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A Developmental Model for the Supervision of Psychotherapy: The Effect of Level of Experience on Trainees' Views of Ideal Supervision

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A DEVELOPMENTAL MODEL FOR THE SUPERVISION OF PSYCHOTHERAPY: THE EFFECT OF LEVEL OF EXPERIENCE ON TRAINEES' VIEWS OF IDEAL SUPERVISION

by

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VITA

The author, Sharon A. Moskowitz, is the daughter of David Moskowitz and May Kaplan Moskowitz. She was born March 26, 1953, in New York, New York.

Her elementary education was obtained in the public schools of Detroit, Michigan and Ferndale, Michigan, and secondary education at Southfield Senior High School, Southfield, Michigan, where she graduated in June, 1970. She attended the University of Michigan, and in August, 1974, received the degree of Bachelor of Arts with a major in psychology.

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INTRODUCTION

One of the most important elements in the training of a psychotherapist is the direct supervision of his or her clinical work. Supervision is the most widely used method of training therapists, yet there is little agreement regarding what constitutes effective supervision.

There is a large literature on the theory and practice of psychotherapy supervision. Much of this literature focuses on describing specific approaches; i.e., models of the supervisory process which define the content areas which the supervisor should emphasize and the techniques which should be used. Many approaches have been presented. Of particular concern in this study are the imitative approach which emphasizes the supervisor's function as a role model, the didactic patient-centered approach which emphasizes direct teaching of dynamics, theory, and technique, and the therapist-centered approach which emphasizes exploration and resolution of the trainee's difficulties in functioning as a therapist. There is currently no consensus regarding which approach to supervision is most effective, and this question has rarely been examined in empirical studies.

Another major focus in the literature concerns the interpersonal aspects of supervision, or those aspects of the relationship with the supervisor which are believed to facilitate the trainee's learning. Many different factors have been described as important, for example, the supervisor's provision of empathy, respect, and support, and the trainee's selective identification with the supervisor. But again there has been little research in this area.

In writings concerning the essential pedagogical and interpersonal aspects of supervision, little attention has been given to the question of whether trainees at different levels of professional development require or respond better to different supervisory styles. Authors generally present their own approach as the most effective one for all trainees at all times. But it is possible that different approaches may be most effective at different points in training. Changes in the supervisory relationship may also be necessary. However, developmental views of the supervisory process are rarely presented in the literature.

The current study addressed the question of whether the level of experience of the trainee is an important factor in determining the approach to supervision that is most effective and the critical aspects of the supervisory relationship. This question was

examined by directly assessing the opinions and needs of graduate students in clinical psychology who were at different stages of their training. It was hypothesized that the content of supervision, the techniques used by the supervisor, and the nature of the supervisory relationship should change according to the trainee's level of experience in order to meet his or her changing needs and expectations. A developmental model of supervision which specifically describes the most effective type of supervision at different stages of the supervisee's training was tested. In addition, two especially problematic areas in supervision, the exploration of the trainee's personal conflicts and the handling of problems in the supervisory relationship, were explored.

REVIEW OF RELATED LITERATURE

Approaches to Supervision

The Theoretical Literature. The major goal of supervision is to increase the trainee's skills as a psychotherapist. There is little consensus, however, as to what methods of supervision are most effective in reaching this goal. Many different approaches to supervision have been presented in the literature.

While there are always some differences between the approaches presented by any two authors, methods of supervision may be categorized in terms of three primary approaches: an imitative approach, a didactic patient-centered approach, and a therapist-centered approach. (A similar classification of the three main types of supervision has been previously used by Rioch, Coulter, & Weinberger, 1976, although they did not provide a name for each approach. Many other authors have utilized the latter two categories in discussing different types of supervision, some with and some without the use of these names for the two approaches, for example, DeBell, 1963; Kadushin, 1974; Nash, 1975; Shapiro, Pinsker, & Bueno, 1973; Tischler, 1968; and Truax & Carkhuff, 1967.) These approaches differ in terms of the conceptualization of how

learning occurs, some of the aims of supervision, the content emphasized in supervisory sessions, and the techniques which are used by the supervisor. Methods of supervision are either pure examples of a specific approach or integrate selected elements of these three primary models.

The imitative approach was used very early in the history of training therapists. This type of supervision was a major characteristic of the early control analysis, i.e., the analysis conducted by a beginning psychoanalyst under supervision (Fleming, 1953). In this type of approach, the trainee presents material from the therapy or analytic session, and the supervisor responds by demonstrating what he or she would have done in that situation. The trainee is expected to imitate the supervisor's methods and techniques, and learning occurs through identification and imitation (Rioch et al., 1976).

This model has received considerable criticism. Fleming (1953) states that the trainee needs to learn why the supervisor would have used a certain technique, rather than merely being told what to do. Fleming believes that this approach may lead to passive, mechanical imitation of the supervisor, without any true understanding of the reasons for an intervention or any consideration of proper timing and the patient's needs. The danger of training therapists who are merely disciples or extensions of the supervisor, rather than creative, independent therapists

has also been stressed by other authors (DeBell, 1963; Ekstein & Wallerstein, 1972; Keiser, 1956).

No current authors believe that supervision should exclusively consist of an imitative approach. However, the importance of identification with the supervisor is still stressed by many authors, and imitative learning is often considered to be an important element in integrative models.

The two other primary approaches to supervision also have their bases in the training of psychoanalysts. Early in the history of analytic training, there was considerable debate regarding the function of the supervisor in the control analysis and the best method and focus of training. In the early debate, one viewpoint stressed that the control analysis should focus on analyzing the trainee's difficulties with the patient in terms of his or her countertransferences and blind spots (Kovacs, 1936). Problems with the patient were felt to reflect unresolved personal problems of the trainee, which needed to be identified and resolved in order to be an effective analyst. Thus, the control analysis was seen as an extension of the trainee's personal training analysis. This viewpoint has given rise to the modern therapist-centered approach. The other early viewpoint regarding the control analysis stressed that it should primarily be a didactic experience,

rather than an analysis of countertransference and blind spots (Bibring, 1937). The supervisor should provide explanations about the patient and the process of analysis, and direct and correct the trainee's interventions. It was felt that the affective problems of the trainee in working with the patient should be dealt with in his or her personal analysis, not in supervision. The modern equivalent of this viewpoint is the patient-centered approach. (See Ekstein, 1960, or Fleming & Benedek, 1966, for a historical review of psychoanalytic training.)

The didactic patient-centered approach to supervision focuses on the problems, dynamics, and needs of the patient and on teaching techniques to the trainee. Learning is equated with gaining an understanding of the patient and a knowledge of technique. Tarachow (1963) is the best known proponent of this approach. He has described in detail the approach he uses in supervising psychiatric residents in conducting psychoanalytically oriented psychotherapy. Tarachow states the following basic rule of supervision. "The teaching of the resident should be instruction in terms of the problems and needs of the patient, as expressed in the specific clinical phenomena of the patient. The supervisor is an instructor and not a psychotherapist" (p. 303).

Tarachow believes that the optimal method of

teaching the trainee is through focusing on the pathology and dynamics of the individual patient who is being treated. The supervisor may also teach in terms of the general problems of patients, and the theory of treatment and the therapeutic relationship. When the supervisor recognizes a characteristic problem in the trainee's manner of dealing with the patient, he or she should not directly confront the trainee. Rather, the supervisor should attempt to help the trainee from the patient's side of the matter, for example, by explaining what the patient needs. If there is extreme difficulty, the trainee's transference to the supervisor may also be utilized in order to correct inappropriate reactions and attitudes. For example, Tarachow suggests that the supervisor may consciously offer himself or herself as a transference figure for identification, and be a model of interest in the area where the trainee is having difficulties. Thus, if the trainee tends to overintellectualize in dealings with the patient, the supervisor should show great interest in the affect of the patient, so the trainee will come to identify with this interest. Confronting the trainee with the difficulties should only be done as a later step, if other methods have failed. Tarachow does not believe that the relationship of the supervisor and trainee should be an explicit focus of

exploration in supervision. When difficulties occur in the supervisory relationship, the supervisor should attempt to overcome them without interpretation.

A didactic patient-centered approach is also used in most supervision of behavior therapy. Gray (1974) has described one program used in training psychiatric residents. The focus of supervision is on directly training the therapist to observe and define the client's behavior and to appropriately utilize specific techniques to bring about change in the client. Communicating an experimental, methodological orientation towards treatment is also an aim of the supervisor.

Gray emphasizes the direct observation of behavior and the provision of immediate feedback in supervision. He feels that the supervisor should directly observe the trainee's therapy sessions or utilize audiotapes or videotapes. The supervisor deliberately attempts to mold effective therapeutic behavior in the trainee through instruction and gradual shaping in the performance of specific techniques, focusing on one skill at a time, and through providing the trainee with specific and detailed feedback on his or her performance. The supervisor should focus on providing positive reinforcement for effective behavior.

Other authors also believe that supervision should focus on the problems of the patient and the teaching of

technique, in training both psychotherapists and psychoanalysts (Keiser, 1956; Nemiah, 1971; Zetzel, 1953).

A number of criticisms have been directed at this approach to supervision. Rioch et al. (1976) believe that when the focus of supervision is on explaining the client's dynamics, it fosters a view of the client as an object to be analyzed, rather than a living human being. Fleming and Benedek (1966) react to the fact that the supervisor actively interprets the patient's behavior to the trainee and prescribes techniques. They feel that such an approach does not help the trainee to learn to do these things independently, and does not help to develop the ego functions of introspection, empathy, and interpretation which are necessary for conducting therapy. Truax and Carkhuff (1967) state that when this approach is used, the trainee does not receive an analogue of the therapy situation, and the chance to experience a role model who may be imitated in conducting therapy. The supervisor didactically teaches and gives advice while the trainee is taught to do otherwise in conducting therapy, and the conditions such as empathy which the trainee needs to use in therapy are not offered to him or her by the supervisor.

The third primary approach to supervision is the <u>therapist-centered approach</u>. This method of supervision focuses on the needs and problems of the trainee. Learning is equated with the trainee's growth and increased

self-awareness, and not just the acquisition of intellectual knowledge. The process of supervision is more experiential.

Ekstein and Wallerstein (1972) are the best known proponents of the therapist-centered approach. They state that the goals of supervision are to help the trainee acquire professional self-awareness and therapeutic skills, and to maintain standards of service to the patient. Affective, interpersonal, and intellectual learning are all seen as necessary.

Ekstein and Wallerstein describe their approach as it is used in the supervision of psychoanalytically oriented psychotherapy with trainees from various disciplines. They believe that the major obstacle to the growth of therapeutic sensitivity and competence is the mobilization of idiosyncratic patterns that determine the way the trainee learns and the way he or she reacts to the patient. Therefore, supervision focuses on the trainee's "learning problems" with the patient and "problems about learning" with the supervisor; i.e., the trainee's ways of responding which are determined by his or her characteristic, inappropriate patterns of response and not by objective considerations. The parallels between the trainee's functioning with the patient and with the supervisor are stressed. The supervisor identifies the trainee's problems as they unfold within the context of

the trainee-patient and trainee-supervisor relationships, points them out to the trainee, and helps the trainee resolve them. It is stressed that these problems are not merely an obstacle to learning, but that becoming aware of difficulties and working towards their resolution is the very process of learning. Ekstein and Wallerstein feel that the trainee needs to work out his or her characteristic problems with the patient before the trainee can objectively see the technical problems posed by the particular patient. Thus, the focus on the trainee's problems is felt to be essential with beginning supervisees, while in the more advanced stages of training, the focus may shift to more purely technical and theoretical problems.

Ekstein and Wallerstein stress that this type of supervision is not a hidden form of therapy for the trainee. While both supervision and psychotherapy are helping processes with many of the same affective components, there is a crucial difference in purpose between them. The major purpose of supervision is to help the trainee become a better therapist. Thus, all problems of the trainee are seen in this context, and the area of focus is restricted to the use of the professional self, without consideration of personal functioning.

Other authors from various disciplines also stress that the primary focus of supervision should be on helping

the trainee to develop greater self-awareness and a better use of his or her own personality in conducting therapy (Ornstein, Ornstein, & Lindy, 1976; Wessel, 1961).

The major criticism of the therapist-centered approach is that this model is essentially a form of psychotherapy for the trainee, and the supervisor's role should be that of a teacher, not a therapist (Tarachow, 1963). The problem of expecting the trainee to explore his or her difficulties with a person who also functions as an evaluator has also been raised (Cohen & DeBetz, 1977).

While a sharp dichotomy is often drawn between exploring the trainee's difficulties and conflicts or not doing so at all, in actuality there are a number of ways to deal with these issues. The patient-centered view that personal conflicts should not be identified in supervision, and the therapist-centered view that they should be extensively explored and resolved, may represent endpoints on a continuum of various degrees of exploration. Intermediate levels of exploration are possible. For example, the supervisor may identify the trainee's conflicts without interpretation (DeBell, 1963; Shapiro et al., 1973), or may provide a partial interpretation without engaging in extensive exploration with the trainee (Fleming & Benedek, 1966). It should also be noted that when any degree of exploration is suggested, all authors

state that identification or exploration of conflicts should be confined to the trainee's professional functioning, and not deal with their manifestations in his or her personal life (Burgum, Durkin, Gondor, Miller, Pfeffer, & Zucker, 1959; DeBell, 1963; Ekstein & Wallerstein, 1972; Escoll & Wood, 1967; Fleming & Benedek, 1966; Shapiro et al., 1973).

A number of authors have described integrative approaches to supervision which explicitly combine elements of the three primary models. Fleming and Benedek (1966) propose an approach for analytic training which is primarily therapist-centered but incorporates didactic and imitative learning. They state that the primary goals of supervision are to help the trainee develop the functions of self-analysis, introspection, empathy, and interpretation, which are the tools of analytic work, and to regard psychoanalysis as a process. The importance of experiential learning is stressed.

Fleming and Benedek feel that the supervisor needs to assess the state of rapport in both the therapeutic and the supervisory relationships, evaluate the trainee's understanding and technique, and diagnose his or her specific learning needs. Based on the evaluation of the trainee's learning needs and the assessment of whether the difficulties represent a lack of knowledge and experience or a countertransference or transference problem,

the supervisor decides the content to emphasize in supervision and the teaching technique to use. For all learning needs, the supervisor should aim at helping the trainee to exercise his or her own self-observing and integrative functions in learning about the patient and his or her own functioning. In addition, the supervisor may supply didactic information or demonstrate his or her own approach and techniques when the learning needs represent a gap in knowledge. When the difficulties concern countertransference to the patient or transference to the supervisor, the supervisor may point out the difficulty, give a partial interpretation, and stimulate the trainee's self-analysis of the problem.

Rioch et al. (1976) also present an integrative model which stresses the therapist-centered approach. They believe that the supervisor should primarily focus on working with the trainee's anxieties and defenses, and on helping the trainee to find his or her own way of understanding the therapeutic process and conducting therapy. The process taking place within supervision should be explored, especially when there are difficulties which interfere with the trainee's learning. But the supervisor should also maintain a lesser focus on explaining the client and dynamics, and on demonstrating methods and techniques which the trainee may imitate.

An integrative approach is also commonly used in

the supervision of nondirective or client-centered therapists. Truax and Carkhuff (1967) describe an approach which integrates didactic and experiential learning. They state that the goal of training is not just to produce a technician who has skills in employing a variety of techniques, but also to produce "an open and flexible person possessed with a great amount of self-awareness and self-knowledge, sensitive and attuned to receiving and communicating vital messages with other persons" (p. 218).

Truax and Carkhuff feel that supervision should focus on the implementation of the therapeutic conditions of accurate empathy, nonpossessive warmth, and genuineness. The supervisor provides specific didactic training to the supervisee on how to communicate high levels of these conditions to a client. In addition, the supervisor provides high levels of these conditions to the trainee in order to encourage self-exploration of feelings, values, and attitudes, and so lead to the most effective use of the trainee's professional self. By providing these conditions to the trainee, the supervisor is also serving as a role model. Thus, the supervisor is viewed as actively "shaping" the trainee's behavior in the context of an interpersonal relationship which is analogous to the therapeutic relationship. There is imitative learning, didactic learning of technique, and experiential learning focusing on the trainee's growth and self-awareness.

The issue concerning the most effective approach to supervision is essentially a question of which of three types of learning is the most valuable for producing effective therapists and so should be the primary focus in supervision. Should training focus on providing students with a role model to imitate, or on direct teaching of dynamics and techniques, or on facilitating the trainee's independent learning, self-awareness, and resolution of characteristic difficulties? While most authors acknowledge that each of these types of learning has some place in the supervisory process, there is little agreement regarding their relative importance and little consideration of the conditions under which this may vary.

Research Findings and the Perspective of the Trainee. At the present time, there is no empirical research which explores the effectiveness of any approach to supervision in terms of trainees' subsequent performance with patients. It should be noted that there are research studies which assess the effectiveness of entire training programs, especially training in the client-centered orientation. But this research assesses the effects of many factors besides direct supervision, as the programs include other components of training such as classroom learning. Matarazzo (1978) provides a review of this research.

