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Live-Supervision and Trainee Perceived Counseling Efficacy Ratings

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Live-Supervision and Trainee Perceived Counseling Efficacy Ratings

Abstract
The potential additive impact of live-supervision modalities upon counselor self-efficacy beliefs (CSEs) was explored using linear regression models. Though live-supervision had no additive effect on CSE beliefs in a sample of 89 counseling and clinical psychology trainees, clear preferences for certain training modalities were revealed. A connection between general self-efficacy beliefs (GSEs) and counseling self-efficacy beliefs as measured by two validated measures was also found. CSEs varied per therapeutic orientation, with significant effects for humanistic and interpersonal orientations. Discussion of findings and suggestions for future research are presented.

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LIVE-SUPERVISION AND TRAINEE PERCEIVED COUNSELING EFFICACY RATINGS

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

HILLSBORO, OR

BY

BEVYN KAYE ROWLAND, MA

IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

JULY 23, 2010

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ABSTRACT

The potential additive impact of live-supervision modalities upon counselor self-efficacy beliefs (CSEs) was explored using linear regression models. Though live-supervision had no additive effect on CSE beliefs in a sample of 89 counseling and clinical psychology trainees, clear preferences for certain training modalities were revealed. A connection between general self-efficacy beliefs (GSEs) and counseling self-efficacy beliefs as measured by two validated measures was also found. CSEs varied per therapeutic orientation, with significant effects for humanistic and interpersonal orientations. Discussion of findings and suggestions for future research are presented.

Key terms: Live-supervision, counselor training, supervisor as model, counseling self efficacy beliefs, general self efficacy beliefs (GSE), counseling self efficacy scale (COSE)
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vi</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>3</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>3</td>
</tr>
<tr>
<td>Social Cognitive Model of Counselor Training</td>
<td>4</td>
</tr>
<tr>
<td>Direct Supervision Modalities.</td>
<td>7</td>
</tr>
<tr>
<td>Live-supervision</td>
<td>11</td>
</tr>
<tr>
<td>Current Study.</td>
<td>16</td>
</tr>
<tr>
<td>METHODS</td>
<td>17</td>
</tr>
<tr>
<td>Measures</td>
<td>18</td>
</tr>
<tr>
<td>Procedure</td>
<td>20</td>
</tr>
<tr>
<td>RESULTS</td>
<td>21</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>28</td>
</tr>
<tr>
<td>Findings</td>
<td>28</td>
</tr>
<tr>
<td>Limitations</td>
<td>30</td>
</tr>
<tr>
<td>Implications</td>
<td>31</td>
</tr>
<tr>
<td>Future Directions</td>
<td>33</td>
</tr>
</tbody>
</table>
REFERENCES .................................................................35

APPENDICES

A. Demographics and Training History ..............................................................40
B. Counseling Self-Estimate Inventory .............................................................43
C. General Self Efficacy Scales .................................................................48
LIST OF TABLES

Table 1. Linear regression coefficients for COSES scores.................................22

Table 2. Frequency of supervision modalities used in clinical training ..................24

Table 3. Interventions trainees would like more in clinical supervision .................25

Table 4. Interventions trainees would like less in clinical supervision....................26

Table 5. Trainee ratings of helpfulness of supervision interventions .....................27
Live-supervision and Counseling Self-Efficacy Ratings

Clinical supervisors of psychotherapeutic trainees are charged with a crucial, two-fold responsibility: to safeguard client welfare and to foster the learning of competent practitioners in the field of counseling and clinical psychology. Some consensus regarding best practices for clinical supervision has been established (Falender et al., 2004), though empirically-driven training methodologies are lacking in the theoretical and practical literature. This paucity of evidence-based theory and practice of clinical supervision is problematic for the field, in that supervisors need to be armed with the most efficacious and applicable modalities of training. A codified theory (or theories) of supervision, guided substantially by evidence of efficaciousness is sorely needed in the field.

A theory of supervision which takes into account the developmental needs of trainees is central to the issue. Supervisors must assess for, acknowledge, and align supervision to meet the varying needs of trainees. Thus, in addition to a theory to guide training, supervisors need access to supervision techniques which provide opportunities for assessment as well as imparting skills to developing clinicians. Methods of supervising trainees which foster the developmental needs of trainees, provide opportunities for teaching and modeling effective therapeutic interventions, and allow for close oversight and assessment of performance are certainly called for.

Live-supervision modalities may provide part of the answer to this dilemma. Longstanding suggestions for trainees to see therapy applied in real settings (e.g. Luchins, 1949; Peterson et al., 2006) are appropriately accommodated by live-supervision, particularly those in which the supervisor models interventions with real clients. These interventions at once offer
opportunity for supervisors to assess clinical ability and effectively teach counseling skills through modeling. This approach is ideal for quality control of training (e.g. what is taught in therapeutic practice settings) as well as evaluation of performance of the trainee. Some data exists to support the use of such modalities. This method of training, however, is costly and requires other resources of time and expertise which may have impacted the frequency of utility in training settings in the past few decades. Technological advances have been made which ameliorates some of these resource strains. And if evidence supports the use of such modalities, strides should be made to incorporate them more into training programs, by appropriate means with regard to expense and resource demands.

The Social Cognitive Model of Counselor Training (SCMCT) offers a theoretical framework to understand the ways in which novice trainees best learn the skills of their craft. Training opportunities which incorporate chances for trainees to have mastery experiences, learn from competent models, and receive feedback regarding their performance are all central tasks of supervision and training. Per the SCMCT, one of the results of successful completion of these tasks is increased counseling self-efficacy beliefs (the degree to which trainees have confidence in their ability to counsel real clients). Live-training modalities are uniquely suited to provide opportunities for these tasks to be achieved in clinical supervision. In fact, these methods may be the most underutilized, powerful tools of training in the field of clinical and counseling psychology. This present study seeks to explore the relationship between counseling self-efficacy beliefs of novice practitioners and live-training approaches.
BACKGROUND

Competent practice is the overarching goal of clinical and counseling psychology programs. Fundamental to this goal is the application of theoretical knowledge. Thus, after a workable knowledgebase has been established via coursework, psychotherapeutic trainees require opportunity to “engage in the real phenomena of professional psychology practice” (Peterson et al., 2006). Supervision is the guide and guard of this endeavor. If novice clinicians are to work with real clients, trainees need a professional touchstone. Clinical work with clients offers rich opportunities for trainees, who benefit most from a wide variety of experiences with clients in a supportive supervisory context (Litz & Salters-Pedneault, 2008).

How to most effectively supervise the work of trainees is a fruitful, growing area of discourse in the field and myriad definitions of clinical supervision have been offered throughout the literature. Most provide a frame that includes core components of teaching and feedback as a basis for learning which will guide competent practice. According to Barrett and Barber (2005) the primary goals of supervision are “to teach theory, skills and technique, and self-awareness.” A definition of supervision offered by Loganbill et al. (1982) is frequently cited and emphasizes the interpersonally driven, facilitative functions of supervision. Taken together, supervision is at once an instructive and assessing force that is enhanced by the relationship between trainee and supervisor. Though supervision formats can vary, the most common are one-to-one and group supervision (Bernard & Goodyear, 2008). Whether it occurs individually or in teams, the major functions of supervision are to provide a structure that supports the learning that takes place in practice and provides opportunity for feedback and assessment of competence.
The Social Cognitive Model of Counselor Training

As with theoretical understanding of psychotherapeutic process and change in general, a unified theory of clinical psychotherapy supervision has not emerged to guide counseling training. Several promising theories are receiving attention through research and practice in the field (see Bernard & Goodyear, 2008 for a review). Many supervisory approaches have evolved from major therapeutic orientations like Cognitive Behavioral, Psychodynamic, and Feminist therapy. Other approaches to clinical supervision, such as integrated developmental (see Falender & Shafranske, 2004) and transtheoretical (see Aten et al., 2008) models, offer more flexible and robust ways of understanding how supervisor and trainee interactions elicit development of counseling skills.

