ Marriage and Family Therapy
   ☐ Rehabilitation Counseling
   ☐ Other (please specify): _____

6. Length of time receiving post-masters supervision: _____

7. Theoretical orientation (pick the best that describes your work):

   ☐ Person-Centered
   ☐ Cognitive/ Cognitive-Behavioral
   ☐ Reality
   ☐ Psychodynamic
   ☐ Gestalt/Experiential
   ☐ Adlerian
   ☐ Solution-Focused
   ☐ Other (please specify): _____

8. Certification/ licensure of your supervisor (check one):

   ☐ LPCS
   ☐ LCSWS
   ☐ LMFTS
   ☐ Other (please specify): _____

9. Your work setting:

- ☐ In-Home Outpatient Therapy
- ☐ In-Home Community Support Team
- ☐ Hospital setting
- ☐ School
- ☐ Private Practice office
- ☐ Doctor's office
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Other (please specify): _____

10. Symptom severity of the client who you asked to complete the survey:

☐ Mild ☐ Moderate ☐ Severe

APPENDIX I: DEMOGRAPHIC QUESTIONAIRE CLIENTS

Please answer the following questions:

1. Your age (check one): ☐ 20-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80
   ☐ Other (please specify): _____

2. Your gender (check one): ☐ Male ☐ Female ☐ Transgendered ☐ Unspecified

3. Your race/ethnicity (check one):

   ☐ White
   ☐ Black or African American
   ☐ Latino/a
   ☐ Asian or Asian American
   ☐ American Indian/Alaskan Native
   ☐ Pacific Islander or Native Hawaii
   ☐ Biracial/Multiracial
   ☐ Other (please specify): _____

4. Your educational level:

   ☐ Grammar School
   ☐ High School or equivalent
   ☐ Vocational/technical school (2 year)
   ☐ Some college
   ☐ Other (please specify): _____
   ☐ Bachelor's degree
   ☐ Master's degree
   ☐ Doctoral degree
   ☐ Professional degree (MD, JD, etc)

APPENDIX J: THE SUPERVISORY WORKING ALLIANCE-TRAINEE

Instructions: On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her supervisor. Beside each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel (or think), select the number ―7; if it never applies to you, select the number ―1. Use the numbers in between to describe the variations between these extremes.

Please work fast. Your first impression is what is wanted.

1. I feel uncomfortable with my supervisor.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My supervisor and I agree about the things I will need to do in supervision.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I am worried about the outcome of our supervision sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. What I am doing in supervision gives me a new way of looking at myself as a counselor.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. My supervisor and I understand each other.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. My supervisor perceives accurately what my goals are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I find what I am doing in supervision confusing.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. I believe my supervisor likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. I wish my supervisor and I could clarify the purpose of our sessions.

1	2	3	4	5	6	7

Never Rarely Occasionally Sometimes Often Very Often Always

10. I disagree with my supervisor about what I ought to get out of supervision.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

11. I believe the time my supervisor and I are spending together is not spent efficiently.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

12. My supervisor does not understand what I want to accomplish in supervision.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

13. I am clear on what my responsibilities are in supervision.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

14. The goals of these sessions are important to me.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

15. I find what my supervisor and I are doing in supervision will help me to accomplish the changes that I want in order to be a more effective counselor.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

16. I feel that what my supervisor and I are doing in supervision is unrelated to my concerns.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

17. I believe my supervisor is genuinely concerned for my welfare.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

18. I am clear as to what my supervisor wants me to do in our supervision sessions.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

19. My supervisor and I respect each other.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

20. I feel that my supervisor is not totally honest about his or her feelings towards me.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

21. I am confident in my supervisor's ability to supervise me.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

22. My supervisor and I are working toward mutually agreed-upon goals.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

23. I feel that my supervisor appreciates me.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

24. We agree on what is important for me to work on.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

25. As a result of our supervision sessions, I am clearer as to how I might improve my counseling skills.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

26. My supervisor and I trust one another.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

27. My supervisor and I have different ideas on what I need to work on.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

28. My relationship with my supervisor is very important to me.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

29. I have the feeling that it is important that I say or do the "right" things in supervision with my supervisor.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

30. My supervisor and I collaborate on setting goals for my supervision.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

31. I am frustrated by the things we are doing in supervision.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

32. We have established a good understanding of the kinds of things I need to work on.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

33. The things that my supervisor is asking me to do don't make sense.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

34. I do not know what to expect as a result of my supervision.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

35. I believe the way we are working with my issues is correct.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

36. I believe my supervisor cares about me even when I do things that he or she does not approve of.

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

APPENDIX K: CLIENT PERCEPTION OF IMPROVEMENT SURVEY

For each of the following, please choose the answer that best describes how **much you have improved** in that area of your life since you started counseling. Please mark your answer by circling the number. There are no right or wrong answers.

1. My overall health has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

2. My level of energy has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

3. My ability to take care of myself without help has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

4. My control over my life has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

5. My chances for living as long as I would like to have improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

6. My sex life has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

7. My overall family happiness has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

8. My relationship with my spouse, lover, or partner has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

9. My ability to make friends has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

10. The emotional support from my family has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

11. Emotional support from people other than your family has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

12. My ability to take care of family responsibilities has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

13. How much I worry has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

14. My performance at my school/work has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

15. My ability to take care of my financial needs has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

16. My peace of mind has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

17. My ability to achieve personal goals has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

18. My happiness in general has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

19. My life satisfaction in general has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

20. My personal appearance has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

21. My overall quality of life has improved

Not at all	Very Little	Some	Moderately	Significantly	Completely
1	**2**	**3**	**4**	**5**	**6**

APPENDIX L: SWEEPSTAKES DRAWING

Thank you for participating in my research. If you choose to, at the conclusion of the survey, you may submit your email address into a drawing for a chance to win a $20 gift card to Amazon.com. If you choose to submit your email address, it will be entered into an Excel spreadsheet. Two weeks after the survey is closed, winners of the gift cards will be randomly selected through Excel and will be contacted by me at the email address you provided for this study. At that time I will include a link that will allow you to receive the money over the internet. At that point, the Excel spreadsheet, all of its contents, and any email correspondence between you and I will be immediately destroyed via computer software that destroys data permanently. Only the winners of the gift cards will be notified. Please feel free to contact me if you have any questions regarding these procedures. If at any point during this study you decide you would like to opt out, simply exit the survey by closing your web browser's window. There will be no adverse action taken against you for opting out of this study. Thank you again for your participation in the survey.

Sincerely,

Hanna Lainas MA, NCC, LPC
Doctoral Candidate
University of North Carolina at Charlotte
Contact: hlainas@uncc.edu; 828-719-0895