One study has explored the impact of part of the client-centered integrative approach to supervision. Karr and Geist (1977) studied the effect of the supervisor providing high levels of the facilitative conditions of empathy, respect, genuineness, and concreteness to the trainee. Tapes of supervisory sessions and the trainee's therapy sessions were rated according to the level of facilitative conditions which were provided in each. A significant positive relationship was found between the supervisor providing high levels of respect, genuineness, and concreteness to the trainee, and the trainee providing high levels of these same conditions to the client. No relationship was found for empathy. While this study only assessed the effects of one part of the client-centered approach, it may be interpreted as demonstrating the effectiveness of imitative learning.

While there is little research regarding the effectiveness of different approaches to supervision, the views of supervisees have been examined in a number of studies. Kadushin (1974) conducted a nationwide survey of social work supervisors and supervisees. The supervisees were all practicing social workers who held the M.S.W. degree. The supervisees were asked to rate the importance of various functions, objectives, and orientations of supervision. The most important function of supervision was felt to be teaching the knowledge, skills,

and attitudes necessary for effective job performance. The objectives of supervision which were rated as most important were insuring that clients receive good services and providing for the professional development of the supervisee. Finally, these social workers felt that the most desirable type of supervision would be an even mixture of a task-oriented approach which stressed the development of professional skills, and an approach stressing emotional growth, self-understanding, and an awareness of the nature of the relationship with the client. Thus, supervisees seemed to feel that a combination of a didactic patient-centered approach and a therapist-centered approach would be most effective in insuring the attainment of their goals. It is important to note, however, that the respondents in this study were practicing social workers who received supervision, and their views and needs may be different than those of psychotherapy trainees.

Nash (1975) studied psychiatric residents and clinical psychology trainees. As part of this study, supervisees completed a scale designed to assess the primary focus of their current supervisory experiences. This scale had been intended to reflect a didactic patient-centered approach and a therapist-centered approach, but a factor analysis revealed that the trainees' perceptions of the supervision they actually received did not fall

into this dichotomy. Rather, three types of supervision were found. The first was "career-focused" supervision, in which the supervisor and trainee discussed the trainee's professional identity, their relationship, and readings from the literature, and the supervisor shared his or her own experiences and explicitly acted as a role model. This approach may be viewed as combining aspects of imitative and therapist-centered models. The second type of supervision was a "therapy relationship-focused" approach, in which the primary topics in supervision were the dynamics of the therapeutic relationship, conflicts aroused in the trainee by the patient, and transference and countertransference issues. This type of supervision represents aspects of a therapist-centered approach. The third type of supervision was a "nontechnically-focused" approach, in which the supervisor focused on the patient's dynamics and did not discuss therapeutic techniques, the trainee's errors, or possible future therapeutic interventions. This approach does focus on the patient as in a didactic patient-centered approach, but differs in its disregard of technique.

Nash found that "therapy relationship-focused" supervision had a significant positive relationship to the trainees' perceptions of the quality of supervision. Trainees found the clarification of the therapeutic relationship, including their own feelings, to be very useful.

The "nontechnically-focused" type of supervision was found to have a negative relationship to trainees' views of the quality of supervision. Trainees found the discussion of dynamics to be of little value when there was no discussion of technical issues. Thus, certain elements of a therapist-centered approach, specifically the exploration of the therapeutic relationship and the trainee's feelings about the patient, were felt to be most helpful.

A number of authors have examined trainees' views on the exploration of their personal conflicts as manifested in transferences and countertransferences. Such exploration is an important part of the therapist-centered approach.

In the study by Kadushin (1974), approximately half of the social workers stated that if personal problems arose in their work with a client they would want the supervisor to identify the problems and to help in resolving them. Eleven percent of the supervisees preferred that the supervisor identify the problems and then aid in their getting help outside of the supervisory relationship.

Lewis, Moskowitz, Rand, Stearns, Wagner, Constantine, Logan, and Saunders (Note 1) surveyed interns in clinical psychology. The trainees felt that exploring personal conflicts which may affect their therapeutic effectiveness was an important function of supervision.

Barnat (1973b), in discussing his own and his peers' experiences as clinical psychology trainees, also stated that they wanted their supervisors to help them deal with personal problems which arose while doing therapy.

Rosenblatt and Mayer (1975) collected autobiographical accounts of stressful practicum experiences from social work students. In contrast to the previous studies, they found that trainees viewed "therapeutic supervision" as highly stressful and objectionable. Therapeutic supervision was described as a style in which the supervisor believes that certain actions or feelings of the trainee are inappropriate, ascribes them to personality problems of the trainee, and proceeds to explore them in detail. Supervisees did not object to their actions being labelled as inappropriate, but to the fact that the difficulties were attributed solely to "deficiencies" within the trainee, not to the context of the interaction with client or supervisor.

Conflicting views are presented by trainees regarding the exploration of their own difficulties and conflicts, which is a central element of the therapist-centered approach. However, because there are different ways for a supervisor to focus on a conflict, it is unclear if these views all refer to the same process. The study by Rosenblatt and Mayer (1975) does suggest an important point in terms of the supervisor's method of

dealing with the trainee's conflicts. That is, it may be most helpful if the supervisor focuses on the interactional aspects of the conflict, rather than solely on the trainee's intrapsychic difficulties. For example, the trainee may be taught to explore countertransference in a way which helps to elucidate aspects of the client's personality, and the effect of the countertransference on the client and the therapeutic relationship may also be a point of focus.

While no consensus is evident among trainees regarding which approach to supervision is most helpful, few studies have systematically assessed trainees' views of differing approaches. There is some preliminary evidence that trainees do utilize imitative learning (Karr & Geist, 1977), and that many trainees favor the exploration of their countertransferences and feelings about the patient, which is one aspect of a therapist-centered approach (Barnat, 1973b; Kadushin, 1974; Nash, 1975; Lewis et al., Note 1). There is also some evidence that trainees view the direct teaching of technique as helpful (Kadushin, 1974; Nash, 1975).

Summary. The theoretical literature reveals little consensus regarding the relative effectiveness of imitative, didactic patient-centered, therapist-centered, and integrative approaches. In addition, few studies have directly assessed the views of trainees regarding which

approach is seen as most useful and best fits their own goals and needs. There is some evidence that aspects of each of the three primary approaches are viewed as helpful, but no evidence regarding their relative importance. However, it should be stressed that the most effective approach to supervision may depend on the level of experience of the trainee. This will be considered in greater depth in a later section of this review.

Characteristics of the Supervisory Relationship

The Theoretical Literature. While the approach used by a supervisor and the nature of his or her relationship with the trainee are not entirely independent factors, the interpersonal aspects of supervision hold enough importance to be considered separately. This section will focus more explicitly on features of the supervisor-trainee relationship.

Many authors believe that a positive supervisory relationship is necessary in order for learning to occur. For example, Cohen and DeBetz (1977) state that success in supervision depends on the quality of the relationship between the supervisor and trainee, and Fleming and Benedek (1966) stress the importance of establishing a "learning alliance" with the trainee, which they view as analogous to the therapeutic alliance. It has also been stressed that establishing a positive relationship is

especially important with beginning trainees, who are inevitably quite anxious (Fleming & Benedek, 1966; Wolberg, 1977).

The specific factors which lead to a good relationship with the trainee have been described by many authors. As was previously noted, Truax and Carkhuff (1967) stress the importance of the supervisor communicating a high level of empathy, nonpossessive warmth, and genuineness to the trainee. The need for a teaching atmosphere in which these conditions are offered is also stressed by Rogers (1957). Authors with different theoretical orientations have discussed the importance of similar factors, although different terminology is often used. Cohen and DeBetz (1977) state that an atmosphere of "responsive mutuality" should be fostered in supervision, in which there is shared respect and sensitivity between supervisor and trainee. The supervisor should be empathic, perceptive, and responsive to the trainee's needs. Fleming and Benedek (1966) also stress that the supervisor's empathic perceptiveness and responsiveness are instrumental in establishing and maintaining the learning alliance. Mutual trust, understanding, and rapport between supervisor and trainee are important. DeBell (1963) stresses the supervisor's empathy and tact, Ackerman (1953) emphasizes mutual liking and respect, and Wolberg (1977) states that the supervisor should be

tolerant, flexible, and able to extend warmth, support, and acceptance to the trainee. Gray (1974) discusses the importance of the supervisor providing a nonaversive atmosphere, with punishment and anxiety largely avoided, and the importance of positive reinforcement.

Another factor which has been described as necessary for a good supervisory relationship is that the supervisor and trainee share the same goals and expectations (Cohen & DeBetz, 1977; Fleming & Benedek, 1966). Cohen and DeBetz (1977) believe that it is crucial that the trainee and supervisor discuss their goals and expectations at the very beginning of supervision and agree on their objectives.

Many authors also believe that the trainee's identification with the supervisor is an important aspect of the supervisory relationship. As was previously described, Truax and Carkhuff (1967) feel that when the supervisor communicates empathy, warmth, and genuineness to the trainee, he or she serves as a role model for the trainee's implementation of these conditions in therapy. Other authors have stressed the importance of identification in terms of the trainee's development of a professional identity, rather than for direct modeling of appropriate therapeutic behavior. Ekstein and Wallerstein (1972) state that one of the major ways in which the trainee develops a professional identity is through

identifying with and selectively emulating teachers and supervisors. Shapiro et al. (1973) believe that the supervisor needs to give the trainee a feeling of what it's like to be a member of his profession. The supervisor demonstrates a role to the trainee, in terms of values, beliefs, and customs. Tarachow (1963) also believes that the supervisor should be a model for identification. He feels that the basic role of the supervisor is a parental one, in which the trainee learns attitudes, values, and a role through identification with the supervisor as an ideal.

In sum, there is basic agreement that a positive supervisory relationship characterized by empathy, respect, and rapport is necessary for good supervision. The importance of the trainee's selective identification with the supervisor is also generally acknowledged. In addition, certain authors believe that explicitly stated and shared goals are also necessary for good supervision.

Research Findings and the Perspective of the Trainee. A positive supervisory relationship is generally assumed to be necessary in order for a fruitful learning experience to occur. One author has explicitly examined the validity of this assumption. Gale (1976) attempted to examine the relative importance for psychiatric residents of (a) rapport between student and supervisor, and

(b) the material taught in supervision. Residents completed an open-ended questionnaire regarding one supervisory relationship. Rapport with the supervisor and the quality of his or her teaching were each separately rated as good or poor. The results indicated that if rapport between supervisor and trainee was poor, trainees could still feel that good teaching had occurred; however, if rapport was good there was a greater likelihood that teaching would be perceived as good. Thus, rapport may not be essential to a good learning experience, but it does seem to facilitate this.

Relevant findings regarding the importance of a positive relationship with the supervisor are also provided by Nash (1975). She found that trainees' perceptions of the quality of supervision were more strongly related to the interpersonal aspects of the relationship than to the content which the supervisor emphasized.

Thus, a good supervisory relationship is an important aspect of supervision in that it may enhance the trainee's receptivity to whatever the supervisor teaches. Many authors have examined trainees' views regarding the characteristics of positive and negative supervisory relationships, or have presented anecdotal accounts of their own experiences as trainees.

In a discussion of the relationship between one psychiatric resident and his supervisor (Greben, Markson,

& Sadavoy, 1973), the resident, Sadavoy, described his perception of the helpful components of the relationship. He felt that selective identification with the supervisor was necessary for learning to apply therapeutic skills, and that the following aspects of the supervisory relationship facilitated identification: open and clear communication between supervisor and supervisee, the provision of pertinent personal feedback by the supervisor, and maintenance of an optimal level of tension and challenge in the relationship. Sadavoy stressed the need for a benevolent, supportive atmosphere in supervision in order to decrease the anxiety felt by the beginning trainee, and the need for the trainee and supervisor to discuss difficulties in their relationship as they occur. He also felt that a supervisory contract should be routinely established at the beginning of the relationship in order to clarify the goals and methods of supervision and the roles of both parties.

In discussing his own experience as a clinical psychology trainee, Barnat (1973a, 1973b) stressed the anxiety of the beginning student and the importance of identification with the supervisor. He emphasizes the need for "tolerant sponsorship" on the part of the supervisor in order to facilitate identification. Barnat (1973b) also described supervisory styles which he and his peers found objectionable. They reacted negatively

toward supervisors who focused on the technical or theoretical aspects of therapy or supervision, rather than on the relationships involved and on needs and feelings. They also disliked being pressured to utilize specific structured techniques with clients.

The views of trainees have also been examined in a number of studies. Tischler (1968) interviewed first year residents in psychiatry regarding their perceptions of the supervisory experience. He found that residents viewed their supervisors as models of professional functioning with whom they could identify, as potential sources of external support, and as teachers and evaluators.

Kadushin's (1974) survey of social workers examined the characteristics of the supervisor which facilitate learning. Supervisees were found to place the greatest emphasis on the competence of the supervisor, in terms of his or her knowledge and technical skills as a practitioner and an educator. Respondents felt that their greatest sources of satisfaction in supervision were that they could share the responsibility and obtain support for difficult decisions, and obtain help in dealing with problems with their clients. Thus, support is again emphasized, although greater emphasis seems to be placed on the supervisor's technical competence. Kadushin also compared supervisees who indicated great satisfaction with their current supervisory relationship with those who expressed

great dissatisfaction. The following qualities of the supervisor were found to significantly differentiate positive and negative experiences: showing little appreciation of the supervisee's work, arbitrary use of authority, not providing real help in dealing with problems with clients, restricting the supervisee's autonomy, and not being sufficiently critical so the supervisee is aware of what he or she is doing wrong.

In a similar study, Lewis et al. (Note 1) asked clinical psychology interns to rate both a positive supervisory experience and a negative supervisory experience in terms of the characteristics of the supervisor. The following qualities of the supervisor significantly differentiated positively perceived experiences from negatively perceived experiences. The preferred supervisors were rated higher in terms of their clinical skills, command of theory, provision of honest and accurate feedback to the trainee, provision of support and encouragement, warmth, availability and dependability, and their personal compatibility with the trainee.

In her study of psychiatric residents and clinical psychology trainees, Nash (1975) assessed the characteristics of the supervisor which were related to the trainee's perception of the supervisory experience as either a helpful or an unhelpful one. The perceived goodness of supervision was strongly related to the

perception of the supervisor as warm, involved, likeable, sensitive, egalitarian, not tradition bound, and possessing a good sense of humor. Supervisors who were perceived as critical, challenging, and competitive, and who took an authoritarian, controlling stance were not seen as providing helpful supervision.

Rosenblatt and Mayer (1975) described four styles of supervision which social work students considered objectionable. These styles were based primarily on characteristics of the supervisor. The first was "constrictive supervision," or not giving the trainee enough autonomy in handling cases. Trainees also objected to the opposite style of "amorphous supervision," in which the supervisor offered little guidance on how to work with the client or did not clarify his or her expectations of the trainee. The third objectionable style was "unsupportive supervision," in which the supervisor did not help to allay the trainee's initial anxieties and sometimes increased them by being aloof, overcritical, or hostile. The final style, "therapeutic supervision," has been described previously.

In summary, there is basic agreement that a positive supervisory relationship is necessary in order to promote optimal learning on the part of the trainee. While different authors describe the elements that characterize a positive relationship in different ways, there

is general agreement that the supervisor should be supportive, especially with beginning trainees, warm, and likeable, and provide a good model for identification. The importance of clear communication between supervisor and trainee, and of the supervisor's provision of accurate feedback have also been stressed. The characteristics of the supervisor which are generally viewed as negative are being unsupportive or critical, too controlling of the trainee's work, and not providing enough guidance.

Conflicts Between Supervisor and Trainee. While there is considerable agreement that a good supervisory relationship is necessary, little attention has been given in the theoretical literature to the question of how problems in the relationship are resolved. It should be stressed that conflicts between supervisor and trainee do not merely reflect the trainee's transference problems, but may have realistic bases as well. For example, there may be major differences in personality styles or in theoretical orientations that lead to a strained relationship. Some authors state that trainees need to be able to discuss their reactions to the supervisor when problems arise (Rioch et al., 1976; Shapiro et al., 1973; Wolberg, 1977), but the process of resolving difficulties in the relationship has not been discussed in detail.

A number of authors have examined the methods

which trainees use to cope with actual difficulties in the supervisory relationship. The fact that difficulties in the relationship may be an extensive problem, rather than a rare occurrence, is suggested by the findings of Lewis et al. (Note 1). Eighty-five percent of the clinical psychology trainees in this study reported that they had experienced a major conflict with a supervisor during the internship year. These conflicts generally involved personality clashes or differences in theoretical orientation or therapeutic style.

Lewis et al. (Note 1) found that 60 percent of the trainees who experienced major difficulties in the supervisory relationship discussed the conflict with the supervisor. However, in their study of social work trainees who were involved in stressful practicum experiences, Rosenblatt and Mayer (1975) found that none of the trainees openly confronted the supervisor and discussed the difficulties in their relationship. This seemed to be due to a fear of antagonizing the supervisor and possibly receiving a negative evaluation. Only one-third of the trainees discussed their difficulties with their field advisors. The most common method of coping was through "spurious compliance," or giving the impression of willingness to cooperate or comply. Trainees often closely monitored their communications and concealed pertinent information such as their personal feelings.

Barnat (1973b) also stated that trainees generally reacted to problems in the supervisory relationship by subtly selecting the material presented in supervision, so that only tension-free material was discussed. Nash (1975) reported that trainees often distorted their process notes when there was a poor supervisory relationship, so that material to which the supervisor might object and descriptions of the trainee's errors were omitted.