Larson derived the compelling Social Cognitive Model of Counselor Training (SCMCT) from Albert Bandura’s Social Cognitive Theory (SCT). She applied SCT constructs and processes to understand the ways in which trainees’ development of clinical skills are facilitated or mitigated by self-referential beliefs she coined as “counseling self efficacy beliefs,” (1998). In a comprehensive review of the literature on counseling self efficacy (CSE), Larson and Daniels (1998) found solid support of a CSE-driven theory of trainee development.

SCMCT posits that counseling knowledge and effective enactment of that knowledge by trainees in therapeutic sessions is mediated by CSE beliefs. Counseling self efficacy beliefs are defined as “a counselor’s beliefs or judgments about his or her capabilities to effectively counsel a client in the near future,” (Daniels & Larson, 2001; p. 120). The SCMCT predicts that trainees’ motivation and performance will vary per their respective CSE beliefs. For example, trainees
with higher CSE beliefs are thought to take more risks in trying new interventions and are more likely to persevere in the face of therapeutic challenges (Larson, 1998).

Barnes (2004) applied SCMCT to propose a counseling self-efficacy approach to training and supervision. Her two-part paradigm of training emphasized the enhancement of early trainee CSE and on utilizing such beliefs in the context of their development. Taken together, a foundation for supervisors to intentionally and appropriately influence trainee CSE development in service of skill development has been established. This foundation calls for a research agenda to explore the relationships between supervision interventions, trainee CSE, skill development, and the connection to competent psychotherapeutic practice, which Barnes called for in her project.

The SCMCT model considers the multiple sources of information that trainees use to build their beliefs about their counseling self-efficacy. Again, the adoption of Bandura’s model yielded a helpful framework for understanding how self-efficacy cognitions grow in novice therapists. Larson (1998) examined constructs thought to increase CSE: mastery experiences, modeling of target skills, social persuasion (feedback), and affective arousal (anxiety). These are listed in descending order of impact: mastery experiences are the most potent and affective arousal is the least potent contributor in development of CSE beliefs.

Mastery experiences involve first-hand, challenging counseling tasks which the trainee appraises as successfully executed. Modeling requires the trainee to observe competent models who perform therapeutic behaviors. Larson (1998) suggested the best models are the supervisor, other trainees, and the trainee themselves (by way of video recorded sessions or role plays). SCMCT conceptualizes social persuasion as supervisory input conferred by the structure and
content of supervisory feedback. Supportive and corrective feedback, supervision setting, and supervisory working alliance are all subsumed in this construct. The final and important (though thought to be the least potent of the four) source of information about CSE comes from the trainee’s perceived affective arousal. That is, trainees interpret their levels of anxiety as way of determining their performance or efficacy.

Trainees estimate their CSE by way of all four of these sources of information. Arguably, the supervisory interaction can provide requisite stimulus for all of these factors. Supervisors can facilitate, provide feedback about, and direct attention to mastery experiences. They can serve as and/or select appropriate models for trainees to observe and learn from. Trainees rely on the supervisory context to guide them in development of efficacious interventions. Further, trainees experience varying degrees of anxiety, often as a function of the quality of the supervisory alliance. Supervisors who provide positive feedback (especially when calling attention to trainee mastery experiences) increase trainee CSE beliefs and lower anxiety levels (Daniels & Larson, 2001). If counseling self-efficacy beliefs are as integral to the learning and practice of therapy skills as the SCMT posits, the supervisor clearly has a monumental role.

The underlying goal of increased CSE beliefs, of course, is the development of competent psychotherapeutic practice. Supervisors in the field are charged with the responsibility of teaching, facilitating, and evaluating competence across many therapeutic domains. Nelson (2007) cogently described these and emphasized the importance of competence in basic psychological knowledge, therapeutic relationship building, assessment, intervention, research, consultation, supervision, and ethics.
Supervisors are endowed with a tremendous responsibility to foster the growth of and assess for trainee competence. Given the heavy load of their role, supervisors need to select and implement the most effective supervisory interventions to ensure their trainees build competence in requisite areas. From a perspective of empiricism, raw data approaches (e.g. objective observation of clinical work of trainees) would seem the most effective modalities to teach, facilitate, and evaluate clinical skill. Indeed, training standards underscore raw data approaches as superior (Storm et al., 2001). Such approaches utilize direct or indirect observation of the trainees’ learning and practice. Further, it is simple to consider how observational access to trainee therapeutic work would be superior in allowing the supervisor to assess trainee knowledge and skill level.

From the perspective of the SCMCT, the supervisory role would be enhanced by direct access to trainees’ clinical work as well. Direct supervisory modalities fortify the factors needed to facilitate mastery, modeling, social influence, and anxiety. Taken together, development of clinical competence and increased CSE beliefs are best served by direct supervision modalities.

Direct Supervision Modalities

As alluded to, supervision modalities fall into two broad categories: direct or indirect. Video review and live-supervision are direct (raw data) approaches that provide access to the actual performance of trainee clinical skills. Case consultation and progress note review are types of indirect approaches which rely entirely on trainee self-report. By way of empirical vantage, direct modalities offer the supervisor access to both micro and macro counseling skills. From appropriate application of an intervention (macro) to more nuanced relational variables (micro),
clinical supervisors are better equipped to teach, assess, and aid in the development of clinical skills when direct approaches are used.

Given the considerable contribution of direct supervision on trainee competence and counseling self efficacy, discussion of the history, clinical strengths, and data from the body of research is merited. Focus of this discussion will be primarily on live-supervision approaches, as they offer the most direct access to trainee work and most easily support supervisory goals of SCMCT. Remarkably, some clinical supervision researchers have noticed an underrepresentation of in-the-room supervision in training programs in the United States (Esposito & Getz, 2005). If data supports the effectiveness of these interventions, then incorporation of direct types of supervision is called for in the training of clinical and counseling psychology supervisees.

Description and Types of Direct Supervision

The history of live-training is often traced to the 1960s, when Jay Haley and Salvadore Minuchin first developed their direct approach of training for novice marriage and family therapists (Bernard & Goodyear, 2008). Scherl and Haley (2000) noted the original western psychotherapy, hypnosis, was taught by live-supervision. Live-supervision seemed to disappear around the same time that confidentiality became a critical component of client care. The advent of the one-way mirror in the 1950s facilitated the return of direct observation approaches, while allowing for client privacy. Both with and without empirical scrutiny, other areas of therapy have adopted components of this training model, including counseling and clinical psychology. Advantages and disadvantages of this type of training has been evaluated and discussed in a fairly limited body of literature from the perspective of supervisors, trainees, and clients (Bubenzer et al., 1991; Schwartz et al., 1988; Locke & McCollum, 2001; Mauzey et al., 1997;
Wark, 1995). It seems that live-training is still incorporated into most training programs, but types of modalities used may be selected per cost and convenience rather than based on data deeming them most or less efficacious.

