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EMPIRICAL PAPER

Does the supervisor’s teaching style influence the supervisee’s learning prescribed techniques?

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Abstract

Objectives: This study examined the directive and non-directive supervisors’ instructional styles, supervisees’ interactive communications within supervision sessions as well as the relative success of supervisees’ learning to apply specific techniques within psychotherapy. Method: The developers of Time-Limited Dynamic Psychotherapy (TLDP) provided the supervised training for 16 therapists as part of the “Vanderbilt II” psychotherapy project. Supervision sessions were rated for supervisors’ adherence to TLDP content. Both supervisors and supervisee were rated for classroom interactive behaviors of “initiation” speech (e.g., introducing ideas) and “responsive” speech (e.g., amplifying the other speaker’s topic). The third therapy session was targeted for discussion within supervision. Therapy sessions immediately before and after supervision were rated on TLDP adherence. Results: One of the supervisors (Supervisor A) was found to use an instructional style of relatively more initiation-based speech, whereas the other (Supervisor B) used more response-based speech. Technical adherence for supervisees of Supervisor A was significantly higher than those assigned to Supervisor B. Supervisees’ initiation-based speech during supervision predicted less use of TLDP techniques in the therapy session after supervision. Supervisors’ interactive style was not associated with therapy adherence. Conclusions: Relatively more directive and structured supervision may influence the acquisition and use of manual-prescribed therapy techniques.

Keywords: psychotherapist training/supervision/development; psychoanalytic/psychodynamic therapy; brief psychotherapy

Clinical supervision plays an essential role in psychotherapy training. Research on effective supervision has not kept pace with developments in credentialing and guidelines for training programs and only recently has significant attention been given to the creation of professional guidelines for the competent practice of psychotherapy supervision (Falender & Shafranske, 2007). Thus, little is known about the empirical relationship between the activities of supervisors’ and the supervisees’ responses, both within supervision and later behaviors within psychotherapy sessions. Specifically, there is a lack of research on how different supervisory teaching styles might influence adherence to specific interventions or therapy outcomes. Furthermore, there is an absence of research on how supervisees’ responses to different supervisory teaching styles might be associated with the implementation of new therapeutic strategies within therapy sessions (e.g., Falender & Shafranske, 2007).

The limited research that exists on supervisees’ experience with their clinical supervisors has underscored the need for more research evaluating the supervisory relationship as an educative encounter. For example, student therapists report that clinical supervision is vital to learning new treatments (Godley, White, Diamond, Passetti, & Titus, 2001; Najavits, Weiss, Shaw, & Dierberger, 2000). The
reasons that therapists find supervision to be necessary are not clear, but studies indicate that individual supervisors not only help supervisees to appropriately implement manual techniques but also help in decision-making about how to be flexible in contextualizing those techniques, especially during difficult clinical encounters (Godley et al., 2001; Najavits, Ghinassi, & Luborsky, 2004).

Beyond self-reports of supervisees, observations of therapists’ in-session behaviors have demonstrated that supervision is an effective method for training therapists to adhere to techniques from a manual (e.g., Butler, Strupp, & Schacht, 1995; Rounsaville, O’Malley, Foley, & Weissman, 1988). However, there is considerable variation among therapists in their relative abilities to incorporate new techniques into their treatment repertoire (Henry, Strupp, Butler, Schacht, & Binder, 1993), and it is unclear whether this variability might be accounted for by supervisory teaching techniques and interactive styles. Some evidence suggests that therapist performance is enhanced when supervisors are more empathic, trustworthy, and supportive, and when they develop a good “teaching alliance” in supervision (Shanfield, Matthews, & Hetherly, 1993). In a study on structured training and supervision, Hilsenroth, DeFife, Blagys, and Ackerman (2006) found that higher amounts of supervisory teaching interventions were related to increased usage of techniques in Short-term Psychodynamic Psychotherapy. However, there is a paucity of studies that examine the association between supervisory teaching interventions and specific targets of therapist performance.

Understanding how individual supervisors are differentially effective in their instructional styles would facilitate the conceptualization and specification of supervisory competencies (Falender & Shafranske, 2007; Miller & Binder, 2002). Education research on the teacher–student relationship and learning outcomes may offer useful methods for studying the psychotherapy supervision process. For example, Flanders (1972) developed a straightforward and commonly used observational rating system to code teacher directive vs. non-directive instructional styles and complimentary student initiative vs. (passive) learning styles. In classroom education literature, the Flanders’ method has been used to study teacher–student communication styles in a variety of settings and countries (e.g., Oggunyi, 1984; Yu & Kim, 2008). This coding system has not yet been applied to the study of therapy supervisor–supervisee interactions.