While open discussion between supervisor and trainee is the only method suggested for coping with conflicts in the supervisory relationship, it generally appears that most problems are not discussed and often not resolved. This creates major difficulties for the trainees' learning, in that they become more concerned with concealing difficulties in their performance than with learning from them.

Summary. There appears to be a basic agreement between the views of supervisors and the views of trainees regarding the importance of a positive supervisory relationship for facilitating the trainee's learning. There is also general agreement that such a relationship is characterized by good rapport, empathy, warmth, and clear communication, and that the trainee's selective identification with the supervisor is an important aspect of the relationship. However, trainees place a much greater

emphasis on the supervisor's supportiveness than is found in the theoretical literature. Support is continually stressed by trainees, especially beginners, and seems to be the major aspect of the relationship which decreases anxiety and permits learning to occur. However, this may be one aspect of the relationship which changes as the trainee gains experience.

There is little focus in the theoretical literature on negative supervisory relationships or ways of dealing with conflicts between supervisor and trainee. Surveys of trainees and their anecdotal accounts provide a description of the characteristics of negatively perceived supervisory relationships, and also indicate that many problems in the relationship may go unresolved and lead to significant difficulties in learning. Methods of coping with problems between supervisor and trainee need to be studied in greater depth.

Developmental Views of Supervision

A number of authors have described the special needs of beginning trainees. It is often emphasized that the beginning trainee feels anxious and unsure of his or her own abilities and needs a supportive relationship with the supervisor (Barnat, 1973a, 1973b; Greben et al., 1973; Rosenblatt & Mayer, 1975; Tischler, 1968; Wolberg, 1977; Zetzel, 1953). The importance of helping

the trainee cope with this anxiety and of identifying initial defensive facades which interfere with learning have also been described (Ekstein & Wallerstein, 1972; Shapiro et al., 1973; Wolberg, 1977). Another factor which has been stressed is the importance of the supervisor serving as a role model to help the beginning student develop a professional identity (Barnat, 1973a, 1973b; Ekstein & Wallerstein, 1972; Shapiro et al., 1973; Tischler, 1968). It has also been stated that beginning trainees want their supervisors to tell and show them exactly what to do in conducting therapy (Tischler, 1968; Wolberg, 1977).

A few authors have described their views of some changes which occur in supervision as the trainee gains experience. Ornstein et al. (1976) state that with beginning trainees, the focus should be on helping them to develop self-awareness and their own personal styles of doing therapy. After trainees have had more experience, the focus shifts to the process of therapy and the intricacies of the therapist-patient relationship. As was previously described, Ekstein and Wallerstein (1972) believe that the focus of most supervision should be on identifying and resolving the trainee's characteristic difficulties with the patient and supervisor. But as the trainee reaches an advanced stage of training and has dealt with most of these difficulties, the focus then

shifts to the consideration of technical and theoretical problems. In this advanced stage, trainees are more active and independent in supervision, and use the supervisor primarily to discuss their own ideas and test different models of therapeutic strategy which they are considering.

These authors begin to provide a view of some of the characteristics of supervision with trainees of differing levels of experience. However, they do not provide a comprehensive account of the changes which occur over the course of training, and there is little acknowledgment that major shifts in the supervisor's approach might be necessary. One article has explicitly presented a developmental view of supervision, which describes changes in the trainees' needs and interests, and in which the supervisory process differs greatly depending on the trainees' level of experience.

Gaoni and Neumann (1974) feel that there are four stages of supervision. In the first stage, supervision is primarily a teacher-pupil relationship. Supervisees completely lack knowledge and experience, and expect constant advice, support, and direct guidance on patient contacts from the supervisor. They are very dependent on the supervisor and view themselves primarily as mediators between the supervisor and the patient. The second stage is similar to an apprenticeship relationship. The emphasis

is still on the patient, and the trainees focus on developing their diagnostic and therapeutic skills. Identification with and imitation of the supervisor are important processes at this stage. During the third stage, the focus shifts to the development of the individual therapeutic personality of the supervisee. Trainees now want less focus on the patient's dynamics, and more focus on their own problems in relating to the patient and the supervisor. Transference and countertransference become major topics. During this stage trainees are more selective in their identification and imitation, and only integrate the skills of the supervisor which suit their own personalities. They want the supervisor to help them to develop their own styles and to encourage independence, spontaneity, and originality. The fourth stage of supervision is that of mutual consultation between equals. Supervisees have largely developed their own styles and identities as therapists, and supervision becomes an exchange of opinions and advice between equals, although one has more experience. This stage continues throughout one's professional career.

While Gaoni and Neumann do not describe this model in terms of the approaches to supervision which are presented in the literature, it may be conceptualized as a model which prescribes basic shifts in the overall approach to supervision in accordance with the level of

experience of the trainee. Thus, in the first stage, the supervisor utilizes an imitative approach, with a primary emphasis on directly demonstrating to the trainee what he or she should do with the patient. The second stage primarily utilizes a didactic patient-centered approach, with a focus on understanding the patient and teaching techniques. Imitative learning also remains important at this stage. In the third stage, the focus shifts to the trainee, and thus, to a therapist-centered approach. The final stage may be viewed as consultation, rather than a specific supervisory approach. In terms of the supervisory relationship, this model postulates a shift in the relationship from one which emphasizes support and guidance and in which the trainee is quite dependent on the supervisor, to an equal collaborative relationship between independent professionals.

It should be noted that Gaoni and Neumann's (1974) view of the important elements at various stages of training differs from that of some authors whose views were described previously. Ekstein and Wallerstein (1972) feel that a focus on the trainee's problems in relating to the patient and supervisor precedes a focus on dynamics and techniques, while Gaoni and Neumann feel that the process proceeds in the opposite order. Other authors feel that a focus on the trainee's self-awareness and

development of a personal style is most important at the beginning of training (Ornstein et al., 1976).

Two studies which directly assessed the views of trainees provide some support for Gaoni and Neumann's (1974) model of developmental changes. Nash (1975) found that the responses of trainees who had different amounts of experience suggested a developmental sequence, which described the evolution of the trainees' needs and interests over the course of training. Beginning trainees seemed to have a strong need for advice and suggestions from the supervisor about what to do in therapy. They appeared to be concerned with learning how to listen to the patient, and so valued supervisors who modeled a consistently attentive attitude. They also appreciated supervisors who took a careful approach to the material and explicitly demonstrated their reasoning in arriving at any conclusions about the patient; abstract theorizing was not seen as helpful. Another attribute of beginning trainees was that they exhibited a certain amount of defensiveness and appeared unable to utilize criticism in a constructive manner. Supervisors who enhanced their self-confidence and sense of professional self-esteem were valued. In the next stage of training, after at least a year of experience, trainees seemed to be more self-confident and welcomed feedback from the supervisor, even if such feedback was critical. At this point in

training, trainees wanted to discuss theory with their supervisors. They seemed to focus on integrating their experiences and knowledge into a coherent theoretical framework, and began to identify with a particular orientation. The final stages of training were characterized by an increased desire to learn about the trainee's own functioning and to explore countertransference issues. At all stages of training, supervisees still stressed the importance of the supervisor's empathy and respect.

Lewis et al. (Note 1) surveyed clinical psychology interns. The trainees were asked to rate the importance of specific goals of supervision and qualities of the supervisor at the end of the internship year, when the study was conducted, and as they viewed them at the beginning of the year. Significant changes were found to occur over the internship year in both the trainees' objectives and the qualities of a supervisor which were seen as important. At the beginning of the internship, trainees were primarily concerned with acquiring skills. They tended to use the supervisor as a role model and as a source of support. As the year progressed, trainees seemed to develop greater confidence in their therapeutic skills. They then decreased their focus on skill acquisition, and began to stress the development of their own styles of doing therapy and the integration of various theories into a personal theoretical framework. They also

focused on examining the effect of their own personalities on the therapeutic situation. As trainees became more concerned with developing their own viewpoints and styles, they became more independent of the supervisor and showed less reliance on imitating or identifying with him or her. Less emphasis was placed on the importance of the supervisor being supportive, warm, and continually available, and on personal compatibility with the supervisor. At both the beginning and end of the internship year, trainees stressed the importance of the supervisor's experience and clinical expertise, and the importance of obtaining feedback on both their strengths and their weaknesses. However, at the end of the year the supervisor seemed to be viewed more as an experienced colleague than as an authority figure.

These studies provide some preliminary support for the views of Gaoni and Neumann (1974) that the beginning trainee needs direct advice and much support from the supervisor, and that identification with and imitation of the supervisor are important at an early stage of training. Many other authors have also described the importance of support, advice, imitation, and/or identification for beginning trainees (Barnat, 1973a, 1973b; Cohen & DeBetz, 1977; Ekstein & Wallerstein, 1972; Fleming & Benedek, 1966; Greben et al., 1973; Rosenblatt & Mayer, 1975; Shapiro et al., 1973; Tischler, 1968; Wolberg, 1977;

Zetzel, 1953). These studies also support Gaoni and Neumann's view that trainees first want to focus on learning therapeutic techniques and understanding the patient and only later in training turn to a focus on transference and countertransference issues, their own impact on the therapeutic situation, and developing a personal style of therapy. This is directly opposite to the views of Ekstein and Wallerstein (1972) regarding developmental changes in the focus of supervision. These studies also add to Gaoni and Neumann's model through noting the importance of theory to trainees with more experience.

There is preliminary support for a developmental model which proposes that supervision should shift from an imitative approach, to a primarily didactic patient-centered approach, and then to a therapist-centered approach as the trainee gains experience. The supervisory relationship is also seen as changing in specified ways according to the level of experience of the trainee. However, one of the studies which supports this model (Lewis et al., Note 1) utilized trainees' retrospective views of their experiences, while the other study (Nash, 1975) proposed a developmental sequence based on post hoc findings with subjects. These studies must be viewed as providing preliminary support for a developmental model of supervision, rather than any conclusive findings. No research

to date has formulated a developmental model a priori and then tested its validity with trainees at various stages, either through a cross-sectional or a longitudinal design. Such a study is needed in order to test the validity of this developmental viewpoint.

Purpose of the Study and Hypotheses

The major purpose of this study was to test a developmental model of supervision. It is proposed that learning proceeds sequentially through several stages characterized by the trainee's evolving needs and interests, and that effective supervision entails changes in the approach used and in certain aspects of the supervisory relationship according to the level of experience of the trainee. Based on the theoretical and research literature on the supervision of psychotherapy, and primarily on the model proposed by Gaoni and Neumann (1974), the following developmental sequence for supervision is proposed to best fit the needs of trainees at various stages of training.

Stage 1. During the beginning phase of training, trainees primarily focus on learning skills which they may immediately use in contacts with patients. They are anxious about their ability to function as therapists and about beginning supervision, and have little sense of themselves as professionals. At this stage, supervision should primarily follow an imitative model, wherein the super-

visor demonstrates techniques which the trainee may use and gives direct advice and suggestions. The supervisor needs to be very supportive of the beginning trainee, and allow his or her dependence and imitation. The supervisory relationship should also be characterized by an empathic recognition of the trainee's anxieties and difficulties, warmth, respect, and positive feedback for all successes. The supervisor's competence as a clinician is regarded as important throughout training.

Stage 2. During the next stage of training, trainees have more confidence in their skills and ability to relate to patients. They are still concerned with acquiring skills, but now focus more on learning to understand the patient's dynamics, needs, and feelings, and aspects of the therapeutic relationship. They also focus on general questions of theory and technique. There is less direct imitation of the supervisor although identification with the supervisor is operative. At this stage, the supervisor should follow a didactic patient-centered approach, which focuses on explaining the patient and teaching theory and techniques. The supervisor still needs to be somewhat supportive, but trainees can now utilize accurate feedback on their performance, even when it is critical. The qualities of empathy, warmth, and respect on the part of the supervisor remain important in this stage and all following stages.

Stage 3. Trainees have now acquired confidence in their abilities, a general understanding of the patient and the technical aspects of therapy, and a basic sense of professional identity. They now become primarily interested in learning about the impact of their own personalities on the therapeutic situation, and integrating their knowledge and experience into a personal theoretical framework and a personal style of conducting therapy. Transference and countertransference issues, and the identification of blind spots and characteristic personal styles are now emphasized. The supervisory relationship may also become an explicit focus for trainees. At this stage, supervision should follow a therapist-centered approach, aimed at developing self-awareness and better utilization of the trainee's own personality as the primary tool of effective therapy. Support and modeling are no longer critical elements of the supervisory relationship. Identification with the supervisor is now highly selective, and the trainee welcomes honest feedback, even when it is critical.

Stage 4. This stage characterizes the final point in training. Trainees have now developed professional identities and feel secure in their skills and use of the self in therapy. Trainees now want to use the supervisor as a sounding board to test their own ideas about the patient, techniques, and the process of treatment.

The supervisory process now becomes a form of consultation, in which the trainee and supervisor share ideas and the trainee independently utilizes the supervisor's suggestions. The supervisory relationship is now that of junior and senior colleagues. Primary importance is placed on the supervisor's knowledge and expertise, rather than on personal characteristics, although the qualities of empathy and respect remain important as in any interpersonal relationship.

The validity of the first three stages of this developmental model was tested by comparing the preferences of beginning, intermediate, and advanced clinical psychology trainees for the three primary approaches to supervision and for specific types of supervisory relationships. The following hypotheses were proposed.

1. Beginning trainees will show a greater preference for the imitative approach to supervision than Intermediate and Advanced trainees.

2. Intermediate level trainees will show a greater preference for the didactic patient-centered approach to supervision than Beginning and Advanced trainees.

3. Advanced trainees will show a greater preference for the therapist-centered approach to supervision than Beginning and Intermediate trainees.

4. The preferred type of supervisory relationship will change in a linear fashion according to level of

experience. Beginning trainees will prefer a relationship characterized by support, directiveness, allowance of dependence, and provision of positive feedback without focus on errors. Advanced trainees will prefer a relationship in which the supervisor encourages independence, identifies their errors, is less directive, and provides less support. Intermediate trainees will prefer a relationship with characteristics between these two extremes.

In addition to testing a developmental model, this study examined the views of trainees regarding the exploration of their own personal conflicts within the context of supervision, and regarding methods of coping with problems in the supervisory relationship. These areas were assessed in an exploratory manner, and specific hypotheses were not proposed.

METHOD

Subjects

Subjects were 159 graduate students in clinical psychology who were enrolled in A.P.A. approved Ph.D. programs at universities in Illinois, or who were receiving internship training at A.P.A. approved facilities in the Chicago area. The sample consisted of 40 first year graduate students, 33 second year graduate students, 43 third year graduate students, and 43 interns. Seventy-eight of the subjects were male and 81 were female. Their age range was from 21 to 46 years, with a mean age of 26.8.

After data was collected from all subjects, they were assigned to three separate groups based on their levels of graduate training and clinical experience. In order to obtain homogeneous groups, subjects were excluded if they had entered their Ph.D. programs with previous Master's degrees in clinical psychology, counseling psychology, educational psychology, or social work, or if they had previous work experience in conducting psychotherapy. The criteria for assignment to each group were as follows.

1. The Beginning group consisted of first year graduate students who had received less than 550 hours of graduate level practicum or clerkship training. There were 27 subjects in this group; 12 males and 15 females, with a mean age of 24.4 years. The Beginning group represented students beginning or in the middle of their first practicum or clerkship training.

2. The Intermediate group consisted of second and third year graduate students who had received between 550 and 1,550 hours of graduate level practicum or clerkship training. Twenty-six subjects were in this group: 12 males and 14 females, with a mean age of 25.4 years. The Intermediate group represented students on a second or third training experience prior to internship.

3. The Advanced group consisted of students receiving internship training who had experienced more than 1,550 hours of applied training during the Ph.D. program. There were 28 subjects in this group: 15 males and 13 females, with a mean age of 28.4 years. The Advanced group represented students in the middle of their internship training.

The groups of Beginning, Intermediate, and Advanced trainees composed the sample used to examine the major hypotheses of this study regarding a developmental model of supervision. Responses from the total sample of 159 subjects were used in the analyses for the exploratory

portions of this study, which examined the views of trainees regarding personal conflicts and conflicts between supervisor and trainee. A complete description of the characteristics of the total sample and of the subjects in each group is presented in Appendix A.

Supervision of Psychotherapy Questionnaire

A questionnaire was specifically developed for this study, based on instruments used in previous studies of supervision (Kadushin, 1974; Nash, 1975; Lewis et al., Note 1). This questionnaire consisted of six sections. Section A contained items designed to collect demographic data on each subject, such as age, sex, amount of training experience, and theoretical orientation. The rest of the questionnaire examined students' views regarding the individual supervision of individual psychotherapy cases.

Section B of the questionnaire assessed trainees' views of the three primary approaches to supervision. The items described possible goals of supervision, which represented specific aspects of the imitative approach (e.g., "Learning specific therapeutic interventions that I can immediately use with my patients/clients"), the didactic patient-centered approach (e.g., "Learning to understand the problems, needs, behavior and/or dynamics of patients/clients"), and the therapist-centered approach (e.g., "Developing self-awareness of my reactions to patients/

clients"). The items were grouped to form a scale for each approach. Trainees were asked to select the three goals which were most important to them and the three which were least important.