A powerful type of direct supervision, observational supervision of therapy requires both context and intervention. Context refers to the milieu of therapy, that is, where and with whom therapy is conducted. A live-supervision context could involve the therapist trainee, the client, and the supervisor observing in the therapy room, or behind a one-way mirror. Supervision intervention within an observational context refers to the manner in which the supervisor interacts with the trainee. The previously described live-supervision context might involve the supervisor conducting co-therapy, providing supervision intervention at a particular moment during the session, or a post-session consultation meeting with the trainee. Other observational supervision approaches include video recording of sessions and post-session consultation.

The most frequently used observational method is video recording with feedback from the supervisor after-the-fact (Carlozzi et al., 1997). Live-supervision, though, requires a context with direct contact between the therapist and supervisor in real therapy (Smith, 1993; West & Bubenzer, 1993). Perhaps the most iconic context of live-supervision evokes an image of a trainee working with a client in one room; a supervisor and other trainees observing from behind the one-way mirror offering feedback. Two other contexts of live-supervision are co-therapy (trainee as co-therapist) and in vivo supervision (trainee as primary therapist, with supervisor in the room).

Both of these contexts involve supervisor presence in the room with therapist and client. Use of the former involves the supervisor taking over for the therapist, the latter involves the
supervisory feedback given during the course of the therapeutic session. Interventions deal with how supervisory feedback is disseminated to the trainee. If the supervisor is in the room, instant feedback can be given. If the supervisor is elsewhere, feedback can be achieved via walk-in, phone-in, instantaneous feedback by way of “bug-in-the-ear” (earpiece) or “bug-in-the-eye” (computer monitor), or in the form of during- or post-therapy consultation.

Research on Direct Supervision Methods

The most robust collection of data regarding live-supervision comes from the marriage and family therapy literature. In a review of methods of supervision in that school of clinical training, DeRoma, Hickey, and Stanek (2007) found that 85% of training programs studied in the U.S. used direct practices and asserted that “most supervisors agree that live-supervision is the strongest supervisory technique” (p. 418). Despite acknowledged barriers to the utility of live-supervision, they strongly recommended these methods over indirect-observational and didactic techniques.

Video recording seems to have become the standard in most psychotherapeutic training programs. Indeed, it offers a practical, affordable raw data alternative to more resource-consuming live-supervision methods. However, the unique strength of live-supervision (particularly with the supervisor in-room) is opportunity for supervisor modeling of behaviors. Also, the profound value of immediacy in learning “increases the odds that long-term learning will occur because of its immediacy, intensity, and experiential nature,” (Cone, 2001, p. 857).

Critiques of using video recording over live-supervision have recently been presented. First, use of video relies on the judgment of trainees who may not be able to select the most salient moments of a particular session. Indeed, trainee anxiety may drive them to only present
their strongest work, especially if trainees are fearful of criticism (Campbell, 2006). Further, the larger context of the therapeutic encounter is obscured by methods relying on video review. McCollum and Wetchler (1995) referred to the loss of “the phenomenological awareness” that the supervisor can directly appreciate by being in the room, resulting in focus on an “in-depth, telescopic view off one session.” Finally, one of the ideal features of video recording (flexibility) often results in long delays between the recorded session and supervisory feedback. Researchers have warned that such delays reduce the well-documented impact of more immediate feedback on learning processes (Cone, 2001; Dennin & Ellis, 2003).

*Live-supervision Research*

Various studies support the use of different live-supervision (LS) interventions. Bernard and Goodyear (2008) noted that LS has been found to be effective in training supervisees in their initial stages of training, though they caution that it has not been shown to be any better or weaker than other methods of supervision. Particular strengths of LS include availability of supervisor to model interventions (Taibbi, 1995), popularity of LS from the perspective of both supervisors and supervisees (Wark, 1995; Gonzalvez, 2008), and the impact of modeling and immediate feedback on CSE measures of novice trainees (Larson et al., 1999).

Live-supervision is possibly the most powerful supervision modality in terms of capacity to protect client welfare (Esposito & Getz, 2005; Bernard & Goodyear, 2008). The reason for this is two-fold. First, because the supervisor has direct access to the therapy session in real-time, a supervisor may intervene whenever necessary. Also, the actual abilities of the trainee are better observed contextually in a live-setting; thus, immediate access to therapeutic sessions serves trainee development and will ultimately serve to protect future clients by ensuring competence.
The rapport and working alliances between trainees, supervisors, and clients may also be impacted by the use of live-training modalities. There are some data to suggest that use of live-supervision modalities improves the working alliance between supervisor and trainee (Bernard & Goodyear, 2008) and may even be associated with strong working alliances between client and therapist (Kivlighan, Angelone, & Swafford, 1991). These findings fly in the face of assumptions made by many practitioners and trainees, particularly when we consider the documented elevation in trainee anxiety when live-supervision is used. Though the relationship between trainee anxiety and working alliance is not fully understood, these data seem to show that even anxiety-inducing supervision methods may not have a deleterious effect on rapport between supervisor and trainee, nor trainee and client.

Indeed, trainee anxiety levels can be increased due to the fishbowl-like nature of live-supervision. Trainees may feel more exposed when the supervisor is in ear- or eye-shot of therapy sessions with their clients. One study by Wong (1997) found that despite considerably higher trainee anxiety levels using these methods, most individuals in the study valued live-supervision methods and some even became avid proponents, “intent” on being trained in this manner in the future. Ellis, Krengel, and Beck (2002) found that the aversive effects of trainee anxiety to be “trivial” when they explored the impact of direct supervision modalities, including video recording and live-supervision. According to their study, anxiety levels were considerably higher than trainees supervised using indirect methods (such as case review), but the anxiety increase did not seem to interfere with learning.

Some practitioners and supervisors have been concerned about the disruptions that are inherent in live-supervision methodology. Be it supervisor walk-ins, direct intervention during therapy, or other more covert methods (such as feedback by way of computer monitor or bug-in-
the natural therapeutic flow of a session is, indeed, disrupted. Bernard and Goodyear (2008) pointed out the possibility of negative impact of disruption on counselor creativity in sessions. Certainly, at earlier stages of training this would especially be the case. Data is mixed about how disruptive and how damaging live-supervisor intervening is, to both training and therapeutic endeavors (Kivlighan, Angelone, & Swafford, 1991). Some researchers suggest that the requisite interruptions may discourage the interpersonal depth of some therapeutic approaches (Bernard & Goodyear, 2008). When perceived impact on clients was measured, Locke and McCollum (2001) found that clients were satisfied with therapy supervised in a live format as long as “perceived helpfulness outweighed intrusiveness.”

In a 3-year study of clinical psychology interns and their clients, Hunt and Sharpe (2008) found that in-session communication was consistently rated highly by interns. Methods of supervision intervention studied were both walk-in and phone-in communication. Interns preferred supervisor walk-ins, because they found it to be less disruptive. When examining perceived impact on clients, the researchers found that impact on client perceptions of their trainee therapists was minimal. Per the results of this long-term study, the credibility and rapport were not damaged by use of these two live-supervision methods.

Most of the proposed deleterious effects of live-training modalities can be mediated with appropriate forethought, planning, and awareness of trainee developmental level. First, live-supervision may best be implemented during early stages of counselor training. This would allow for the positive impact of modeling of core clinical behaviors and interventions. It would also occur at a time during which trainee creativity is secondary to mastery of core micro and macro skills. This is not to imply that live-supervision only be used with novice trainees. A current study by Nunes, 2010, is investigating the use of live-supervision of advanced clinicians who
recently learned motivational interviewing. Attending to the data, certain types of live supervisory feedback is preferred over others. More research in this area is merited and should continue to include perspectives of supervisors, trainees, and clients.