In one of the only published randomized control trials of psychotherapy supervision in manualized training (referred to as the Vanderbilt II Psychotherapy Study; Strupp, 1993), 16 doctoral-level licensed therapists learned new technical interventions in Time-Limited Dynamic Psychotherapy (TLDP; Strupp & Binder, 1984). TLDP is a dynamic-interpersonal treatment which is grounded in two basic aims (Levenson & Strupp, 2007). First, TLDP has a patient focus, where therapist and patient focus on what is referred to as the patient’s Cyclical Maladaptive Pattern. This pattern is based on chronic interpersonal difficulties that result from a cycle of actions and expectations toward others, which in turn influences how others act toward them, and further reinforces longstanding, introjected views of the self. Second, these patterns are altered by using the patient–therapist relationship as a vehicle for change.

After approximately one year of TLDP supervision, therapists demonstrated higher levels of adherence compared to a year-long baseline level of practice before training. Recent findings indicated that the post-supervisory increases in therapist technical adherence were linked to supervisors’ discussion of specific technical content, and that this increase was independent of whether the trainees spoke about these technical skills during supervision (Anderson, Crowley, Patterson, & Heckman, 2012).

In the Vanderbilt II study, there was anecdotal evidence that differences in supervisors’ teaching styles appeared to be associated with differences in trainee acquisition of manual-prescribed techniques (Henry et al., 1993). Henry et al., observed that one supervisor (Supervisor A) offered more directive instruction than the other supervisor (Supervisor B), and this difference may have influenced therapists’ adherence to the manual.

One aim of the current study is to test those anecdotal observations with new ratings of the “Vanderbilt II” supervision and post-supervision therapy sessions. More formal and systematic observational measures of trainer style and technical adherence were used in order to more rigorously assess whether supervisory style predicted therapists’ technical adherence. Specifically, we tested the following three hypotheses and one non-directional exploratory analysis.

(1) Instructor–Student interaction styles would differ between the groups in that Supervisor A would be more directive (or initiation-based) and that supervisees’ would be more non-directive (response-based); whereas Supervisor B would be more non-directive, complemented by students being more directive (i.e., initiation-based speech);

(2) TLDP-specific strategies would be discussed more frequently within supervision sessions with Supervisor A than with Supervisor B;

(3) Treatment adherence to TLDP-specific strategies in the therapy sessions immediately
Method

Participants

Therapists. Sixteen licensed psychotherapists (8 psychologists, 8 psychiatrists; 10 males, 6 females) participated in this study. Therapists were clinically experienced with an average 4.3 years (SD = 3.4 years) post-doctoral clinical experience. Although therapists had previously received formal didactic training in psychodynamic therapy, none of the therapists had received any specialized training in TLDP or any short-term dynamic therapy using a manual.

Patients. The sample consisted of 40 patients who were seen during the supervised training years in the Vanderbilt II study (a subsample of the 80 patients that received psychotherapy in the study). Inclusion criteria in the Vanderbilt II study were based on the presence of significant distress on a symptom screening measure and a formal DSM diagnosis based on a clinical interview with a research clinician. Patients were offered up to 25 psychotherapy sessions and they attended a mean of 22 sessions. The study design included three cohorts: (1) a year-long pre-training period with no supervised training, (2) a second year (“training”) devoted to intensive training in TLDP with weekly supervision, and (3) a third year (“booster/post-training”) of less intensive supervisory contact in which therapists were assumed to be applying TLDP on their own, but with less supervisory contact. Each of the 16 therapists had seen one patient during the “training” cohort (i.e., 16 patients). During the booster/post-training cohort, an additional 24 patients were seen by therapists who received continuing supervision on these cases. [Eight cases from this cohort received no supervision because case assignments came later in the year and hence those cases were not included in the present study (since supervision sessions were not available)].

Patients in the current study had a mean age of 39.5 years (range: 24–59 years). The sample was mostly female (73.8%) and Caucasian (90.5%). The most common DSM Axis I diagnoses (using the National Institutes of Health Diagnostic Interview Schedule) were depressive disorders (66.7%), followed by both anxiety disorders (20.5%), and other disorders (20.5%). Most patients also met criteria for an Axis II diagnosis (61.5%). More than half of patients met criteria for more than one diagnoses (53.8%). The majority of patients with a personality disorder had received at least one additional axis I diagnosis (87.5%), leaving only a small number of patients with a dual diagnosis but without an axis II diagnosis (7.7%; all being anxiety and depressive disorders).