Section C assessed trainees' views regarding the importance of those characteristics of the supervisory relationship which are hypothesized to change over the course of training. Descriptions of two supervisors were presented. One consisted of the characteristics which are predicted to be important at the beginning of training and the other consisted of the characteristics which are proposed to be important to advanced trainees. Students were asked to indicate their view of the ideal supervisor on a 7-point scale, with each description representing one pole of the scale.

Section D of the questionnaire provided an alternate method for assessing both the approach to supervision which trainees find most helpful and the characteristics of the supervisory relationship which are most important to trainees. Items were constructed as statements, and most represented specific aspects of the three approaches to supervision. For example, an imitative item was "The most important thing that a supervisor can do is to display behavior and responses that I can imitate in conducting therapy," a patient-centered item was "The primary focus of supervision should be on teaching general thera-

peutic techniques that can be used with many patients/ clients," and a therapist-centered item was "The most important thing that a supervisor can do is to help me identify and resolve my characteristic problems and blind spots in working as a therapist." These items were grouped to form a scale for each approach. Other items represented the aspects of the supervisory relationship which are hypothesized to change over the course of training (for example, "The ideal supervisor is very supportive"). Trainees used a 5-point Likert-type scale to rate their level of agreement with each item.

Section E of the questionnaire examined trainees' views regarding the exploration of personal conflicts within the context of supervision. Each item described a hypothetical situation which portrayed a different type of personal conflict. Trainees were presented with a group of set alternatives which described different degrees of exploration, and asked to select the response they would prefer from a supervisor in each situation. Section F explored trainees' views and experiences regarding methods of handling conflicts between supervisor and trainee. Structured items and open-ended questions were used. The complete questionnaire and the composition of the scales used for each approach to supervision are presented in Appendix B.

The Supervision of Psychotherapy Questionnaire was

developed in the following manner. First, based on previous questionnaires and on the theoretical literature, items were written which referred to aspects of the three approaches to supervision and to characteristics of the supervisory relationship. Each item was written in the form of a statement to be used with a Likert-type scale. The face validity and clarity of these items was then assessed. Descriptions of the proposed three stages of training were given to 19 clinical psychologists who were faculty members at Loyola University. These descriptions presented the approach to supervision and important characteristics of the supervisory relationship at each stage. A form containing the items was also given to the faculty members. They were asked to read each item and indicate the stage of training which it described. Ten faculty members returned this form. All items which were not rated as referring to the correct stage by at least 80 percent of the respondents were discarded. In addition, a few items were rephrased in order to improve their clarity. Of the remaining items, 18 which referred to the approaches to supervision were selected for inclusion in the Likert-type scale (Section D). Each approach to supervision was represented by a scale consisting of six items, with half of the items phrased in the negative direction. A subset of these items was rephrased and included in Section B in a different format. Nine items

were used, with three composing the scale for each approach. All remaining items which referred to characteristics of the supervisory relationship were included in the Likert-type scale (Section D). There were five of these items, and two were phrased in the negative direction. These items were rephrased and combined for the descriptions of the two supervisors used in Section C. Items for the two exploratory sections of the questionnaire (E and F) were constructed based solely on previous instruments and on the experimenter's own experiences.

The questionnaire derived from this procedure was then administered to 10 graduate students in clinical psychology who had completed internship training and would not participate as subjects in the study. While completing the questionnaire, students were asked to indicate any items which were unclear, to suggest additional response categories for specific items, and to provide any other comments or criticisms. Based on their suggestions, certain items were changed in order to improve their clarity and ease of response. The resultant version of the questionnaire was used in this study.

Procedure

Prior to any contact with subjects, the experimenter contacted the director of the clinical psychology division at each of the seven A.P.A. approved graduate

programs in Illinois, and the director of clinical psychology training at each of the 10 A.P.A. approved internship programs in the Chicago area. The purpose and procedures of the study were explained, and permission was obtained to ask students to participate in the study. All of the graduate schools and internship sites agreed to participate in this study.

The following procedure was used for questionnaire administration at all of the internship sites and at three of the graduate schools. The experimenter arranged with the appropriate staff person to go to a psychology seminar at each internship site and to seminars or core courses at each graduate school. At each class and seminar, the study was briefly explained to the students and their participation was requested. Any questions were then answered, and the questionnaire was distributed to all students who chose to participate. Subjects were asked to return the completed questionnaire to a specified person (generally a secretary) by a certain date. If the return rate for the questionnaires was less than 70 percent on that date, the experimenter posted a notice reminding the students about the study and returned once again to collect any additional questionnaires.

A slightly different procedure was used at the other four graduate schools. It was not possible for the

experimenter to personally go to these schools in order to speak to students. Therefore, distribution of the questionnaires was conducted by a clinical psychology faculty member or graduate student at each school. A cover letter which briefly described the study was attached to each questionnaire, and they were distributed either personally or by being placed in students' mailboxes. Subjects were again asked to return the completed questionnaires to a specified person by a certain date, and a reminder notice was posted if the initial return rate was low.

Of the 246 questionnaires which were distributed at all of the graduate schools and internship sites, a total of 167, or 67.9 percent, were returned to the experimenter. Eight of these questionnaires were not included in the sample; three of these were completed by postdoctoral interns, three by interns who were enrolled in graduate programs other than clinical psychology, and two by fourth year graduate students. Thus, the total sample consisted of 159 subjects.

The return rate for the questionnaire was very different at graduate schools than at internship sites. At internship facilities, 87.5 percent of the distributed questionnaires were returned to the experimenter, while 62.1 percent of those distributed at graduate schools were

returned. No major differences were apparent among the return rates for first, second, and third year graduate students (61.5 percent, 56.9 percent, and 66.2 percent, respectively). Return rates were slightly higher at graduate schools where questionnaire distribution was conducted personally, either by the experimenter or by another person, than at schools where questionnaires were distributed by being placed in students' mailboxes. Return rates were 65.2 percent and 55.2 percent, respectively.

RESULTS

The Developmental Model

Approach to Supervision. The following statistical procedures were used to compare the responses of the Beginning, Intermediate, and Advanced groups in terms of their endorsements of each approach to supervision. For Section D, the Likert-type scale, ratings of all negatively phrased items were first converted to the positive direction. Each subject's ratings of the six items which composed the scale for each approach were then added, in order to derive a total score for each approach scale. These total scores were used as the dependent variables in three separate one-way analyses of variance, with Group as the independent variable in each analysis. The first one-way analysis of variance examined scores on the Imitative Scale, the second analyzed scores on the Patient-Centered Scale, and the third analyzed scores on the Therapist-Centered Scale. Planned comparisons of the group which was hypothesized to endorse each approach with the other two groups were also used for all three analyses.

Similar procedures were used for Section B of the questionnaire, which also assessed trainees' views

regarding the three approaches to supervision. Trainees' rankings of the items in this section were converted to a 3-point scale rating each item as most important (3), somewhat important (2), or least important (1). A total score for the three items on each approach scale was computed. These three scores were used as the dependent variables in three separate one-way analyses of variance, with Group as the independent variable in each analysis. Planned comparisons of the groups were also computed.

The one-way analysis of variance on Section D Imitative Scale scores revealed no significant overall differences among the three groups of subjects. However, a planned comparison of the Beginning group with the other two groups of trainees revealed a trend towards differing endorsements of this approach, $t(76) = 1.24$, $p < .10$, one-tailed test. Beginning trainees showed higher scores on the Imitative Scale than did Intermediate and Advanced trainees. Results for the Section B Imitative Scale were consistent with the results for Section D. No overall differences among the three groups were found in the one-way analysis of variance, while a planned comparison revealed a trend towards a difference between the Beginning group and the Intermediate and Advanced groups, $t(73) = 1.29$, $p < .10$, one-tailed test. The Beginning trainees again showed a greater endorsement of the imitative approach to supervision than the other groups.

Imitative Scale scores for each group are presented in Table 1.

The one-way analysis of variance on Section D Patient-Centered Scale scores revealed a trend towards differing endorsements of this approach by each group, $F(2,77) = 2.87$, $p < .06$. However, the planned comparison did not indicate that the Intermediate group showed the greatest preference for the patient-centered approach, as had been predicted. Intermediate level trainees showed lower scores on the Patient-Centered Scale than the Beginning or Advanced trainees. No differences among the groups were found in the analyses of the Section B Patient-Centered Scale. Patient-Centered Scale scores for each group are presented in Table 2.

Significant differences among the three groups of subjects were found in the one-way analysis of variance on the Section D Therapist-Centered Scale, $F(2,75) = 3.04$, $p < .05$. A planned comparison of the Advanced group with the Beginning and Intermediate groups revealed a significant difference on this scale, $t(75) = 1.67$, $p < .05$, one-tailed test. The Advanced trainees showed significantly greater endorsement of the Therapist-Centered Scale than the other trainees. However, it should be noted that this seemed to be primarily due to the difference in scores between the Advanced students and the Beginning students. Beginners showed less preference

Table 1

Imitative Scale Scores by Level of Experience

Group	Section D[a]		Section B[b]	
	Mean	S.D.	Mean	S.D.
Beginning	19.23	3.47	5.04	1.07
Intermediate	18.12	3.24	4.48	1.16
Advanced	18.43	2.94	4.82	1.39

[a]The range of possible scores was from 6 to 30.

[b]The range of possible scores was from 3 to 9.

Table 2

Patient-Centered Scale Scores by Level of Experience

Group	Section D[a]		Section B[b]	
	Mean	S.D.	Mean	S.D.
Beginning	21.00	2.51	6.78	1.17
Intermediate	20.46	2.44	6.88	1.05
Advanced	22.21	3.22	6.71	1.54

[a]The range of possible scores was from 6 to 30.

[b]The range of possible scores was from 3 to 9.

for the therapist-centered approach than more advanced students. These results were not confirmed by the Section B Therapist-Centered Scale. No differences among the three groups were found in the analyses of these scale scores. Therapist-Centered Scale scores for each group are presented in Table 3.

Thus, the results indicated that Beginning trainees showed the greatest preference for the imitative approach to supervision, and endorsement of this approach tended to decrease at higher levels of experience. Endorsement of the therapist-centered approach to supervision tended to increase as trainees gained experience, so that Advanced trainees showed the greatest preference for this approach. Endorsement of a patient-centered approach to supervision did not seem to be meaningfully related to a student's level of experience.

Characteristics of the Supervisory Relationship. The following statistical analyses were used to compare the responses of Beginning, Intermediate, and Advanced trainees in terms of their views of the importance of specific characteristics of the supervisory relationship. Subjects' ratings of the ideal supervisor in Section C of the questionnaire were used as the dependent variable in a one-way analysis of variance, with Group as the independent variable. An analysis of linear trend was

Table 3

Therapist-Centered Scale Scores
by Level of Experience

Group	Section D[a]		Section B[b]	
	Mean	S.D.	Mean	S.D.
Beginning	21.68	3.61	6.26	1.10
Intermediate	23.40	3.07	6.64	1.32
Advanced	23.86	3.34	6.46	1.73

[a]The range of possible scores was from 6 to 30.

[b]The range of possible scores was from 3 to 9.

also computed. This determined whether the importance of a group of characteristics of the supervisor changes in a linear fashion over the course of training, as hypothesized. Similar procedures were used with the five items which referred to the supervisory relationship in Section D, the Likert-type scale. Item ratings were first converted to the positive direction. Subjects' ratings of these items were then used as the dependent variables in five separate one-way analyses of variance, with Group as the independent variable in each analysis. Analyses of linear trend were also computed. These analyses assessed changes in specific aspects of the supervisory relationship independent of changes in other aspects.

The one-way analysis of variance on Section C scores revealed a significant difference among the three groups in terms of the characteristics of the supervisory relationship which were important to them, $F(2,77) = 12.46$, $p < .001$. An analysis of linear trend revealed that the type of supervisory relationship which was preferred changed in a linear fashion according to level of experience, $F(1,77) = 22.75$, $p < .001$. The Beginning group preferred a supervisor with more of the characteristics ascribed to Supervisor A than did the other two groups, while the Advanced group preferred a supervisor closer to Supervisor B. The Intermediate group fell between the other two, although closer to the Advanced

students. Thus, the characteristics of support, direction, provision of positive feedback, and no focus on errors were more important to Beginning trainees than to those with more experience. At increased levels of experience, trainees placed less emphasis on support and direction, while preferring that a supervisor encourage their independence and point out their errors. The scores for each group on Section C are presented in Table 4.

In order to independently consider specific characteristics, one-way analyses of variance with analyses of linear trend were also computed for the items in Section D which referred to the supervisory relationship. These analyses revealed significant linear differences among the three groups of subjects in endorsement of a supervisor being directive, $F(1,78) = 3.87$, $p < .05$, and providing positive feedback without focusing on errors, $F(1,78) = 6.16$, $p < .02$. Beginning students showed the most preference for these characteristics, and endorsement decreased at higher levels of experience. Significant linear differences among the groups were also found in endorsement of a supervisor allowing the trainee's dependence, $F(1,78) = 4.19$, $p < .04$. However, the direction of this difference was not as predicted; the Advanced students showed the highest scores on this item, while the Beginning students showed the lowest scores. No differences among the groups were found in

Table 4

Characteristics of the Supervisory Relationship by Level of Experience

Item		Group		
		Beginning	Intermediate	Advanced
Section C Total Score	Mean	4.22	5.31	5.63
	S.D.	1.37	.97	.84
Supportive	Mean	3.63	3.39	3.32
	S.D.	1.01	.85	.98
Directive	Mean	2.74	2.54	2.29
	S.D.	.76	.86	.94
Allows Dependence	Mean	2.44	2.65	3.04
	S.D.	1.01	1.06	1.14
Encourages Independence	Mean	4.62	4.54	4.61
	S.D.	.50	.51	.50
Provides Positive Feedback and No Focus on Errors	Mean	2.22	1.89	1.68
	S.D.	.93	.77	.72

Note. The range of possible scores was from 1 to 7 for the Section C Total Score and from 1 to 5 for all other items.

endorsement of a supervisor being supportive or encouraging the trainee's independence. These characteristics of the supervisory relationship were the ones which were most important to students regardless of level of experience. Item scores for each group are presented in Table 4.

Theoretical Orientation

No specific hypotheses were proposed in this study regarding the effects of theoretical orientation. However, it was decided to conduct a post hoc exploration of the effect of a trainee's theoretical orientation on preference for each approach to supervision, as specific approaches are more closely related in the literature to certain orientations than to others. For example, the major proponents of the therapist-centered approach are authors who hold a psychoanalytic orientation. The patient-centered approach is stressed by authors with a behavioral orientation, as well as by some who are analytically oriented.

In order to assess the effects of theoretical orientation, Beginning, Intermediate, and Advanced students were assigned to groups based only on orientation. Three groups were compared. The psychoanalytic/psychodynamic group consisted of 28 subjects, the behavioral group consisted of 12 subjects, and the eclectic

group consisted of 34 subjects. The number of trainees holding other orientations was too small to permit meaningful comparisons. Six one-way analyses of variance were computed, with scores on the Section B and D Imitative, Patient-Centered, and Therapist-Centered Scales as the dependent variables. Orientation was the independent variable in each analysis. Post hoc comparisons of the Orientation groups were also computed.

It was not possible to assess the interaction of level of experience and theoretical orientation, as the two variables appeared to be related. The percentage of trainees who held a psychoanalytic or psychodynamic orientation continually increased from the Beginning group to the Intermediate group to the Advanced group, while the percentage holding behavioral and eclectic orientations decreased as level of experience increased. (A description of the percentage of students in each group who held each orientation is presented in Appendix A.) Therefore, it was not appropriate to conduct a completely crossed factorial analysis of variance which would assess the interaction of these two factors, and separate analyses were computed.

The one-way analysis of variance on Section D Imitative Scale scores revealed a significant effect of orientation, $F(2,70) = 8.74$, $p < .001$. A post hoc comparison of Orientation groups by a Newman-Keuls Multiple

Range Test revealed that students holding behavioral and eclectic orientations showed significantly higher scores on the Imitative Scale than did students with a psychoanalytic or psychodynamic orientation, $p < .05$. Behavioral and eclectic students did not differ. These results received some support from the findings on the Section B Imitative Scale. The one-way analysis of variance revealed a trend towards a difference among Orientation groups in their endorsement of this approach, $F(2,67) = 2.80$, $p < .07$. Inspection of the means indicated that the psychoanalytic/psychodynamic group again showed the least preference for the imitative approach. The eclectic group showed a slightly greater endorsement, while the behavioral group showed the most endorsement of this approach. Imitative Scale scores for students holding each of these theoretical orientations are presented in Table 5.

No significant effects of theoretical orientation were found in the one-way analyses of variance on the Section D and Section B Patient-Centered Scales. Scores on these scales are presented in Table 6.

A significant effect of orientation was found in the one-way analysis of variance on Section D Therapist-Centered Scale scores, $F(2,69) = 10.72$, $p < .001$. A Newman-Keuls Multiple Range Test revealed that trainees with eclectic and psychoanalytic/psychodynamic orientations showed significantly more preference for this approach

Table 5

Imitative Scale Scores by Orientation

Orientation	Section D[a]		Section B[b]	
	Mean	S.D.	Mean	S.D.
Psychoanalytic/ Psychodynamic	16.79	2.50	4.50	1.29
Behavioral	20.00	3.16	5.50	1.24
Eclectic	19.55	3.07	4.87	1.17

[a]The range of possible scores was from 6 to 30.