The reduction of another negative impact, intrusiveness, has been addressed extensively in the live-supervision literature. In particular, feedback disruptions can be reduced when using more covert methods of live-supervision. Evidence supporting the use of bug-in-the-ear (BITE) interventions (Gallant, Thayer, & Bailey, 1991), bug-in-the-eye or computer assisted approaches (Smith, Mead, & Kinsella, 1998) also provide guidelines for reduced intrusiveness. The advent of so-called “cyber supervision” further reduces disturbances, provided that the trainees are properly prepared for use of the method (Miller, Sanders, & Miller, 2009).

Studies of the impact upon the supervisor have also presented compelling findings in the area of live-supervision. In one study, supervisors using live modalities were found to be more confident in their students’ abilities (Champe & Klieist, 2003). The reason for this may again highlight the unique strengths of the approach. Supervisors likely have superior information about the performance of their trainees in actual treatment settings. Esposito and Getz (2005) suggested that live-supervision may be the best approach when assessing for trainee competence.

Training of supervisors themselves has also seen recent implementation and scrutiny of live-supervision. In the training of supervisors, live-supervision has been shown to be a powerful method (Haber et al., 2009). Perhaps the most obvious and concerning negative impact on supervisors using live-supervision is their considerably increased vulnerability. Indeed, supervisors necessarily have to use more of themselves, display prominently their expertise, and transmute that expertise in the service of trainee learning and competence. In no other
supervision modality does the supervisor take as many risks as they do with the use of live-supervision (Bernard & Goodyear, 2008).

Perhaps the most compelling and pragmatic barrier to the use of live-supervision is the very real limit of fiscal feasibility. A long documented problem, live-supervision makes substantial demands on supervisor time, a very valuable training commodity (Bernard & Goodyear, 2008). Certain forms are clearly more costly than others; however, advances in technology seem to be outpacing these financial barriers. Of course, technology can impose additional costs which must be addressed. For example Miller, Sanders, and Miller (2009) described a very expensive, multi-conferencing training lab for “live, remote, clinical cyber supervision.”

Training centers need to be pragmatic about resource allocation. However, it is clear that the requisite features of live-supervision need not entail complex apparatus. The strengths of the training model can be incorporated with controlled expense, and used judiciously and strategically in the service of novice trainee learning.

Despite higher costs associate with live-supervision, training of Australian psychologists mandates the use of some sort of observational modality. Gonsalvez and McLeod (2008) described training standards which included the use of both one-way mirrors and video. This underscores not only the importance of raw data in the training and assessment of therapeutic clinicians, but also the importance of a live-supervision component in all early training.

Other fields of healthcare practice, both within and outside of the United States, rely heavily on live-supervision as a primary method of training. For example, medical students in the U.S. have consistently ranked live-supervision as the most effective method in medical training
for over 25 years. It is this method that uniquely supports them and helps them feel secure in trying new behaviors in a safe, observed setting (Saba, 1999). A study of genetic counseling training programs showed live-supervision to be an “essential and effective method that promotes student skill development,” (Hendrickson, McCarthy, and LeRoy, 2002). Psychomotor skill trainers for clients with deficits are consistently trained using live-supervision in the mental health nursing field (Tapp & Wright, 1996).

After review of the literature in both psychology and healthcare practice, it becomes clear that the benefits of live-supervision outweigh the barriers, when liabilities are attended to (Esposito & Getz, 2005). Of all the concerns raised by thoughtful researchers and practitioners, no negative impact on clients, trainees, and supervisors has been presented which cannot be easily controlled for. It seems that the biggest barrier to use of the modality may be one of financial cost. Thankfully, the combination of calculated utilization and development of affordable technologies may finally align to create hospitable conditions for increased use of live-supervision. If more data are brought to bear indicating superior efficaciousness of live-supervision, then ethically, the field must respond, regardless of fiscal pragmatics.

Current Study

The present study seeks to add to the live-supervision, empirical literature. Using Social Cognitive Model of Counselor Training (SCMCT) as a framework, a primary question will be addressed: Does the use of live-supervision modalities add to reported self-efficacy beliefs (CSE) beyond that achieved by traditional methods? Given the unique endowments of live-supervision, it is hypothesized that CSE beliefs will be higher for trainees who are supervised “live;” those trained using “traditional” methods are expected to have lower CSE ratings. The foundation for
this hypothesis are Bandura’s social cognitive learning precepts, imbedded in Larson’s SCMCT model. Because live-supervision modalities most adequately provide the requisite opportunities for modeling, mastery, and feedback during clinical learning, trainee CSE beliefs are thought to be positively related.

Ancillary questions will also be answered, particularly regarding trainee preference for various training interventions. It is possible that the well-documented increase in trainee anxiety when using methods of live-supervision may result in lower ranking of these modalities. Perceived helpfulness and overall popularity (how often each modality is endorsed) will also reveal attitudes of participants in the sample.

This study represents a novel use of SCMCT as a theoretical frame for exploring the impact of live-supervision modalities. Studies of live-supervision are also scarce in the literature; taken together, this study is uniquely positioned to contribute to data on clinical supervision.

METHOD

Eighty-nine participants completed this study; there were 67 females and 22 males. Convenience sampling was used to recruit graduate psychology students who were studying counseling or clinical psychology at the School of Professional Psychology of Pacific University, in Hillsboro, Oregon. Participants were in their second to sixth year of training; all had completed at least 6 months of practica training in the field of psychology. Of the sample, 26 had up to 1 year of training, 25 had up to 2 years, and 27 had up to 3 years of practica training. Eleven had between 4 and 6 years of clinical training. All participants were seeking a terminal degree in counseling or clinical psychology. The vast majority (76) were seeking a Clinical PsyD
degree, 8 were seeking an MA in Counseling Psychology, 3 a PhD Counseling, and 1 respecialization Clinical PsyD degree.

Measures

Demographics

Participant data was collected with a demographics questionnaire (Appendix A) which queried standard identity categories such as gender, age, and race. Other, clinically relevant data such as theoretical orientation, type of terminal degree sought, the number of practicum rotations, and types of training settings (e.g. community mental health clinics) were queried.

Information regarding supervision modalities was also collected in this section. Participants were asked to indicate all of the training modalities their supervisors had used. Though not described as such in the questionnaire, the list of modalities represented a blend of direct and indirect methods. The following modalities qualify as live-supervision methods: “role plays (supervisors modeling intervention), role plays (trainees practicing intervention), supervisor walk-in during sessions, one-way mirror during sessions, consultation-breaks with supervisor during session, and in vivo supervision (offers in-session supervision).” Respondents were asked to indicate modalities they preferred, those they disliked, as well as rate each modality in terms of perceived helpfulness on a Likert-type scale. Given the multiple years and multiple training settings queried, participant responses represent an amalgam of their experience. That is, no distinction was made for each trainee practicum. Rather the entirety of their training experiences was measured--possibly involving more than one supervisor and training environment for respondents with more than 1 year of practicum training.
Counseling Self Estimate Inventory (COSE)

The Counseling Self Estimate Inventory (COSE), a measure of counseling self-efficacy beliefs, was developed and validated by Larson and her development group in 1992. For this study, the entire, 37-item instrument was presented (Appendix B), in order, to participants directly following the demographics questionnaire. Each COSE item requires respondents to indicate the degree to which they strongly agree (6) or strongly disagree (1) to various statements regarding their counseling skills. For example, respondents would respond to item 11 “I feel confident that I will appear competent and earn the respect of my client,” with a numerical response, corresponding to their perceived agreement, neutrality, or disagreement using the 6-point scale.