[b]The range of possible scores was from 3 to 9.

Table 6

Patient-Centered Scale Scores by Orientation

Orientation	Section D[a]		Section B[b]	
	Mean	S.D.	Mean	S.D.
Psychoanalytic/ Psychodynamic	21.46	2.82	6.68	1.16
Behavioral	22.33	3.08	7.25	1.76
Eclectic	20.82	2.83	6.67	1.24

[a]The range of possible scores was from 6 to 30.

[b]The range of possible scores was from 3 to 9.

than did students with a behavioral orientation, $p < .05$. The first two groups did not differ significantly, although scores tended to be higher for psychoanalytic/psychodynamic students. The results for the Section B Therapist-Centered Scale were consistent with those for Section D. The one-way analysis of variance revealed a significant effect of orientation, $F(2,67) = 4.28$, $p < .02$. A Newman-Keuls Multiple Range Test again revealed that the eclectic and psychoanalytic/psychodynamic groups showed significantly higher scores on this scale than the behavioral group, $p < .05$. The first two groups did not differ. Therapist-Centered Scale scores are presented in Table 7.

Thus, the results indicated that theoretical orientation had a significant effect on preference for an imitative or therapist-centered approach to supervision. Students who held behavioral and eclectic orientations tended to show a greater preference for the imitative model than those who held a psychoanalytic or psychodynamic orientation. Trainees with a psychoanalytic or psychodynamic orientation and those who are eclectic showed a greater endorsement of the therapist-centered approach than did those with a behavioral orientation. Preference for the patient-centered approach was not significantly related to theoretical orientation.

Table 7

Therapist-Centered Scale Scores
by Orientation

Orientation	Section D[a]		Section B[b]	
	Mean	S.D.	Mean	S.D.
Psychoanalytic/ Psychodynamic	24.36	2.74	6.82	1.39
Behavioral	19.67	3.96	5.42	1.68
Eclectic	22.84	2.67	6.47	1.28

[a]The range of possible scores was from 6 to 30.

[b]The range of possible scores was from 3 to 9.

Validity of the Approach Scales

The scales which assessed endorsement of the imitative, patient-centered, and therapist-centered approaches to supervision were used for the first time in this study. Therefore, an additional analysis was computed in order to examine the internal validity of the scales. A factor analysis with varimax rotation was computed on data from Section D, the Likert-type scale. A three factor solution was specified. Ratings of all 18 items which comprised the three approach scales were included in this analysis, and data from the total sample was used. This analysis determined whether these items actually grouped together into the three dimensions represented by the approach scales. A similar analysis was not computed for the Section B approach scales, as they consisted of a subset of the Section D items.

The first factor described a therapist-centered approach to supervision. Five of the six items on the Therapist-Centered Scale had higher loadings on Factor 1 than on the other two factors. The remaining item on the Therapist-Centered Scale (Item 18) also had a high loading on this factor, although it also tapped aspects of the dimension represented by Factor 3. None of the items on either the Imitative or Patient-Centered Scales showed a strong positive relationship to the dimension reflected by this factor.

Factor 2 described an approach to supervision which was quite similar to the imitative approach. All of the items on the Imitative Scale had their highest loadings on this factor. In addition, one of the Patient-Centered items (Item 3) was more strongly related to Factor 2 than to the other factors. This item stressed the importance of teaching general therapeutic techniques that can be used with many patients. None of the other items on the Patient-Centered Scale or any on the Therapist-Centered Scale had a strong positive relationship to this factor.

Factor 3 described an approach to supervision which was similar to the patient-centered approach. The remaining five items on the Patient-Centered Scale had their highest loadings on this factor. In addition, one of the items on the Therapist-Centered Scale (Item 18) had a stronger relationship to this factor than to the others, although it also tapped aspects of the dimension represented by Factor 1. This item concerned the importance of discussing the transference and countertransference issues involved in actual relationships with patients. None of the other items on the Therapist-Centered Scale or any on the Imitative Scale had a strong positive relationship to this factor. The factor structure matrix is presented in Table 8.

Thus, strong support was found for the internal validity of two of the approach scales. The Therapist-

Table 8

Factors Derived from the Section D Approach Scales

Item Number	Factor 1	Factor 2	Factor 3
Imitative Scale			
5	.1758	.3759	-.1580
10	-.1191	.4977	-.0077
11	.1581	.3406	.2977
15	-.2519	.4245	.1998
17	.0580	.5534	.0261
19	-.2189	.4181	.3136
Patient-Centered Scale			
3	-.0549	.3763	.0262
7	.0315	.1713	.2097
12	-.3442	.1789	.4609
16	.0315	-.0907	.2481
21	-.1974	.1371	.2811
22	.0351	.0475	.4263
Therapist-Centered Scale			
2	.4404	-.0639	.0401
4	.4116	.0092	.0444
6	.3007	-.0710	.0212
9	.6852	.1120	-.0084
13	.4088	.0284	-.1003
18	.4799	-.3525	.5426
Eigenvalue	1.99	1.36	1.01

Centered Scale consisted of items which all measured aspects of the same theoretical dimension. The Imitative Scale also consisted of items which all tapped the same theoretical dimension. The Patient-Centered Scale was generally found to be valid, although it was a weaker scale than the other two. Five of the items on this scale measured aspects of a single theoretical dimension. However, the sixth item was more strongly related to the Imitative items than to the other Patient-Centered items. Therefore, its inclusion in the total score for this scale weakened its power to assess preference for a patient-centered approach, as a small portion of the scale actually reflected preference for a different type of approach to supervision.

Personal Conflicts

Trainees were presented with descriptions of five hypothetical situations, each of which portrayed a different type of personal conflict. They were asked to select the response they would prefer from a supervisor in each situation. Results from the total sample of students were examined (N = 157), and the responses of the Beginning (N = 27), Intermediate (N = 26), and Advanced (N = 28) groups were also compared. This area was examined in an exploratory manner, and specific hypotheses were not proposed. Therefore, the results are presented

in a descriptive fashion and statistical analyses of the data were not routinely conducted. However, when large differences among the groups were apparent, a chi-square test was used to analyze the results.

The first situation concerned the feelings of anxiety which are often experienced by beginning trainees; i.e., feeling anxious about work with patients and unsure of one's own competence as a therapist. Two different responses were preferred by large groups of students. Thirty-six percent of the total sample of trainees indicated that they would like the supervisor to identify these feelings and provide reassurance, while 40 percent preferred that the supervisor identify these feelings and help them to explore and resolve them. A small group of trainees (19 percent) also wanted the supervisor to identify the feelings and deal with them during supervision, but by giving a partial interpretation rather than extensively exploring the feelings with them.

Preference for each of these responses seemed to be related to trainees' levels of experience. When the conflict involved the anxiety felt at the beginning of training, students with more experience were more likely to feel that the supervisor should provide reassurance. Fifty percent of the Advanced group and 42 percent of the Intermediate group preferred this response, compared to only 26 percent of the Beginning group. Beginning students

were more liable to prefer that the supervisor help them to explore and resolve these feelings. This response was selected by 52 percent of the Beginning trainees, 35 percent of the Intermediate trainees, and 32 percent of the Advanced trainees. However, a chi-square test revealed that the difference among the groups in preferences for these two responses was not statistically significant. No other differences among Beginning, Intermediate, and Advanced students were noted. The percentage of students in the total sample and in each group that selected each response is presented in Table 9.

More consensus among students was apparent when the situation involved a trainee's difficulty in working with one patient due to countertransference issues. Almost all students wanted the supervisor to identify this problem and help them to understand its basis. Sixty-nine percent of the total sample of trainees felt that a supervisor should help them to explore and resolve this problem during supervision, while 28 percent felt that the supervisor should provide a partial interpretation but not engage in extensive exploration of the problem. No major differences in preferred response were found among Beginning, Intermediate, and Advanced trainees. The percentage of students that selected each response is shown in Table 10.

These responses were also preferred by many students when the situation involved difficulties in

Table 9

Preferred Supervisor Response to Beginning Anxiety

Supervisor's Response	Total Sample	Group		
		Beginning	Intermediate	Advanced
Neither Identify Nor Discuss	2%	7%	4%	-
Identify	1%	-	-	-
Identify and Reassure	36%	26%	42%	50%
Partial Interpretation	19%	15%	15%	18%
Explore and Resolve	40%	52%	35%	32%
Outside Help	2%	-	4%	-

Table 10

Preferred Supervisor Response to Problem with One Patient

Supervisor's Response	Total Sample	Group		
		Beginning	Intermediate	Advanced
Neither Identify Nor Discuss	1%	-	4%	-
Identify	-	-	-	-
Identify and Reassure	1%	4%	-	-
Partial Interpretation	28%	26%	19%	39%
Explore and Resolve	69%	70%	73%	61%
Outside Help	1%	-	4%	-

working with many patients, due to the trainee's characteristic blind spots or style of relating to others. The majority of students in the total sample (63 percent) wanted the supervisor to identify this problem and help them to explore and resolve it, while a smaller group (16 percent) preferred that the supervisor provide only a partial interpretation. However, a group of students felt that a different type of response was preferable when difficulties involved work with many patients. Nineteen percent of the trainees felt that the supervisor should identify this type of problem, but then refer them for outside help rather than working on the issues during supervisory sessions.

Trainees' levels of experience seemed to be related to the amount of conflict exploration which was preferred. Advanced students were more likely than the other groups to want the supervisor to provide a partial interpretation, rather than extensively exploring the problem. Twenty-five percent of the Advanced group preferred this response, while only 7 percent of the Beginning students and 8 percent of the Intermediate students did so. The Beginning students were most liable to prefer that the supervisor help them to explore and resolve this problem within supervisory sessions, and the percentage of students endorsing this response decreased at higher levels of experience. This response was selected

by 82 percent of the Beginning group, 72 percent of the Intermediate group, and 60 percent of the Advanced group. A chi-square test revealed, however, that these differences were not significant. No differences among the groups were noted in preferences for any of the other responses. The percentage of students in the total sample and in each group that selected each response is presented in Table 11.

Another type of personal conflict involved the relationship with the supervisor, rather than work with patients. When the situation involved difficulty in working with the supervisor due to transference issues on the part of the trainee, the majority of students in the total sample (61 percent) again preferred that the supervisor identify the problem and help them to explore and resolve it. A smaller group (16 percent) preferred the provision of a partial interpretation. However, a group of students (23 percent) did not agree with these responses, and their preferences were distributed among many other alternatives. No major differences in preferred response were found among Beginning, Intermediate, and Advanced trainees. The percentage of students that selected each response is presented in Table 12.

Responses were quite different when the situation involved problems which did not directly affect work with either patients or supervisor. Various views were pre-

Table 11

Preferred Supervisor Response to Problem with Many Patients

Supervisor's Response	Total Sample	Group		
		Beginning	Intermediate	Advanced
Neither Identify Nor Discuss	1%	-	-	-
Identify	-	-	-	-
Identify and Reassure	1%	4%	-	4%
Partial Interpretation	16%	7%	8%	25%
Explore and Resolve	63%	82%	72%	60%
Outside Help	19%	7%	20%	11%

Table 12

Preferred Supervisor Response to Problem with Supervisor

Supervisor's Response	Total[a] Sample	Group		
		Beginning	Intermediate	Advanced
Neither Identify Nor Discuss	6%	4%	4%	-
Identify	7%	7%	16%	7%
Identify and Reassure	3%	11%	-	4%
Partial Interpretation	16%	22%	16%	22%
Explore and Resolve	61%	56%	60%	67%
Outside Help	6%	-	4%	-

[a]One percent preferred both the provision of a partial interpretation and a referral for outside help.

sented regarding the preferred response if the supervisor was aware of problems in trainees' personal lives which were not affecting their functioning as therapists. Over half of the total sample (57 percent) felt that the supervisor should not identify or discuss these problems, unless the trainee chose to initiate a discussion. The remaining students felt that the supervisor should identify the problem. However, the specific responses which they preferred were distributed among many alternatives, with few students endorsing any exploration of these problems within supervision. No major differences among the Beginning, Intermediate, and Advanced groups were noted. The percentage of students that selected each response is shown in Table 13.

In summary, it was only when problems resided solely in trainees' personal lives, and did not affect their professional functioning, that a majority of students felt that the supervisor should not refer to the problem in any way. Students consistently felt that supervisors should identify their personal conflicts when they affected work with either patients or supervisor. However, the responses which were preferred in addition to identification depended on the specific type of conflict. When the conflict involved beginning anxiety, many students felt that the only additional response which was necessary was to provide reassurance, although

Table 13

Preferred Supervisor Response to Personal Problem

Supervisor's Response	Total Sample	Group		
		Beginning	Intermediate	Advanced
Neither Identify Nor Discuss	57%	56%	61%	57%
Identify	11%	11%	8%	7%
Identify and Reassure	11%	19%	8%	15%
Partial Interpretation	6%	7%	4%	7%
Explore and Resolve	4%	7%	4%	-
Outside Help	11%	-	15%	14%

others preferred greater exploration of the problem. Reassurance was not felt to be an appropriate response when the problem more directly affected actual work with patients or supervisor. Almost all students felt that countertransference difficulties with one patient should be dealt with in supervision to some extent, most often to the point of exploring and resolving the problem within supervisory sessions. When the difficulties affected work with many patients or with the supervisor, the majority of students again felt that the problem should be explored in supervision to some extent. However, subgroups of students preferred alternate responses in both situations, including referral to an outside source of help. No significant differences among the preferred responses of Beginning, Intermediate, and Advanced trainees were found for any type of conflict. Table 14 presents a comparison of the responses which were preferred by the total sample in each type of personal conflict.

Conflicts Between Supervisor and Trainee

The views and experiences of students regarding methods of handling conflicts between supervisor and trainee were examined in an exploratory manner. Results from the total sample of subjects were examined (N = 158), and responses were also compared according to the types of

Table 14

Preferred Supervisor Response in Each Type of Personal Conflict

Supervisor's Response	Type of Conflict: Beginning Anxiety	Problem with One Patient	Problem with Many Patients	Problem[a] with Supervisor	Personal Problem
Neither Identify Nor Discuss	2%	1%	1%	6%	57%
Identify	1%	-	-	7%	11%
Identify and Reassure	36%	1%	1%	3%	11%
Partial Interpretation	19%	28%	16%	16%	6%
Explore and Resolve	40%	69%	63%	61%	4%
Outside Help	2%	1%	19%	6%	11%

[a]One percent preferred both the provision of a partial interpretation and a referral for outside help.

conflicts which trainees had actually experienced. As with the other exploratory area of the study, the results are presented in a descriptive fashion and statistical tests were not routinely conducted. A chi-square test was used only when large differences were apparent.

Students were asked to indicate the response they would prefer from a supervisor if a conflict arose in the supervisory relationship. Results from the total sample of students were examined. All of the respondents indicated that they would want the supervisor to openly identify the conflict. Most of the students (86.1 percent) wanted the supervisor to identify the problem and discuss it with them, while a minority (13.9 percent) preferred that the supervisor identify the problem and then wait for them to initiate further discussion.

Subjects who had current or previous training in conducting psychotherapy were asked to indicate whether they had ever experienced a major conflict with a supervisor. Fifty-two of the respondents, or 38.8 percent, had experienced a major conflict which made it difficult for them to learn from supervision. These conflicts had various causes, including differences in theoretical orientation, differing views on appropriate therapeutic approach or techniques, difficulties with the supervisor's style of conducting supervision, and personality clashes or personal difficulties between supervisor and trainee.

The students who had experienced a supervisor-trainee conflict were asked to consider one such conflict. A large majority (76.9 percent) of these students indicated that they had discussed or attempted to discuss the conflict with their supervisors. These discussions were generally initiated by the trainee. Of those students who had discussed the conflict, 83.8 percent indicated that they had initiated the discussion, while 16.2 percent indicated that the discussion had been initiated by the supervisor. Discussion of the problem led to some improvement in the situation in over half of the cases. Of the trainees who had discussed the conflict, 32.5 percent reported that the discussion led to a workable relationship with the supervisor and it became an adequate training experience. Twenty-five percent of the students reported that the discussion led to resolution of the conflict and the training experience became an excellent one. However, the discussion did not lead to any improvement for the rest of the students. The situation remained the same after the discussion for 17.5 percent of the trainees, 10 percent reported that the situation became worse, and 10 percent indicated that the discussion led to a decision that they should change supervisors. (An additional 5 percent reported that they were still involved in the conflict situation and could not yet report an outcome of the discussion.)

Students were asked to indicate why the discussion was not helpful, if it had not led to any improvement in the situation. They selected as many reasons as were applicable. The most commonly selected reasons were that the supervisor did not change his or her behavior or views in the way that the student wished (47.8 percent), and that the supervisor felt that it was the trainee's own personal problem (43.5 percent). A small group of students (21.7 percent) felt that the supervisor had acted as though they were wrong and should change their views. Other reasons were indicated by smaller groups of students.

As was previously reported, 23.1 percent of the students who had experienced a conflict did not discuss the problem with the supervisor. These students were asked to indicate their reasons for not discussing the conflict, checking as many as were applicable. The most commonly selected reason was that the trainee thought a discussion would cause the supervisory relationship to become even more conflictual (66.7 percent). Students were also reluctant to discuss the conflict due to beliefs that the supervisor would act as though his or her own views were correct and the trainee was wrong (50 percent), and that the supervisor would label it as the trainee's personal problem (41.7 percent). Small groups of students thought that they might receive a

negative evaluation if they discussed the problem (33.3 percent), or that the supervisor would just deny that the problem existed (25 percent).

Many of the students who did not discuss the conflict sought the support of peers as an alternate way of dealing with the problem (66.7 percent). Small groups of students talked to another staff person about the conflict (33.3 percent), or changed supervisors without first discussing the reason with the original supervisor (16.7 percent). In terms of the effects of the undiscussed conflict on actual supervisory sessions, many students did not report that it led to any changes in their behavior during supervision. However, 33.3 percent of the students indicated that they censored the verbal reports or process notes given to the supervisor, so that areas which might lead to conflict were omitted, and 25 percent indicated that they appeared to comply with the supervisor but did what they wanted in therapy sessions.

The responses of students who had been involved in different types of conflicts were also compared, in order to determine whether the type of conflict influenced the method of coping with it or its resolution. Three categories of supervisor-trainee conflicts were compared. Subjects were assigned to these categories based on their written descriptions of the nature of their conflicts.

(Two students did not provide written descriptions and were not included in these analyses.)

The first category consisted of conflicts which were primarily due to differences between supervisor and trainee in theoretical orientation or views on appropriate therapeutic approach. Twenty percent of the students who described a conflict, or 10 trainees, reported that the conflict was of this type. The second category consisted of conflicts which primarily involved the supervisor's style of conducting supervision. Many of these conflicts involved dissatisfaction with the amount of direction or support which was provided by the supervisor. Thirty percent of the students, or 15 trainees, reported this type of conflict. The third category consisted of conflicts which were not directly related to different opinions about how to work with the patient or the supervisor, but rather primarily reflected a personality clash or personal issues on the part of trainee or supervisor. Fifty percent of the students who described a conflict, or 25 trainees, reported that the conflict was of this type.

Conflicts which involved differences in theoretical orientation or therapeutic approach were more often discussed than those which involved other issues. Ninety percent of the students who experienced conflicts involving orientation or approach had discussed the

problem with their supervisors. Of the students who experienced conflicts involving personality issues, 76 percent had discussed the conflict, while 66.7 percent of the students who had problems involving style of supervision had done so. However, a chi-square test which compared the number of students who discussed and did not discuss each type of conflict revealed that the differences by conflict type were not significant. Students, rather than supervisors, tended to initiate the discussion in all types of conflicts, with no major differences by conflict type. Trainees initiated the discussion in 87.5 percent of conflicts involving personality issues, in 80 percent of conflicts involving style of supervision, and in 77.8 percent of conflicts involving orientation or therapeutic approach.

Whether discussion of the conflict led to a successful outcome did seem to be influenced by the nature of the conflict. Conflicts involving the style of supervision were almost always resolved successfully. Of the students who had discussed this type of conflict with their supervisors, 60 percent reported that the supervisory relationship became an excellent one, while 30 percent reported that the discussion led to a workable relationship and an adequate training experience. The remaining 10 percent indicated that the situation remained the same after the discussion.

When the conflict involved theoretical orientation or therapeutic approach, a majority of students reported that discussion led to some improvement in the situation, but the effects were less positive than in style conflicts. Fifty percent of the students who discussed orientation/approach conflicts reported that the supervisory relationship became an adequate one after the discussion, while only 12.5 percent reported that the relationship became excellent. The remainder of the students indicated that the situation had remained the same or become worse.

Conflicts involving personality issues seemed to be the most difficult to resolve. Only 27.8 percent of the students who discussed this type of conflict reported that the relationship became adequate, and only 11.1 percent indicated that the discussion led to an excellent training experience. This was the only type of conflict in which discussion ever led to a mutual decision that the trainee should change supervisors. This outcome was reported by 22.2 percent of the students. The remaining students indicated that the situation had remained the same or become worse. The effects of discussion in each type of supervisor-trainee conflict are presented in Table 15.

A chi-square test was used to analyze these differences in the outcome of discussion by type of conflict.

Table 15

Effect of Discussion by Type of Supervisor-Trainee Conflict

Effect of Discussion	Type of Conflict		
	Orientation/ Approach	Style of Supervision	Personality Issues
Excellent	12.5%	60.0%	11.1%
Adequate	50.0%	30.0%	27.8%
Same	25.0%	10.0%	22.2%
Worse	12.5%	-	16.7%
Changed Supervisors	-	-	22.2%

The number of students who reported that the conflict was resolved (i.e., the supervisory relationship became adequate or excellent) and the number who reported that it was not resolved (i.e., the situation remained the same or became worse, or they changed supervisors) in each type of conflict were compared. Effects of the discussion were grouped together in this manner because a separate category for each possible outcome led to extremely small expected cell frequencies in many cells. The chi-square test revealed that the previously described differences in outcome of the discussion according to type of conflict were statistically significant, $\underline{X}^2(2) = 6.98$, $\underline{p} < .05$.

The reasons that students felt a discussion had not led to improvement in the situation were not analyzed by type of conflict, due to the small number of subjects in some groups who reported no improvement. Similarly, the number of students in each group who did not discuss the conflict was too small to allow for meaningful comparison of their reasons and alternate actions.

In summary, while all students indicated that they wanted supervisors to openly identify conflicts in the supervisory relationship, and the majority preferred that the supervisor also initiate a discussion of the problem, this rarely seemed to occur in actual conflict situations. Most conflicts were discussed, but in the great majority of cases these discussions were initiated by trainees.

Discussion of the problem was the method most often used to try to deal with actual conflict situations. This means of coping with the problem was successful in just over half of all the cases, and the effect of the discussion was significantly related to the type of conflict which was involved. A discussion almost always led to successful resolution of the conflict when the problem involved the supervisor's style of conducting supervision. It had less success in conflicts involving differences in orientation or approach, and the least success in conflicts involving personality issues. When conflicts with the supervisor were not discussed, many students sought the support of peers as an alternate way of coping with the problem. Some trainees also coped by censoring the reports they gave to the supervisor, and/or appearing to comply with the supervisor's suggestions while actually disregarding them.

DISCUSSION

The Developmental Model

This study tested a developmental model of supervision. It was proposed that the trainee's learning proceeds sequentially through several stages characterized by different needs and interests, and that effective supervision therefore entails changes in the approach used and in certain aspects of the supervisory relationship according to the level of experience of the trainee. It was hypothesized that a comparison of groups of students at different stages of training would reveal that Beginning trainees show the greatest preference for an imitative approach to supervision, Intermediate level trainees show the greatest preference for a didactic patient-centered approach, and Advanced trainees show the greatest preference for a therapist-centered approach. It was also hypothesized that the preferred type of supervisory relationship would change in a linear fashion as trainees gained experience.

Approach to Supervision. The results of this study provided support for the hypotheses concerning preference for the imitative and therapist-centered

approaches to supervision. Beginning trainees tended to have higher scores on both of the Imitative Scales than students in the Intermediate and Advanced groups. Advanced students had significantly higher scores on one of the Therapist-Centered Scales than the Beginning or Intermediate trainees. The hypothesis concerning preference for the patient-centered approach was not supported by the results of this study. Intermediate level trainees did not show a greater preference for this approach to supervision than students in the other groups.

It should be stressed that the findings did not indicate that only one approach to supervision was considered to be valuable by the Beginning and Advanced trainees. That is, Beginning trainees did not want supervisors to focus only on the content areas or use only the teaching techniques which constitute the imitative approach. Nor did Advanced trainees want the focus of supervision to be limited only to the content and techniques of the therapist-centered approach. Rather, the ideal method of supervision seems to be an integrative one which combines elements of all three approaches, with changes occurring in the relative importance of each approach in this totality as students gain experience. Relative to the other approaches, the content and techniques of the imitative approach should be given more emphasis in the supervision of beginning trainees than

in the supervision of more experienced students. Beginners place greater value on the type of learning provided by the imitative approach. Similarly, the goals and techniques of the therapist-centered approach should be given more emphasis relative to those of the other approaches when supervising advanced trainees than when supervising students with less experience, and especially beginners.

The results of this study confirm that beginning students want to learn specific therapeutic interventions to use with their patients, and value the supervisor's direct advice, suggestions, and modeling of appropriate techniques and responses. The results also confirm that the needs and interests of trainees change over the course of training. By an advanced stage, students are more concerned with developing self-awareness and a better utilization of their own personalities in conducting therapy, and value the supervisor's focus on transference and countertransference issues and exploration of their characteristic problems and blind spots. These results concerning developmental changes are consistent with the findings of Nash (1975) and Lewis et al. (Note 1). Nash reported that beginning trainees had a strong need for advice and direction from supervisors, while advanced trainees desired a focus on learning about their own personal functioning as therapists and on exploring countertransference issues. In examining the goals of trainees,

Lewis et al. found that an emphasis on skill acquisition and a utilization of the supervisor as a role model preceded a focus on developing a personal style of conducting therapy and examining the effect of one's own personality on the therapeutic interaction. Thus, all of the studies which examined developmental changes in the needs of trainees confirm Gaoni and Neumann's (1974) theoretical view that supervision of beginning students should focus on teaching specific techniques, while supervision of advanced students should focus on the development of the individual therapeutic personality of the trainee. An opposing theoretical view was proposed by Ekstein and Wallerstein (1972), who believe that a focus on the trainee's characteristic problems in relating to patient and supervisor should precede a focus on technique. Other authors state that a focus on the trainee's development of self-awareness and a personal style is most important at the beginning of training (Ornstein et al., 1976). These views have not been supported by any of the empirical studies.

This study found that another factor was also important in determining trainees' preferences for the approach used in supervision. Results indicated that theoretical orientation was related to preference for the imitative and therapist-centered approaches. Students who held behavioral and eclectic orientations were found to

have significantly higher scores on one Imitative Scale, and tended to have higher scores on the other Imitative Scale, than students who held a psychoanalytic or psychodynamic orientation. Trainees with a psychoanalytic or psychodynamic orientation and those who are eclectic had significantly higher scores on both of the Therapist-Centered Scales than trainees with a behavioral orientation.

Thus, level of experience and theoretical orientation were both found to affect trainees' preferences for the imitative and therapist-centered approaches to supervision. The effects of orientation were indicated in post hoc findings, and this study was not designed to answer the question of which factor is the major determinant of preference for the approach used in supervision. As was previously described, in this study it was not possible to assess the interaction of these two factors because they appeared to be related. The percentage of trainees who held a psychoanalytic or psychodynamic orientation increased from the Beginning group to the Intermediate group to the Advanced group, while the percentage holding behavioral and eclectic orientations decreased as level of experience increased.

It is not known whether the increased adherence to a psychoanalytic or psychodynamic viewpoint among more experienced students, and the corresponding decrease in

adherence to other orientations, reflects a common phenomenon among graduate students in clinical psychology or whether it reflects only the specific influence of the graduate school and internship programs included in this sample. If this is a common phenomenon, these factors may be completely intertwined so that an analysis of which is primary may not be possible. That is, the increased experience may be accompanied by a change in orientation, and then both of these factors may influence preference for greater focus on the content and techniques of a different approach. Further research should first assess whether developmental changes occur in preference for different theoretical orientations. If this is not the case, the relative influence of each of these factors on preference for different approaches to supervision should then be examined. For example, a future study could include larger groups of advanced students who are behavioral and eclectic and larger groups of beginning students who hold a psychoanalytic or psychodynamic viewpoint, and thereby assess the interaction of level of experience and theoretical orientation.

The possible effect of the specific measures used in this study should also be considered. Two measures were used to assess preference for each approach to supervision. The Section D Imitative, Patient-Centered, and Therapist-Centered Scales each consisted of six items

which represented aspects of that approach. Students used a 5-point Likert-type scale to rate their level of agreement with each item. The Section B Imitative, Patient-Centered, and Therapist-Centered Scales each consisted of three items which represented aspects of that approach. From all nine items, students selected the three which were most important to them and the three which were least important, and these rankings were converted to a 3-point rating scale. These approach scales were used for the first time in this study. Any flaws in the scales may have influenced the results. The face validity of all of the scales was confirmed prior to their use, and the internal validity of the Section D Imitative and Therapist-Centered Scales was strongly supported by the factor analysis conducted on data from the total sample. All of the items on each scale were found to measure aspects of the same theoretical dimension. However, the Section D Patient-Centered Scale was found to contain one item which did not tap the same theoretical dimension as the rest of the scale. Therefore, this scale was weaker than the other two and not entirely internally consistent. The results of this study did not support the hypothesis concerning the effect of level of experience on preference for a patient-centered approach, and in addition, theoretical orientation was not found to affect endorsement of this approach. These negative

results may have been due to the weakness of the scale, rather than accurately reflecting a lack of relationship between preference for a patient-centered approach and other variables. A refinement of this scale is necessary prior to its further use, which may then more accurately determine which variables affect preference for a patient-centered approach to supervision. The Section D Imitative and Therapist-Centered Scales are valid measures of these approaches and may be used in their current state.

The internal validity of the Section B approach scales was not assessed in a separate analysis because the items included in these scales were a subset of those used in Section D. However, it should be noted that the Section B Patient-Centered Scale contained an item comparable to the one Section D item which was found to be inconsistent with the rest of that Patient-Centered Scale. This item contributed even more to the total score on the Section B Scale, as it was one of only three items. Therefore, this scale is not a valid measure of the patient-centered approach, and it is not surprising that no relationship was found between scores on this scale and other variables.

The Section D scales appear to be more sensitive than those in Section B. In two of the four analyses conducted on scores on the Imitative and Therapist-Centered Scales, stronger differences among groups of

subjects were found when comparing their Section D scale scores than when comparing scores on the Section B scale. It is likely that this is due to the larger number of items included in each Section D scale. Each scale measured more aspects of the approach it represented. It thus provided a better assessment of overall agreement, as students may disagree with one specific aspect of an approach but otherwise endorse it. In addition, the wider range of scores possible on the Section D scales may add to their power.

One other problem with the Section B approach scales was also noted. The method of rating these scales involved a forced choice among the items, with students only being allowed to rate three items as most important to them. It is possible that students were hesitant to choose items which appeared to be related, i.e., items which actually represented aspects of one approach, as the only ones which were "most important." They may instead have tended to distribute this rating among dissimilar items, as aspects of every approach have some importance at each stage of training. This possibility was suggested by the written comments of a few students.

Thus, the Section D approach scales appear to be more useful and valid in assessing preference for different approaches to supervision. It is suggested that

these scales, or ones with a similar format, are most appropriate for use in future studies of supervision.

The factor analysis on the items comprising the Section D approach scales provided evidence concerning the internal validity of these scales. The results of the factor analysis may also suggest an alternate way to conceptualize the major approaches to supervision. The extraction of Factor 1 confirmed that students view the therapist-centered approach as an independent, theoretically consistent dimension. However, Factors 2 and 3 may be interpreted as representing dimensions of supervision which are different than the imitative and didactic patient-centered approaches. As was previously described, all of the Imitative Scale items had their highest loadings on Factor 2, which indicated that this scale was internally consistent. However, one of the Patient-Centered Scale items was also strongly related to this factor. This item stressed the importance of teaching general therapeutic techniques which may be used with many patients. The inclusion of this item with the Imitative Scale items suggests that the dimension reflected by Factor 2 may be more meaningfully conceptualized as describing an approach which focuses on teaching the technique of conducting therapy. This dimension includes obtaining general knowledge as well as learning about the appropriate interventions for specific circumstances. It

covers the supervisor's use of many methods for teaching the technical aspects of therapy, including modeling, providing advice, and engaging in didactic teaching.

In terms of Factor 3, the other five items on the Patient-Centered Scale had their highest loadings on this factor. One of the Therapist-Centered Scale items was also strongly related to this factor, as well as tapping aspects of the dimension reflected by Factor 1. This item concerned the importance of discussing the transference and countertransference issues involved in actual relationships with patients. While Patient-Centered Scale items are more strongly represented by this factor than by the other two, the dimension reflected by Factor 3 may be more meaningfully conceptualized as describing an approach which focuses on learning about the patient and the process of therapy. This dimension includes obtaining a practical and theoretical understanding of the patients' needs, behavior, and dynamics, and of the interpersonal aspects of the therapeutic relationship.

Based on the results of the factor analysis, it may therefore be meaningful to students to conceptualize approaches to supervision in a way other than that described by the imitative, patient-centered, and therapist-centered approaches. In this study, students seemed to view approaches to supervision in terms of a slightly different categorization. One approach described

a focus on teaching the techniques and specific interventions necessary for conducting psychotherapy, a second approach described a focus on learning about the patient and understanding the process of therapy, and a third approach described a focus on learning about and improving one's own personal functioning as a therapist. (The latter is the same as the therapist-centered approach.) This categorization as well as the one used in the current study should be examined in further research regarding trainees' preferences for different approaches to supervision.

Characteristics of the Supervisory Relationship. The results of this study provided support for the hypothesis concerning changes in the supervisory relationship according to level of experience. Two methods were used to assess preference for specific characteristics of the relationship. These characteristics were considered as a group by presenting descriptions of two supervisors, one consisting of the characteristics predicted to be important at the beginning of training and the other consisting of the characteristics predicted to be important at an advanced stage (Section C). Students indicated their view of the ideal supervisor on a 7-point rating scale, with each description representing one pole of the scale. These characteristics were also considered

separately in individual items which represented each aspect of the supervisory relationship (Section D). Students used a 5-point Likert-type scale to rate their level of agreement with each item, and the results for each were analyzed independently.