This instrument has been used extensively in studies that explore CSE beliefs in clinicians. It is a widely used instrument in the field and has demonstrated reliability and validity (Larson, 1998; Larson et al., 1992). The COSE total score has a high internal consistency (α=.93), high 3-week test-retest reliability (r=.87), and strong criterion and convergent validity coefficients. Development and validation of this measure also revealed several factors within the COSE instrument. However, Larson et al. (1992) recommend using the total COSE score when studying overall CSE beliefs in clinicians. This study will examine the unitary construct of CSE beliefs, thus the total COSE score will be used.

General Self Efficacy Scale (GSE)

Schwarzer and Jerusalem (1995) developed the General Self-Efficacy Scale (Appendix C) to measure overall perceived self efficacy beliefs of individuals. It is a 10-item instrument,
and like the COSE, it requires respondents to indicate the degree to which they agree with each item using a Likert-like scale. For example, respondents are posed with a statement like, “When I am confronted with a problem, I can usually find several solutions.” They are then asked to rate (1=Not at all true; 4=Exactly true) their response using the scale.

This instrument has been used in over 1000 studies, world wide (Schwarzer, 2009) for a variety of research topics, though counselor self-efficacy has not been among them. Shown to be internally consistent ($\alpha= .86$) in original validation studies, recently the GSE has been shown to have good internal consistency across nationalities (e.g. Japanese, $\alpha= .91$; Indians, $\alpha= .75$). For U.S. samples, Cronbach’s alpha for the measure was 0.87 (See Scholz, et al., 2002 for a full review).

Procedure

Participants were recruited using email listserv contacts at Pacific University. The email text directed participants to an online questionnaire. All materials were presented singularly using the SurveyMonkey web-based data collection system. Informed consent, trainee demographics and training history were included early in the survey. The Counseling Self-Estimate Inventory (COSE) and The General Self Efficacy Scales (GSE) were presented in order. Both instruments are public domain measures and did not require permission for use in this study.

A quasi-experimental design was employed; given the small population, random selection of participants was not possible. Participants were invited to join the study and those who chose to take part made for a self-selecting sample. Trainee responses to the online questionnaire provided the primary study variables: Counseling Self-Estimate Inventory (COSE)
total scores (to measure counseling self-efficacy beliefs), General Self-Efficacy total scores (GSE), and supervision modalities used. Other data collected allowed for descriptive statistical analyses.

Participants were recruited via email in January 2010. Data was collected online between January 2, 2010 and April 31, 2010. Individuals who completed the online informed consent were directed to the demographics questionnaire. All of the items of the COSE were presented in order, followed by all items of the GSE, in order.

RESULTS

For the 89 participants, the average COSE score was 156.5, (SE= 9.513). Using a multiple linear regression model, impact of live-supervision on COSE and GSE was explored. Of the 89 participants, 72 had experienced some sort of live-supervision, 17 had not. All participants had been trained using traditional methods, thus a linear regression of live-supervision would show additive impact of live-supervision, because all participants had been trained using traditional methods.

The only significant factor in the model was the GSE mean score, 23.29 (SE=7.67). That is, for every point the GSE mean score increased, the COSE score increased by 23.29 points, on average. Live-supervision did not have an effect on the COSE score, nor did the years of training.

Other training experiences were added to the model in the form of therapeutic orientation. Again, years of experience and use of live-supervision did not have a significant effect while GSE mean score did. Two additional, significant effects were found, however. Participants with a humanistic therapeutic orientation had lower scores (18.72 points, on average) than those who
did not have this orientation. Participants identifying an interpersonal therapeutic orientation had higher scores (13.83 points, on average) than those who did not have this orientation. Table 1 shows the coefficients and significance levels.

Table 1

**Linear regression coefficients for COSES scores**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>69.19 (24.05)</td>
<td>88.75 (24.17)</td>
</tr>
<tr>
<td>Live Method</td>
<td>7.89 (6.91)</td>
<td>8.03 (6.70)</td>
</tr>
<tr>
<td>Years of Experience</td>
<td>1.89 (2.48)</td>
<td>3.43 (2.59)</td>
</tr>
<tr>
<td>GSE Mean Score</td>
<td>23.29** (7.66)</td>
<td>16.54* (7.67)</td>
</tr>
<tr>
<td>Integrative Orientation</td>
<td>—</td>
<td>-2.47 (5.62)</td>
</tr>
<tr>
<td>CBT Orientation</td>
<td>—</td>
<td>3.45 (5.60)</td>
</tr>
<tr>
<td>Behavioral Orientation</td>
<td>—</td>
<td>-7.19 (7.30)</td>
</tr>
<tr>
<td>Humanistic Orientation</td>
<td>—</td>
<td>-18.73* (8.11)</td>
</tr>
<tr>
<td>Interpersonal Orientation</td>
<td>—</td>
<td>13.83* (6.58)</td>
</tr>
<tr>
<td>Feminist Orientation</td>
<td>—</td>
<td>-20.75 (14.85)</td>
</tr>
<tr>
<td>R-squared</td>
<td>0.1389</td>
<td>0.2929</td>
</tr>
<tr>
<td>Adjusted R-squared</td>
<td>0.1085</td>
<td>0.2023</td>
</tr>
</tbody>
</table>

*Significant at the p<0.05 level
**Significant at the p<0.01 level

Descriptive statistics from this study reveals intriguing data regarding use of different modalities in training of this sample of clinicians as well as preference for certain types of modalities. Table 2 shows the number of respondents who have been trained in each modality. Nearly all respondents had supervisors who used audio/video review of student clinician sessions (n=81) and didactic training by supervisor (n=71). Over half of respondents had been trained using role plays during supervision with either the student (n=51) or the supervisor (n=58) as the
model for the intervention. A relatively small proportion (21.3%) had been privy to video review of supervisor sessions with client. The least common supervision method used with this sample was the one-way mirror modality (n=2).

Table 2

*Frequency of Supervision Modalities Used in Clinical Training*

<table>
<thead>
<tr>
<th>Modality</th>
<th>Number Trainees Reported Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio/video review of student clinician sessions w/ client</td>
<td>81</td>
</tr>
<tr>
<td>Audio/video review of supervisor sessions w/client</td>
<td>19</td>
</tr>
<tr>
<td>Didactic training (teaching via lecture/discussion)</td>
<td>71</td>
</tr>
<tr>
<td>Didactic training with clinical topic videos</td>
<td>28</td>
</tr>
<tr>
<td>Role plays (supervisors modeling intervention)</td>
<td>58</td>
</tr>
<tr>
<td>Role plays (trainees practicing intervention)</td>
<td>51</td>
</tr>
<tr>
<td>Supervisor walk-in during sessions</td>
<td>13</td>
</tr>
<tr>
<td>One-way mirror during sessions</td>
<td>2</td>
</tr>
<tr>
<td>Consultation-breaks with supervisor during session</td>
<td>11</td>
</tr>
<tr>
<td>In vivo supervision (offers in-session supervision)</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 3 reports trainee preference for particular interventions to be used more. Role plays with supervisor-as-model was the most popular; only 2 respondents indicated preference for supervisor walk-ins. As expected, use of video recorded sessions was the most popular. Of
particular interest, incorporation of recorded sessions of supervisor therapeutic work was highly endorsed. It appears that in this sample, participants clearly express a preference for supervisor-as-model in training.