Significant linear differences among the groups were found in their preferences for certain characteristics of the supervisory relationship. When these characteristics were considered as a group, Beginning trainees, as hypothesized, placed the most importance on a supervisor's supportiveness, directiveness, and provision of positive feedback with no focus on errors. Preference for these aspects of the relationship decreased in a linear fashion at higher levels of experience, so that Advanced trainees placed the least importance on support and direction, while preferring that a supervisor encourage their independence and point out their errors. The independent analyses of preference for each of these characteristics revealed that the factors which significantly differentiated the groups were endorsement of a supervisor being directive and providing positive feedback without focus on errors. Beginning students had the highest scores on the items representing these factors, and scores decreased at higher levels of experience.

It should be stressed that while Beginning students differed from more advanced students in preference for a

supervisor being directive and providing positive feedback without focusing on errors, this was because the more advanced students were more negative about the value of these characteristics. Intermediate and Advanced trainees showed an aversion to supervisors displaying these characteristics, while Beginners tended to be neutral at best about their value. The aspect of the supervisory relationship which was most valued by students at all stages of training was the supervisor's encouragement of independent functioning, and the aspect next in importance was the supervisor's supportiveness.

The results of this study confirm some of the findings of Nash (1975) regarding preferred changes in the supervisory relationship. Nash also found that beginning students preferred greater directiveness on the part of the supervisor and less focus on their errors than students with more experience. The greater importance of directiveness in the supervision of beginning students than those with more training was proposed in the theoretical model of Gaoni and Neumann (1974).

Another factor which has often been described as especially important in the supervision of beginning students is the supervisor's provision of support. The importance of support for beginning trainees has been stressed by many authors (Barnat, 1973a, 1973b; Greben et al., 1973; Rosenblatt & Mayer, 1975; Tischler, 1968;

Wolberg, 1977; Zetzel, 1953), and one study noted that its importance tended to decrease as students gained experience (Lewis et al., Note 1). This study confirms that support is important for beginners, but not that it is only valued by this group of trainees. Rather, the supervisor's supportiveness was considered to be important by students at all stages of training.

Conclusions. The results of this study provide partial support for a developmental model of supervision. The importance of the imitative approach in the supervision of beginning students, and the importance of the therapist-centered approach in the supervision of advanced students were confirmed. However, the possibility that differences in preference for these approaches were primarily determined by theoretical orientation rather than by level of experience cannot be ruled out. The results also confirmed that changes occurred in preference for certain aspects of the supervisory relationship according to level of experience. Support was not found for hypotheses concerning the optimal approach with intermediate level students and concerning changes in other aspects of the supervisory relationship. Thus, Stages 1 and 3 in the proposed developmental sequence were found to be mostly valid descriptions of the needs and interests of beginning and advanced students. But based on these results, it is not possible to describe

the middle portion of training as a stage with different, well-defined characteristics.

The results do indicate that the needs and interests of students change over the course of training, and the types of changes which were found are consistent with the results from the two other studies in this area. Therefore, it appears that these developmental changes are phenomena which are not restricted to this sample. However, the generalizability of these results should continue to be assessed in further studies with different groups of trainees. A longitudinal study of trainees is especially needed, in which all developmental changes may be closely examined from the beginning of training through an advanced stage. This would particularly aid in determining what occurs during the middle portion of training.

This study and the previous studies do not provide proof that greater learning actually results from the use of differing approaches to supervision or from changes in aspects of the supervisory relationship at different stages of training. Rather, they presented students' own views of their learning needs. It is possible to argue, for example, that while beginning students prefer a greater focus on the specific interventions they should use with patients, they will actually learn more if they are convinced to examine their own impact on the therapeutic situation. Further research is necessary in order

to determine whether the use of a supervisory approach which reflects the stated needs and interests of a group of trainees actually leads to greater learning about psychotherapy and to better performance in subsequent work with patients. For example, future studies could assess the types of supervision which groups of students actually receive, and relate differences in approach to an objective measure of changes in students' therapeutic competence.

However, it would be unwise to disregard the views of trainees regarding supervision until more empirical evidence is collected. Trainees have definite ideas about their needs and the aspects of supervision which are most helpful to them at different points in their training. This direct information from trainees is a valuable resource which may be used to improve the quality of supervision. It is recommended that the needs and preferences of students be seriously considered, and that supervisors attempt to meet these needs. At the very least, this will lead to trainees viewing supervision as a positive and useful experience and facilitate greater receptivity to the process of learning. It is also suggested that the needs and interests of supervisors should be considered when trainees are assigned for supervision. Supervisors who prefer to focus on teaching techniques and specific interventions, or who are com-

fortable with providing advice, modeling, and much guidance to students may be best suited to supervise beginning trainees. Supervisors who have a great interest in transference and countertransference issues, or prefer to focus on the development of the therapeutic personality of the trainee may be best suited to supervise advanced trainees. Matching students and supervisors according to their needs and interests may lead to more productive and enjoyable supervisory experiences for both participants.

Personal Conflicts

This study also assessed trainees' views regarding the exploration of different types of personal conflicts within the context of supervision. This area was examined in an exploratory manner, and specific hypotheses were not proposed.

The results indicated that a majority of students felt that supervisors should not refer to problems in trainees' personal lives which do not affect their professional functioning. This was the only type of personal conflict in which most students did not desire any intervention by the supervisor. Students consistently felt that supervisors should identify their personal conflicts when they affected work with either patients or supervisor. However, the responses which were preferred in

addition to identification depended on the specific type of conflict. When the conflict involved the anxiety experienced at the beginning of training, many students felt that the only additional response which was necessary was to provide reassurance, although others preferred greater exploration of the problem during supervision. Reassurance was not felt to be an appropriate response when the problem more directly affected actual work with patients or supervisor. Almost all students felt that countertransference difficulties with one patient should be dealt with in supervision to some extent, most often to the point of exploring and resolving the problem within supervisory sessions. When the difficulties affected work with many patients or with the supervisor, the majority of students again felt that the problem should be explored in supervision to some extent. However, in each of these situations, subgroups of students preferred alternate responses by the supervisor, including referral to an outside source of help.

These results indicate that trainees ascribe to the view presented in the theoretical literature, which holds that any identification or exploration of conflicts should be confined to the trainee's professional functioning and not deal with problems in his or her personal life (Burgum et al., 1959; DeBell, 1963; Ekstein & Wallerstein, 1972; Escoll & Wood, 1967; Fleming & Benedek,

1966; Shapiro et al., 1973). These authors have presented various views regarding the extent of exploration which is appropriate in dealing with conflicts affecting professional functioning. But they have discussed personal conflicts as a group, and not considered whether the specific type of conflict should influence the supervisor's response. Surveys of trainees and anecdotal accounts have also considered the area of exploration of personal conflicts as a whole, rather than differentiating among various types of conflicts, and in addition, generally have not differentiated among possible levels of exploration by the supervisor (Barnat, 1973b; Kadushin, 1974; Rosenblatt & Mayer, 1975; Lewis et al., Note 1). The results of this study indicate that trainees feel that different types of conflicts call for different responses on the part of the supervisor. A general prescription regarding the need to just identify conflicts or to explore them to a specified degree appears to be an overly simplistic way to discuss this problematic area.

These results are also relevant to the question of preference for a therapist-centered approach to supervision. The therapist-centered approach differs from the other approaches in that it stresses the importance of a focus on the trainee's personal difficulties in all areas which affect professional functioning. Advanced trainees were found to show greater endorsement of the therapist-

centered approach than less advanced students, and especially than beginners. Therefore, it might be expected that the Advanced trainees also showed a greater tendency than the other groups to prefer that a supervisor help them to explore and resolve personal conflicts which affected work with patients or supervisor. However, this was not indicated by the results in this area. No significant differences were found among the groups of Beginning, Intermediate, and Advanced trainees in endorsement of a supervisor helping them to explore and resolve any type of conflict.

It is difficult to reconcile these results with the findings which indicated that Advanced students preferred more focus on the content and techniques of the therapist-centered approach to supervision. Perhaps the difference lies in the fact that the therapist-centered approach prescribes a general focus on the reactions and personal style of the trainee, while this section assessed a preference for that focus only in situations where actual problems were apparent. Thus, many students at all stages of training may feel that the focus should turn to the trainee when actual difficulties are apparent. But only Advanced students feel that this focus is helpful and consistent with their needs throughout most of supervision.

Conflicts Between Supervisor and Trainee

This study also assessed trainees' views and actual experiences regarding methods of handling conflicts between supervisor and trainee. This area was examined in an exploratory manner, and specific hypotheses were not proposed.

The results indicated that all of the students wanted supervisors to openly identify conflicts in the supervisory relationship whenever they were aware of their occurrence, and the majority preferred that the supervisor also initiate a discussion of the problem. However, this rarely seemed to occur in actual conflict situations. While most conflicts were discussed, in the great majority of cases these discussions were initiated by trainees, not by supervisors. It is not possible to determine, however, whether supervisors were reluctant to discuss these conflicts or whether they were simply unaware of the existence of problems in the supervisory relationship.

Fewer students in this sample indicated that they had actually experienced a conflict with a supervisor than was the case in the one previous study which examined this. Lewis et al. (Note 1) reported that 85 percent of the students in their sample had experienced a major conflict with a supervisor, while only 38.8 percent of this sample reported a conflict. This difference may be due

to the fact that Lewis et al. surveyed interns in clinical psychology, while this sample consisted of students with a broader range of experience. As many of the students in the current study had less experience, and therefore fewer encounters with supervisors, it is to be expected that fewer conflicts would be reported.

The results also indicated that discussing the problem with the supervisor was the method most often used to try to cope with actual conflict situations. In the current study, 76.9 percent of the students reported that they had discussed the conflict. This percentage is much higher than has been reported in previous research. Lewis et al. (Note 1) found that 60 percent of the interns in their sample who had experienced a conflict discussed it with the supervisor, while Rosenblatt and Mayer (1975) found that none of the social work students in their sample had done so. Discussion of the conflict is suggested in the literature as the necessary means of resolving the problem (Rioch et al., 1976; Shapiro et al., 1973; Wolberg, 1977). Surveys of trainees and their anecdotal accounts suggest that when conflicts are not discussed, students often become primarily concerned with concealing difficulties in their performance. They then closely monitor or distort their reports of case material, or conceal the conflict through appearing willing to

cooperate or comply with the supervisor (Barnat, 1973b; Nash, 1975; Rosenblatt & Mayer, 1975).

The present study confirmed that these responses often occur when conflicts remain undiscussed and unresolved. Some of the trainees who did not discuss the conflict reported that they coped by censoring the reports given to their supervisors, and/or appearing willing to comply with their suggestions while actually disregarding them. However, the results also indicated that discussion is not a general panacea for dealing with problems between supervisor and trainee. A discussion did not lead to resolution of the conflict in many cases, and the effect of discussion was significantly related to the type of conflict which was involved. A discussion almost always led to successful resolution of the conflict when the problem involved the supervisor's style of conducting supervision. It had less success in conflicts involving differences in theoretical orientation or therapeutic approach, and the least success in those involving personality issues, and in some cases led to the situation becoming worse.

It may be that discussion was most successful in conflicts which involved the style of supervision because the issues in this type of conflict are most circumscribed, and most liable to be confined to the specific interaction between supervisor and trainee. Conflicts

concerning orientation or approach involve work with patients and may affect the supervisor's or trainee's entire foundation for professional work. Conflicts involving personality issues may involve the individuals' characteristic styles of interaction with others or personal issues they do not want to explore or of which they are unaware. Therefore, it may be less threatening to both parties to consider conflicts involving style of supervision. And it may be easier to make actual changes in behavior in order to resolve the situation, as the extent of these changes is limited to specific supervisory sessions.

This study does suggest ways in which discussions may become more helpful. Many of the reasons which students selected as to why discussions were ineffective seemed to describe interactions in which supervisors ascribed the problem solely to the trainee, rather than considering their own contributions to the conflict. Another reason which was often given was that supervisors did not change their behavior or views to fit the desires of the trainees. It therefore appears that discussion is helpful only when both parties are willing to consider their own contributions to the conflict and discuss their views in a nondefensive manner. Discussions are not helpful, and may actually lead to a worsening of the situation, when either the supervisor or trainee ascribes the

problem solely to the other party and expects him or her to change, rather than viewing the conflict as interactional and requiring accommodation by both participants.

It should be noted that while discussion seems to be the major way to resolve conflicts, this may be impossible in certain cases. Particularly when conflicts involve personality clashes or pervasive personal issues, a resolution within the supervisory relationship may not be possible. Students reported that discussion of these types of conflicts sometimes led to a mutual decision that they should change supervisors. This solution never occurred in other types of conflicts. While changing supervisors does indicate that the original conflict was not resolved, this may not mean that the discussion led to a negative outcome. It may well be that it is impossible to resolve certain conflicts which involve personality issues, and that a change of supervisors is the best or only way to deal with this type of situation.

It should also be stressed that supervisors need to be attuned to the subjective experiences of trainees if they wish to become aware of conflicts in the supervisory relationship and successfully cope with them. This study did not specify objective criteria as to what constitutes a conflict, but just asked students to indicate whether they had experienced "a major conflict which made it difficult to learn from supervision." A number of

students commented that they had experienced problematic situations with supervisors, but had not considered them to be major difficulties or impediments to their learning. Some of these problems were similar to those described by others as major conflicts. This indicates that the same situation may be experienced as a major conflict by one trainee, and viewed by another as only a minor annoyance not requiring correction. It is therefore stressed that each trainee will experience the supervisory relationship in a different way, and supervisors need to be attuned to their individual experiences rather than just to objective considerations of what constitutes a problem.

SUMMARY

This study examined a developmental model for the supervision of psychotherapy. It was proposed that the trainee's learning proceeds sequentially through several stages characterized by different needs and interests, and that effective supervision therefore entails changes in the approach used and in certain aspects of the supervisory relationship according to the level of experience of the trainee. It was hypothesized that Beginning trainees would show the greatest preference for an imitative approach to supervision, which emphasizes learning specific interventions and the supervisor's function as a role model. Intermediate level trainees would show the greatest preference for a didactic patient-centered approach, which emphasizes direct teaching of dynamics, theory, and technique. Advanced trainees would show the greatest preference for a therapist-centered approach, which emphasizes exploration and resolution of the trainee's difficulties in functioning as a therapist. It was also hypothesized that Beginning trainees would prefer a relationship in which the supervisor was supportive, directive, allowed dependence, and provided positive feedback without focus on errors, and that preference for

these characteristics would decrease in a linear fashion at higher levels of experience.

One hundred and fifty-nine graduate students in clinical psychology participated in this study. Each subject completed a Supervision of Psychotherapy Questionnaire. This questionnaire consisted of Imitative, Patient-Centered, and Therapist-Centered Scales which assessed endorsement of each approach to supervision, and scales which assessed preference for specific characteristics of the supervisory relationship. The scores of groups of 27 Beginning, 26 Intermediate, and 28 Advanced trainees were compared in order to test the hypotheses regarding developmental changes.

Additional portions of the questionnaire examined two problematic aspects of supervision in an exploratory manner. These were the exploration of the trainee's personal conflicts, and methods of handling conflicts between supervisor and trainee. Responses from the total sample of students were examined for these portions of the study. The views and experiences of students were presented in a descriptive fashion in terms of the different types of conflicts which may arise.

The results of this study provided partial support for the developmental model. Beginning trainees tended to have higher scores on the Imitative Scale than more advanced students, indicating greater preference for this

approach to supervision. Advanced trainees had significantly higher scores on the Therapist-Centered Scale than less experienced students, indicating greater preference for the therapist-centered approach. In addition, significant linear differences among the groups were found in preference for certain aspects of the supervisory relationship. Beginning students preferred a greater amount of direction from supervisors and less focus on their errors than more advanced students. Intermediate trainees were not found to have higher scores on the Patient-Centered Scale, as was hypothesized, and no strong differences among the groups were found in preference for a supervisor providing support or allowing dependence versus encouraging independence.

This study therefore provided partial support for the developmental model of supervision. It supported the concept of developmental changes in trainees' preferences regarding supervision, and especially described the needs and interests of students at the beginning and advanced stages of training. This suggests that supervision should change in specified ways according to the level of experience of the supervisee. Students may learn more readily if supervision addresses the issues which are most important to them at each stage of training, and emphasizes the type of learning which they consider to be necessary and are most able to utilize.

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APPENDIX A

CHARACTERISTICS OF SUBJECTS

	Total Sample	Group		
		Beginning	Intermediate	Advanced
Number of Subjects:	159	27	26	28
Age:				
Range	21-46	21-32	23-33	25-35
Mean	26.8	24.4	25.4	28.4
Sex:				
Male	49.1%	44.4%	46.2%	53.6%
Female	50.9%	55.6%	53.8%	46.4%
Year in Graduage School:				
First Year	25.2%	100.0%	-	-
Second Year	21.4%	-	34.6%	-
Third Year	28.9%	-	65.4%	7.1%
Fourth Year	15.7%	-	-	53.6%
Fifth Year and above	8.8%	-	-	39.3%
Highest Previous Degree:				
B.A.	78.0%	92.6%	88.5%	82.1%
M.S.W. or M.A. in psychology (clinical, counseling, educational)	11.3%	-	-	-
Other M.A. or M.S.	10.1%	7.4%	11.5%	14.3%
Other Degree	.6%	-	-	3.6%
Pre-Ph.D. Work Experience as a Therapist	20.1%	-	-	-
Amount of Training Experience During Ph.D. Program:				
Range (in hours)	0-8731	0-520	560-1482	1638-8731
Mean (in hours)	1544.6	147.8	982.3	3951.3

	Total Sample	Group		
		Beginning	Intermediate	Advanced
Current Training:				
None	15.7%	40.7%	7.7%	-
Practicum or Clerkship	57.2%	59.3%	92.3%	-
Internship	27.1%	-	-	100.0%
Theoretical Orientation:				
Psychoanalytic/Psychodynamic	36.9%	19.3%	38.5%	51.9%
Behavioral	10.3%	23.1%	11.5%	11.1%
Eclectic	43.9%	50.0%	42.4%	37.0%
Client-centered/ Nondirective	.6%	3.8%	-	-
Systems approach	5.8%	3.8%	3.8%	-
Other	2.5%	-	3.8%	-

APPENDIX B

SUPERVISION OF PSYCHOTHERAPY QUESTIONNAIRE

This questionnaire is designed to explore the feelings and attitudes of clinical psychology students regarding the supervision of psychotherapy. You will be asked to answer questions about your actual experiences in supervision and about your views of the ideal supervisory experience. Current or previous training in conducting psychotherapy is not necessary in order to complete the questionnaire.

Your participation in this study is not required by your graduate school or internship site. However, I would greatly appreciate your taking the time to complete this questionnaire. Your participation is essential for the success of this study.

All responses to this questionnaire will be kept confidential, both for individual subjects and for the group of subjects at each graduate school or internship site. Please answer all of the items, and feel free to add any additional comments about supervision or about this questionnaire. Thank you very much for your cooperation.

Sharon Moskowitz
Loyola University of Chicago

A. Background Information

1. Age: _____

2. Sex: Male _____ Female _____

3. Current year in clinical psychology Ph.D. program:

   1st year___ 2nd year___ 3rd year___ 4th year___ 5th year +___

4. Highest previous degree: (do not include M.A. received during enrollment in your current program)

   B.A./B.S. _____ Major _____
   M.A./M.S./M.S.W. _____ Field_____
   Other _____

5. Are you currently receiving applied training in conducting psychotherapy?

   Yes, practicum or clerkship training _____
   Yes, internship training _____
   No _____

6. At what type of institution are you receiving your current training? (If you are working at more than one place, check as many as apply)

   State hospital: Inpatient _____ Outpatient _____
   V.A. hospital: Inpatient _____ Outpatient _____
   Medical center: Inpatient _____ Outpatient _____
   Community Mental Health Center _____
   University counseling center _____
   Child guidance or family services agency _____
   Other _____
   No current training _____

7. How long have you worked at your current training site?

   Number of months of training _____ Hours per week _____
   No current training _____

8. Amount of previous practicum experience since beginning your clinical psychology Ph.D. program:

No previous experience _____
First training experience: Number of months of training _____
Hours per week _____
Second training experience: Number of months of training _____
Hours per week _____
Third training experience: Number of months of training _____
Hours per week _____
Additional experiences: Number of months of training _____
Hours per week _____

9. What types of psychotherapy have you conducted during your current and previous training experiences? (Check as many as apply)

	Current Training Experience	Previous Training Experiences
Individual therapy: child	_____	_____
Individual therapy: adult	_____	_____
Group therapy	_____	_____
Marital therapy	_____	_____
Family therapy	_____	_____
Other _____	_____	_____
Not applicable	_____	_____

10. Number of supervisors for <u>individual</u> psychotherapy during your current or most recent training experience: _____

11. Average amount of supervision of your individual psychotherapy cases during your current or most recent training experience: (Check one)

1 hour supervision per 1 hour therapy _____
1 hour supervision per 2-3 hours therapy _____
1 hour supervision per 4-5 hours therapy _____
1 hour supervision per 6 or more hours therapy _____
Consultation only when requested _____
Not applicable (no current or previous training _____

12. During all of your training, which of the following techniques for reporting case material have been used in the supervision of your <u>individual</u> psychotherapy cases? (Check as many as apply)

Audiotape _____
Videotape _____
Process notes _____

Direct observation (one-way mirror) _____
Cotherapy with supervisor _____
Discussion of case without use of any of the above _____
Not applicable (no current or previous training) _____

Please put an X next to the technique which has been used most frequently.

13. For all of your training in conducting individual psychotherapy, please estimate the percentage of your supervision that was individual supervision (meetings between yourself and a supervisor) and the percentage that was group supervision (meetings between a supervisor and a group of trainees). The total should equal 100%.

_____% individual supervision
_____% group supervision
Not applicable (no current or previous training) _____

14. During all of your training, which theoretical orientations have you experienced in supervision? (Check as many as apply)

Psychoanalytic/Psychodynamic _____
Behavioral _____
Client-centered/Nondirective _____
Systems approach _____
Eclectic _____
Other _____
Not applicable (no current or previous training) _____

15. Your current theoretical orientation: (Check one)

Psychoanalytic/Psychodynamic _____
Behavioral _____
Client-centered/Nondirective _____
Systems approach _____
Eclectic _____
Other _____

16. As an adult, have you received personal therapy?

Yes _____ No _____

17. Please describe the amount of supervised experience in conducting psychotherapy which you received prior to beginning your clinical psychology Ph.D. program:

_____
_____
_____

The rest of this questionnaire concerns your opinions and feelings about the individual supervision of individual psychotherapy cases. Thus, the items refer only to supervision which occurs in meetings between yourself and a supervisor, and not to supervision which occurs in meetings between a supervisor and a group of trainees. In addition, the items refer to the supervision of individual psychotherapy, not group, marital, or family therapy.

B. The following list consists of possible goals of supervision, or descriptions of what you may hope to gain through your participation in supervision sessions. While all of these goals may be important to some extent, please circle the item numbers of the three goals which are most important to you at the present time. If you are not currently receiving supervision, please indicate which goals will be most important in your next training experience.

1. Learning specific therapeutic interventions that I can immediately use with my patients/clients

2. Learning to conceptualize my cases and my approach to therapy within a theoretical framework

3. Identifying and resolving my characteristic problems and blind spots in working as a therapist

4. Learning general therapeutic techniques that I can use with many patients/clients

5. Developing my own style of conducting therapy

6. Learning through observing the techniques and ideas of an experienced supervisor

7. Obtaining direct advice about working with patients/clients

8. Developing self-awareness of my reactions to patients/clients

9. Learning to understand the problems, needs, behavior and/or dynamics of patients/clients

Now please go back over this list and put an X through the item numbers of the three goals which are least important to you at the present time.

C. The following section presents descriptions of two supervisors with different personal characteristics and styles of supervision. Please use the scale below these descriptions to indicate which of these two supervisors is most similar to your present view of the ideal supervisor. If either of these supervisors would be ideal, circle the number at that end of the scale. If the ideal supervisor combines characteristics of both descriptions, please indicate whether this supervisor would be more similar to Supervisor A or Supervisor B by circling the appropriate number in the middle portion of the scale.

Supervisor A is very supportive. He or she provides a lot of positive feedback on my performance as a therapist, and does not focus on my errors. Supervisor A is directive and tells me what I should do with my patients/clients. Supervisor A allows me to utilize him or her for support and guidance.

Supervisor B is not highly supportive. He or she confronts me with my errors in conducting therapy, as well as providing positive feedback on my performance when it is warranted. Supervisor B is not directive, and encourages me to think for myself about my patients/clients. Supervisor B encourages my independence.

Supervisor A 1 2 3 4 5 6 7 Supervisor B

Mid Point

D. The following section consists of more detailed statements regarding the supervision of individual psychotherapy. Please consider each statement in terms of your feelings about supervision at the present time, and indicate your level of agreement with each statement using the following scale:

1 I strongly disagree with this statement

2 I disagree with this statement

3 I am neutral about this statement

4 I agree with this statement

5 I strongly agree with this statement

	Strongly Disagree				Strongly Agree
1. The ideal supervisor is very supportive.	1	2	3	4	5
2. The ideal supervisor does not directly examine the trainee-supervisor relationship or identify parallel processes in the trainee-supervisor and therapist-patient relationships.	1	2	3	4	5
3. The primary focus of supervision should be on teaching general therapeutic techniques that can be used with many patients/clients.	1	2	3	4	5
4. The most important thing that a supervisor can do is to help me identify and resolve my characteristic problems and blind spots in working as a therapist.	1	2	3	4	5
5. The ideal supervisor does not demonstrate the use of therapeutic techniques by modeling.	1	2	3	4	5
6. The ideal supervisor focuses on my developing greater self-awareness of my reactions to patients/clients.	1	2	3	4	5
7. The ideal supervisor does not teach therapeutic techniques by discussing the general reasons for their use with my patients/clients.	1	2	3	4	5
8. The ideal supervisor does not allow my dependence.	1	2	3	4	5

		Strongly Disagree				Strongly Agree
9.	The ideal supervisor does not focus on helping me to develop a better use of my own personality in conducting therapy.	1	2	3	4	5
10.	The ideal supervisor shows me how to behave and respond when I am conducting therapy.	1	2	3	4	5
11.	When I present material from a therapy session, the ideal supervisor does not tell me what he or she would have done in that situation.	1	2	3	4	5
12.	The most important thing that a supervisor can do is to explain the problems, needs, behavior, and/or dynamics of my patients/clients.	1	2	3	4	5
13.	The primary focus of supervision should be on the development of my own style of conducting therapy.	1	2	3	4	5
14.	The ideal supervisor does not encourage independence.	1	2	3	4	5
15.	The primary focus of supervision should be on my learning specific interventions to immediately use with my patients/clients.	1	2	3	4	5
16.	The ideal supervisor does not focus on teaching me to conceptualize my cases and my approach to psychotherapy within a theoretical framework.	1	2	3	4	5
17.	The most important thing that a supervisor can do is to display behavior and responses that I can imitate in conducting therapy.	1	2	3	4	5
18.	The ideal supervisor does not emphasize discussion of the transference and counter-transference issues involved in my relationships with my patients/clients.	1	2	3	4	5
19.	The ideal supervisor rarely gives direct advice about working with patients/clients.	1	2	3	4	5
20.	The ideal supervisor provides positive feedback on all of my successes, and does not focus on my errors in working with patients/clients.	1	2	3	4	5

		Strongly Disagree				Strongly Agree
21.	The ideal supervisor deals with my characteristic errors in working as a therapist by explaining what my patients/clients need.	1	2	3	4	5
22.	The ideal supervisor does not primarily focus on helping me to understand patients/clients.	1	2	3	4	5
23.	The ideal supervisor is directive.	1	2	3	4	5

E. The following items concern the ways your own feelings and problems may be dealt with in supervision. Please imagine that you are in the following situations and indicate how you would want the supervisor to respond.

1. I am just beginning my training. I am feeling anxious about working with patients/clients and unsure of my competence as a therapist. I would like my supervisor to: (Check one)

_____ Neither identify nor discuss these feelings, unless I initiate a discussion
_____ Identify these feelings without any further discussion or interpretation
_____ Identify these feelings and provide reassurance
_____ Identify these feelings and give a partial interpretation without extensively exploring them with me
_____ Identify these feelings and help me to explore and resolve them
_____ Identify these feelings and help me to obtain help outside of supervision

2. I am having difficulty in working with a particular patient/client. My supervisor feels that I am not responding appropriately to the patient/client, or am not recognizing important aspects of his or her communications or feelings. The supervisor believes that this is due to countertransference problems. I would like my supervisor to: (Check one)

_____ Neither identify nor discuss the problem, unless I initiate a discussion
_____ Identify the problem without any further discussion or interpretation
_____ Identify the problem and provide reassurance
_____ Identify the problem and provide a partial interpretation without extensively exploring it with me
_____ Identify the problem and help me to explore and resolve it
_____ Identify the problem and help me to obtain help outside of supervision

3. I am having difficulty in working with many patients. My supervisor believes that this is due to my characteristic blind spots and style of relating to people. I would like my supervisor to: (Check one)

_____ Neither identify nor discuss the problem, unless I initiate a discussion
_____ Identify the problem without any further discussion or interpretation

_____ Identify the problem and provide reassurance
_____ Identify the problem and provide a partial interpretation without extensively exploring it with me
_____ Identify the problem and help me to explore and resolve it
_____ Identify the problem and help me to obtain help outside of supervision

4. I am having problems in my personal life. While this is not affecting my functioning as a therapist, my supervisor has become aware of these problems. I would like my supervisor to: (Check one)

_____ Neither identify nor discuss the problem, unless I initiate a discussion
_____ Identify the problem without any further discussion or interpretation
_____ Identify the problem and provide reassurance
_____ Identify the problem and provide a partial interpretation without extensively exploring it with me
_____ Identify the problem and help me to explore and resolve it
_____ Identify the problem and help me to obtain help outside of supervision

5. I am having difficulty in working with my supervisor. My supervisor believes that this is due to a transference problem, in which I am reacting to the supervisor based on previous experiences with authority figures. I would like my supervisor to: (Check one)

_____ Neither identify nor discuss the problem, unless I initiate a discussion
_____ Identify the problem without any further discussion or interpretation
_____ Identify the problem and provide reassurance
_____ Identify the problem and provide a partial interpretation without extensively exploring it with me
_____ Identify the problem and help me to explore and resolve it
_____ Identify the problem and help me to obtain help outside of supervision

F. The following questions concern ways of dealing with problems in the supervisory relationship.

1. Have you ever experienced a major conflict with a supervisor which made it difficult for you to learn from supervision?

Yes _____ No _____

If you have never experienced a major conflict with a supervisor, please skip to Item 11. If you have experienced a major conflict with a supervisor, please think about one such conflict and answer the following questions about it.

2. What was the primary reason for this conflict? (Check one)

_____ Differing theoretical orientations
_____ Differing views on appropriate therapeutic approach or techniques
_____ Supervisor's style of conducting supervision
_____ Personality clash
_____ Other _____

3. Please describe the nature of this conflict in more detail:

_____
_____
_____
_____

4. Did you discuss or attempt to discuss this problem with your supervisor?

Yes _____ No _____

5. Who initiated this discussion?

Myself _____ My supervisor _____ Not applicable _____

6. If you discussed or attempted to discuss this problem, what effect did this have on supervision? (Check one)

_____ I continued to work with this supervisor and the situation became worse
_____ The situation remained the same
_____ We resolved the conflict enough to have a workable relationship, but it was only an adequate training experience

_____ We resolved the conflict, and the supervision was an excellent training experience
_____ We agreed that I should change supervisors
_____ Not applicable

7. If the discussion did not lead to any improvement in the situation, why was this so? (Check as many as apply)

_____ The supervisor denied that the problem existed
_____ The supervisor felt that it was my own personal problem
_____ The supervisor did not change his or her behavior or views in the way that I wished
_____ The supervisor acted as though I was wrong and should change my views
_____ We discussed the problem and both felt that the differences were unresolvable
_____ I felt positive about the discussion but it led to no real change
_____ Other _____
_____ Not applicable

8. If you did not talk to the supervisor, what did you do to deal with the problem? (Check as many as apply)

_____ Talked to another staff member
_____ Sought support of peers
_____ Changed supervisors
_____ Appeared to comply with the supervisor, but did what I wanted in therapy sessions
_____ Censored my verbal reports or process notes so that areas which might lead to conflict were omitted
_____ Other _____
_____ Not applicable

9. If you did not talk to the supervisor, what influenced your decision to not discuss the problem? (Check as many as apply)

_____ I thought I might receive a negative evaluation
_____ I thought that the supervisor would act as though his or her views were correct and I was wrong
_____ I thought the supervisor would label it as my personal problem
_____ I thought the supervisor would deny that a problem existed
_____ I thought this would cause the supervisory relationship to become even more conflictual
_____ Other _____
_____ Not applicable

10. Please describe your ways of dealing with this conflict in more detail:

_____
_____
_____
_____

11. If a conflict arose between you and a supervisor, of which the supervisor was aware, which approach would you want the supervisor to take? (Check one)

_____ Identify the problem and discuss it with me
_____ Identify the problem and then wait for me to initiate further discussion
_____ Neither identify nor discuss the problem, unless I initiate a discussion
_____ Try to change his or her behavior or views in order to resolve the conflict without discussing it
_____ Suggest a change in supervisors
_____ Other _____

If you wish to clarify any of your answers or add any additional comments about supervision, please use the rest of this page to do so.

THANK YOU VERY MUCH

Composition of the Scales for
Each Approach to Supervision

Scale	Item Numbers
Section B:	
Imitative	1, 6, 7
Patient-Centered	2, 4, 9
Therapist-Centered	3, 5, 8
Section D:	
Imitative	5, 10, 11, 15, 17, 19
Patient-Centered	3, 7, 12, 16, 21, 22
Therapist-Centered	2, 4, 6, 9, 13, 18

APPROVAL SHEET

The dissertation submitted by Sharon A. Moskowitz has been read and approved by the following committee:

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

April 21, 1981
Date

Patricia A. Rupert
Director's Signature