Table 3

*Interventions Trainees Would Like More in Clinical Supervision*

<table>
<thead>
<tr>
<th>Modality</th>
<th>Respondents Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio/video review of student clinician sessions w/ client</td>
<td>40</td>
</tr>
<tr>
<td>Audio/video review of supervisor sessions w/client</td>
<td>43</td>
</tr>
<tr>
<td>Didactic training (teaching via lecture/discussion)</td>
<td>11</td>
</tr>
<tr>
<td>Didactic training with clinical topic videos</td>
<td>14</td>
</tr>
<tr>
<td>Role plays (supervisors modeling intervention)</td>
<td>45</td>
</tr>
<tr>
<td>Role plays (trainees practicing intervention)</td>
<td>21</td>
</tr>
<tr>
<td>Supervisor walk-in during sessions</td>
<td>2</td>
</tr>
<tr>
<td>One-way mirror during sessions</td>
<td>12</td>
</tr>
<tr>
<td>Consultation-breaks with supervisor during session</td>
<td>8</td>
</tr>
<tr>
<td>In vivo supervision (offers in-session supervision)</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 4 shows trainee preferences for modalities to use less in supervision. Overall, a clear trainee preference for live-training modalities (with the exception of the controversial “in vivo” modality) is revealed by this study. In particular, trainees favored video review of their own
recordings or recordings of their supervisors (n=40; n=43, respectively). Role plays with supervisors modeling interventions was the most favored (n=45) of all interventions. The least preferred methods (those which trainees most strongly wanted supervisor to not employ) were overwhelmingly live-supervision modalities. In descending order, supervisor walk-ins, use of one-way mirrors, and in vivo methods were the most frequently listed as “interventions to not use.”
Table 4

*Interventions Trainees Would Like Less in Clinical Supervision*

<table>
<thead>
<tr>
<th>Modality</th>
<th>Respondents Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio/video review of student clinician sessions w/ client</td>
<td>1</td>
</tr>
<tr>
<td>Audio/video review of supervisor sessions w/client</td>
<td>5</td>
</tr>
<tr>
<td>Didactic training (teaching via lecture/discussion)</td>
<td>11</td>
</tr>
<tr>
<td>Didactic training with clinical topic videos</td>
<td>7</td>
</tr>
<tr>
<td>Role plays (supervisors modeling intervention)</td>
<td>1</td>
</tr>
<tr>
<td>Role plays (trainees practicing intervention)</td>
<td>2</td>
</tr>
<tr>
<td>Supervisor walk-in during sessions</td>
<td>56</td>
</tr>
<tr>
<td>One-way mirror during sessions</td>
<td>35</td>
</tr>
<tr>
<td>Consultation-breaks with supervisor during session</td>
<td>27</td>
</tr>
<tr>
<td>In vivo supervision (offers in-session supervision)</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 5 shows respondent ratings for each modality used by their supervisors in training. The scale for the table is 1-5 (1=least helpful, 3=moderately helpful, 5=extremely helpful). By far, the highest rated modalities were audio/video review of student clinician sessions with clients and role plays with supervisors modeling interventions. Didactic teaching was rated as moderately to definitely helpful by 43.8% of the sample. Of the 26 respondents who had been trained using in vivo techniques, 2 found it to be moderately helpful, while 24 found it to be
extremely helpful.

Table 5

*Trainee Ratings of Helpfulness of Supervision Interventions*

<table>
<thead>
<tr>
<th>Modality</th>
<th>Not Helpful</th>
<th>Neutral</th>
<th>Extremely Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio/video review of student clinician sessions w/ client</td>
<td>3</td>
<td>11</td>
<td>53</td>
</tr>
<tr>
<td>Audio/video review of supervisor sessions w/client</td>
<td>0</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Didactic training (teaching via lecture/discussion)</td>
<td>0</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Didactic training with clinical topic videos</td>
<td>0</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Role plays (supervisors modeling intervention)</td>
<td>0</td>
<td>8</td>
<td>38</td>
</tr>
<tr>
<td>Role plays (trainees practicing intervention)</td>
<td>0</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Supervisor walk-in during sessions</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>One-way mirror during sessions</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Consultation-breaks with supervisor during session</td>
<td>0</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>In vivo supervision (offers in-session supervision)</td>
<td>0</td>
<td>2</td>
<td>24</td>
</tr>
</tbody>
</table>
DISCUSSION

Findings

In this present study, the null hypothesis could not be rejected. Counter to the primary study hypothesis, live-supervision modalities (on the whole) had no additive effect on overall COSE score. However, GSE scores did significantly relate to COSE score; in this sample of participants, as GSE increased so did their COSE score. This suggests that trainees with higher perceived personal self-efficacy have higher counseling self-efficacy beliefs.

Therapeutic orientation of trainees in this sample also revealed a significant relationship. In particular, a significant negative relationship between COSE score and humanistic therapy oriented trainees and a significant positive relationship between COSE score and interpersonal therapy oriented trainees were found. This may belie some sort of unexplored connection between trainee counseling self-efficacy beliefs and therapeutic orientation.

A clear, trainee preference for supervisor-as-model was revealed by this study. Both role plays and video recorded sessions with supervisor as the model were positively rated by participants. This trend underscores what other researchers and trainers in the field have known for some time: trainees crave direct modeling experiences from their supervisors (Bernard & Goodyear, 2008).

Certainly, trainees seek to learn the art and science of therapy from a multitude of sources. Modeling, however, seems to be one which is frequently sought by trainees and perhaps under utilized by supervisors. On this matter, Rønnestad and Skovholt (2003) wrote, “We cannot emphasize enough the intensity by which students search for viable models,” (p. 13). The strong preferences demonstrated by this study, as well as the underrepresentation of supervisor-as-
model interventions in their training, bespeak the tension between what trainees hope for and what is provided in supervision.

As anticipated, participant ratings of other preferred supervision modalities were mixed. There was clear preference for video review of both supervisor and trainee sessions. Live-supervision modalities, in general, were more controversial for this sample. The participants showed clear preference for supervision which does not involve walk-ins, one-way mirrors, and consultation breaks; all of these modalities were ranked highly in the demographics question, “Which do you wish or are glad that your supervisor did not employ?”

In vivo supervision was the most clearly divisive modality in the sample. Close in frequency of preference on both sides of the question, in vivo was the second highest rated intervention to not use, and the fourth highest rated intervention to use more. Interestingly, trainees who had been supervised with the modality showed preference for its use; trainees who had not been privy to this method negatively ranked the modality and did so at a rate of over 55% of the sample. Further, trainees supervised in vivo ranked the modality very highly in terms of helpfulness. This finding may involve the role of supervisee anxiety. It seems that for trainees who had not been supervised in vivo, the idea of the modality might have evoked anxiety and resulted in stronger preferences for it not to be implemented in their training.

Like in vivo supervision, supervisor walk-ins were rated negatively, but without participant experiential basis. Supervisor walk-ins were the most unpopular method with this sample. Of the sample, 56 indicated a preference for the modality to not be used, though only 13 participants in the sample had experienced it. Again, reasons for this may involve trainee anxiety level, concerns about intrusiveness, or other factors.
A heavily used modality, didactic teaching, was also unpopular with this sample. In this instance, ratings seemed more likely based on participant experience than with the in vivo response set. Didactic teaching was the most often used modality but was not seen as particularly helpful by the sample. It could be that trainees have been overexposed to this type of training (particularly in the academic portions of their programs) and value it less in the practicum setting.

The top four ranked modalities in this study were role plays with supervisor as model, review of recorded supervisor sessions, review of recorded trainee sessions, and in vivo supervision. All four were cited as the top methods to use more in training. Further, all four were described as most helpful on a Likert-type scale. It should be noted that all of these methods involve modeling of therapeutic behaviors, with either trainee or supervisor as model. Per the SCMCT, these modalities would also be of the most helpful in terms of the factors that are thought to impact CSE beliefs. Although data from the linear regression models in this study do not show a relationship between modeling interventions and COSES scores, a case can be made for training programs and supervisors to incorporate more of these methods into therapist training. This would capitalize on trainee preferences in training, particularly when learning theory and other data support the use of modeling as training is a worthy endeavor.

Limitations

There are several limitations to address in this study. First, the sampling method and size limit generalizability of the findings. The sample was a self-selected, convenience group in a single clinical training program for degree-seeking clinicians. This means that the findings of this study best describe the experiences of the sample, rather than novice trainees in general. Though
sample size was reasonable for an unfunded project, a larger sample of programs across the U.S. would be ideal. The power of a larger sample from different training programs would reduce possible cohort effects and increase generalizability. Also, inclusion of both masters and doctoral students, as well as counseling and clinical cohorts, may have introduced some unrecognized confounding components into the study.

To draw conclusions regarding the reasons for trainee preference of certain training modalities in this study would be erroneous. It is possible to consider underlying reasons for their preferences, such as anxiety or concern regarding disruptiveness for example. However, to speculate for reasons without measures to explore these reasons is beyond the scope and design of this project.

Also, as with many theoretically-based models, a direct link between CSE beliefs and counseling competence has not been established. Further study of the relationship between CSE beliefs and therapeutic competence needs to be evaluated, and is, too, beyond the scope of this study.

Implications

Though live-training was not shown to have significant, additive effect on trainee counseling self-efficacy, strong trainee preferences for modalities (live or traditional) should be considered. In light of the clear preference for supervisor-as-model, supervisors may selectively choose to include some form of modeling in training of supervisees on a more regular basis. Particularly at the earlier stages of novice training, these methods may prove to be a more powerful teaching tool than during later years. Supervisors, too, may reconsider the element of
didactic training in supervision. Incorporating more experiential components into didactic teaching would capitalize on trainee preferences while also disseminating necessary knowledge.

Awareness of trainee preferences is one factor of a multitude which guides selection of supervision modality. The findings herein increase awareness of preferences but the discretion of the supervisor is formidable. One goal of supervision modality selection is to balance supervisee needs and wants with supervisor competence and ability to incorporate efficacious methods.

The connection between GSE and COSE measures also merits consideration. If general self-efficacy beliefs are positively related to counseling self-efficacy beliefs, a case could be made for training centers to offer or encourage programs designed to engender trainee personal self-efficacy beliefs. Such programs might include credit for so-called personal growth activities. Mentoring may also have a positive effect on GSE for trainees. Further investigation of factors that contribute to such beliefs to guide better understanding is needed, before designing programs to this end. However, the findings of this project point to the compelling link between the personal and professional elements of self-efficacy for psychotherapeutic trainees.

The primary finding of the current study, that trainees with higher GSE scores had higher COSES scores, offers some support for the development of GSE in psychotherapeutic trainees. The relationship between self-efficacy and work-related performance is well documented (Stajkovic & Luthans, 1998; Mabe & West, 1982). However, no studies to date have explored the relationship between general self-efficacy measures and professional self-efficacy beliefs for psychotherapeutic practitioners. In one intriguing study explored the link between CSEs and multicultural counseling competencies. Constantine (2002) found that practitioners with higher counseling self-efficacy beliefs had higher perceived multicultural counseling competencies.
Similar studies of the relationship between general self-efficacy and professional self-efficacy (such as CSE beliefs) are called for.

Future Directions

Further study of training modalities is both necessary and called for in the service of training competent practitioners. Data-driven supervision approaches are tremendously lacking in the field. More empirical evidence supporting efficacy of supervision modalities will ensure that supervisors implement the best methods of training novice counselors. Exploration of both traditional and live-supervision modalities is urgently needed to guide these important choices.

In particular, larger scale studies of live-supervision and supervisor-as-model methods will be helpful to further understand the impact of the training modalities explored in this project. The results of these linear regression models are a point of departure for future research endeavors. Large samples of randomly selected novice trainees will be the most fruitful to this end.

Also, this present study unearths a commonsensical connection between psychotherapist trainee general self-efficacy beliefs and counseling self-efficacy beliefs. Inasmuch as therapists use themselves extensively in their work, this connection may belie a unique one, not found in other professional fields. The extent to which the relationship between GSE and professional measures (like the COSE) relate uniquely in practitioners of clinical and counseling psychology is of interest, and could underscore the importance of higher GSE beliefs for practitioners in the field. Again, the impact of efficacy beliefs on counselor performance is a worthwhile line of research and would be useful in counselor development.
In terms of theoretical directions, to bring the useful theoretical power of the SCMCT to bear, more attention to this domain of therapist development is merited. Again, data-driven studies will be the most useful to provide empirically sound approaches to understanding counselor development as well as the best means for facilitating that development.
REFERENCES


Saba, G.W. (1999). Live-supervision: Lessons learned from behind the mirror. *Academic Medicine, 74,* 856-858.


**APPENDIX A**

Demographics—Trainees

(Presented in online format)

|   |   |
|---|---|---|---|---|---|
| 1. | Age: __________ |
| 2. | Date of Birth: ____/____/____ |
| 3. | What is your racial or ethnic background?  
   | ① Asian/Pacific-Islander  
   | ② Black/African-American  
   | ③ Caucasian/European-American  
   | ④ Hispanic/Latino  
   | ⑤ Native-American/Native Alaskan  
   | ⑥ Mixed (please specify)______________  
   | ⑦ Other (please specify)___________ |
| 4. | What is your gender:  
   | ① Male  
   | ② Female  
   | ③ Other (please specify)_____________ |
| 5. | What degree are you seeking in psychology?  
   | ____________________________________________________________________________ |
| 6. | Including your current placement, how many clinical or counseling psychology practicum rotations/years have you completed?  
   | (If you foresee you will not finish your current practicum for whatever reason, check here: □) |
| 7. | What theoretical orientation best describes your practice of psychology? (Check ALL that apply; if INTEGRATIVE, check core features of your orientation.)  
   | 1. Integrative/Eclectic  
   | 2. CBT  
   | 3. Behavioral  
   | 4. Psychodynamic  
   | 5. Humanistic  
   | 6. Interpersonal  
   | 7. Feminist  
   | 8. Other (please specify):  
   | 9. Other (please specify): |
### In what types of training environments have you worked for practicum rotations?

(Check **ALL** that apply)

1. University/college counseling center
2. Community or university-run outpatient clinic
3. Hospital (private)
4. Hospital (public)
5. Corrections/Forensic
6. Consultation offices
7. Public school districts
8. Other (please specify): _________________________

### What supervision interventions have your supervisors used in training? (Check **ALL** that apply)

1. Audio/video review of student clinician sessions w/ client
2. Audio/video review of supervisor sessions w/client
3. Didactic training (teaching of interventions via lecture/discussion of written material)
4. Didactic training with clinical topic videos (e.g. motivational interviewing training video)
5. Role plays (supervisors modeling intervention)
6. Role plays (trainees practicing intervention)
7. Supervisor walk-in during sessions
8. One-way mirror during sessions
9. Consultation-breaks with supervisor during session
10. In vivo supervision (supervisor present; offers in-session supervision)
11. Other (please specify):
12. Other (please specify):

### Using the following 1-5 scale, rate how helpful each of the supervision interventions were:

1=Not at all helpful, 3=Neutral, 5=Extremely helpful

1. Audio/video review of student clinician sessions w/ client
2. Audio/video review of supervisor sessions w/client
3. Didactic training (teaching of interventions via lecture/discussion of written material)
4. Didactic training with clinical topic videos (e.g. motivational interviewing training video)
5. Role plays (supervisors modeling intervention)
6. Role plays (trainees practicing intervention)
7. Supervisor walk-in during sessions
8. One-way mirror during sessions
9. Consultation-breaks with supervisor during session
10. In vivo supervision (supervisor present; offers in-session supervision)
11. Other (please specify):
12. Other (please specify):
<table>
<thead>
<tr>
<th></th>
<th>Of the following interventions (if any), which do you wish your supervisor employed in training?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Audio/video review of student clinician sessions w/ client</td>
</tr>
<tr>
<td>2</td>
<td>Audio/video review of supervisor sessions w/client</td>
</tr>
<tr>
<td>3</td>
<td>Didactic training (teaching of interventions via lecture/discussion of written material)</td>
</tr>
<tr>
<td>4</td>
<td>Didactic training with clinical topic videos (e.g. motivational interviewing training video)</td>
</tr>
<tr>
<td>5</td>
<td>Role plays (supervisors modeling intervention)</td>
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<tr>
<td>6</td>
<td>Role plays (trainees practicing intervention)</td>
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<tr>
<td>7</td>
<td>Supervisor walk-in during sessions</td>
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<td>8</td>
<td>One-way mirror during sessions</td>
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<td>9</td>
<td>Consultation-breaks with supervisor during session</td>
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<tr>
<td>10</td>
<td>In vivo supervision (supervisor present; offers in-session supervision)</td>
</tr>
<tr>
<td>11</td>
<td>Other (please specify):</td>
</tr>
<tr>
<td>12</td>
<td><strong>None</strong></td>
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<thead>
<tr>
<th></th>
<th>Of the following interventions, which do you wish your supervisor DID NOT employ?</th>
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<tbody>
<tr>
<td>1</td>
<td>Audio/video review of student clinician sessions w/ client</td>
</tr>
<tr>
<td>2</td>
<td>Audio/video review of supervisor sessions w/ client</td>
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<tr>
<td>3</td>
<td>Didactic training (teaching of interventions via lecture/discussion of written material)</td>
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<td>4</td>
<td>Didactic training with clinical topic videos (e.g. motivational interviewing training video)</td>
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<tr>
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APPENDIX B

Counseling Self-Estimate Inventory (COSE)

This is not a test. There are no right or wrong answers. Rather, it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor. Do not respond with how you wish you could perform each item - rather answer in a way that reflects your actual estimate of how you will perform as a counselor at the present time.

Below is a list of 37 statements. Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

1 = Strongly Disagree  4 = Slightly Agree
2 = Moderately Disagree  5 = Moderately Agree
3 = Slightly Disagree  6 = Strongly Agree

PLEASE--Rank your responses using the 1-6 scale for each item.

_____ 1. When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point.

_____ 2. I am likely to impose my values on the client during the interview.

_____ 3. When I initiate the end of a session, I am positive it will be in a manner that is not abrupt or brusque and that I will end the session on time.

_____ 4. I am confident that I will respond appropriately to the client in view of what the client will express (e.g., my questions will be meaningful and not concerned with trivia and minutia).

_____ 5. I am certain that my interpretation and confrontation responses will be concise and to the point.
6. I am worried that the wording of my responses lack reflection of feeling, clarification, and probing, and may be confusing and hard to understand.

7. I feel that I will not be able to respond to the client in a non-judgmental way with respect to the client’s values, beliefs, etc.

8. I feel I will respond to the client in an appropriate length of time (neither interrupting the client nor waiting too long to respond).

9. I am worried that the type of response I use at a particular time, i.e., reflection of feeling, interpretation, etc., may not be the appropriate response.

10. I am sure that the content of my responses, i.e., reflection of feeling, clarification, and probing, will be consistent with and not discrepant from what the client is saying.

11. I feel confident that I will appear competent and earn the respect of my client.

12. I am confident what my interpretation and confrontation responses will be effective in that they will be validated by the client’s immediate response.

13. I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities.

14. I feel that the content of my interpretation and confrontation responses will be consistent with and not discrepant from what the client is saying.

15. I feel that I have enough fundamental knowledge to do effective counseling.
16. I may not be able to maintain the intensity and energy level needed to produce client confidence and active participation.

17. I am confident that the wording of my interpretation and confrontation responses will be clear and easy to understand.

18. I am not sure that in a counseling relationship I will express myself in a way that is natural, without deliberating over every response or action.

19. I am afraid that I may not understand and properly determine probable meanings of the client’s nonverbal behaviors.

20. I am confident that I will know when to use open or closed-ended probes and that these probes will reflect the concerns of the client and not be trivial.

21. My assessment of client problems may not be as accurate as I would like them to be.

22. I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy.

23. When giving responses, i.e., reflection of feeling, active listening, clarification, probing, I’m afraid that they may not be effective in that they won’t be validated by the client’s immediate response.

24. I do not feel that I possess a large enough repertoire of techniques to deal with the different problems my clients may present.
25. I feel competent regarding my abilities to deal with crisis situations that may arise during the counseling sessions – e.g., suicide, alcoholism, abuse, etc.

26. I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals.

27. I may have difficulty dealing with clients who do not verbalize their thoughts during the counseling session.

28. I am unsure as to how to deal with clients who appear noncommittal and indecisive.

29. When working with ethnic minority clients, I am confident that I will be able to bridge cultural differences in the counseling process.

30. I will be an effective counselor with clients of a different social class.

31. I am worried that my interpretation and confrontation responses may not, over time, assist the client to be more specific in defining and clarifying their problem.

32. I am confident that I will be able to conceptualize my client’s problems.

33. I am unsure as to how I will lead my client towards the development and selection of concrete goals to work towards.

34. I am confident that I can assess my client’s readiness and commitment to change.

35. I feel I may give advice.
36. In working with culturally different clients, I may have a difficult time viewing situations from their perspective.

37. I am afraid that I may not be able to effectively relate to someone of lower socioeconomic status than me.
# APPENDIX C

**Generalized Self-Efficacy Scale (GSE)**

Please respond to each of these items using the following scale:

1 = Not at all true   2 = Hardly true   3 = Moderately true   4 = Exactly true

1. I can always manage to solve difficult problems if I try hard enough.
2. If someone opposes me, I can find the means and ways to get what I want.
3. It is easy for me to stick to my aims and accomplish my goals.
4. I am confident that I could deal efficiently with unexpected events.
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.
6. I can solve most problems if I invest the necessary effort.
7. I can remain calm when facing difficulties because I can rely on my coping abilities.
8. When I am confronted with a problem, I can usually find several solutions.
9. If I am in trouble, I can usually think of a solution.
10. I can usually handle whatever comes my way.