Supervisors and training. Each therapist was supervised by one of the authors of the TLDP therapy manual, and supervisees remained with the assigned supervisor throughout the entire training period. Supervision sessions were scheduled weekly and lasted for 15–18 months. The initial 5–10 meetings mainly consisted of didactic instruction in the TLDP manual, which included video examples from “model cases” that had been treated with TLDP by the supervisors and other members of the clinical research team. During this initial period, therapists were assigned their training case and began receiving supervision. Supervision was conducted in groups of 4 supervisees for 2 hr sessions and typically 2 supervisees received individual focus within each training. The case discussions occurred almost exclusively between the supervisee (i.e., therapist of the individual case) and the supervisor, though other members of the group were free to participate in discussion of the cases. Supervision of patients generally followed a traditional supervisory format in which (a) the supervisee presented background information and an overview about the case, (b) an audio-recorded segment from the supervisee’s most recent therapy session was played (recordings of the therapy session being discussed were listened to for an average of 15.3 (SD = 7.8) min during the supervision period, and (c) discussion of the case material transpired between the supervisor and supervisee about the recorded material. During this later period, TLDP interventions and strategies were generally the focus of discussion. The mean total time devoted to the supervision of a supervisee’s treatment of a particular patient within the supervisory sessions was 50.3 (SD = 13.7) min.

Additional details about the sample and design features of the original study may be found in elsewhere (Anderson et al., 2012; Bein et al., 2000; Henry et al., 1993).

Measures

TLDP adherence. Adherence to TLDP was measured using the Vanderbilt Therapeutic
Strategies Scale (VTSS; Butler et al., 1995), which is a measure of therapist adherence to TLDP-specific therapeutic techniques during therapy sessions. A total of 14 items on this scale are specific to TLDP strategies, referred to as the Specific Strategies scale (Butler et al., 1995). Minor changes were made to the scale in order to include items that link Cyclical Maladaptive Patterns and transference-based intervention strategies. Audio recordings of the therapy session were used for the ratings. The VTSS items were rated on the degree to which technical adherence was observed with the session. Ratings were made on a 5-point scale, which ranged from 1 (“none”) to 5 (“main point”). VTSS technical adherence was expressed as the mean item rating.

VTSS ratings used in the present study were originally made by Anderson et al. (2012) and included separate ratings for the content of supervision sessions by supervisors as well as therapy session adherence. For clarity, VTSS ratings from within supervision sessions will be referred to as supervision VTSS and adherence ratings from therapy sessions will be referred to as therapy VTSS. Findings of the earlier study pertained to the influence of supervision content on therapy adherence and did not include supervisor group differences. Also, because of the number of cases had been balanced in each training year for those prior analyses that involved therapy sessions (before and after supervision), there were only a total of 32 therapy sessions for which therapy VTSS adherence was available. As reported by Anderson et al., VTSS specific strategies had good average inter-rater reliability and internal consistency for both supervision VTSS (ICC = .88; α = .85) and therapy VTSS (ICC = .85; α = .88).

**Flanders System of Interaction Analysis.** The Flanders System of Interaction Analysis (FSIA) (Flanders, 1972) is an observational rating system that measures the interactive quality of the student–instructor relationship. The FSIA is consistent with the dominance-submission dimension of the interpersonal circumplex model in that it measures the extent to which teacher and student each control and initiate the instructional dialogue as well as the extent to which each are submissive or responding to the other in that dialogue. The FSIA has been used to measure instructional communication in a wide variety of educational settings, including the training of school counselors (Peace & Sprinthall, 1998), physical education (Yu & Kim, 2008), science instruction (e.g., Ogumniji, 1984), and English language training (Inamullah, Hussain, & Ud, 2008). The FSIA was used to measure the extent to which the learning environment in supervision was more directive (initiation) or non-directive (response). These initiation- and response-based communication styles are operationally defined by the more specific speech behaviors. More specifically, initiation-based communication was defined as speech in which the speaker made “the first move, to lead, to begin, to introduce an idea or concept for the first time, to express one’s own will” (Flanders, 1970, p. 35). Response-based communication was defined as speech in which the speaker takes “action after initiation, to counter, to amplify or react to ideas which have already been expressed, to conform or even to comply to the will expressed by others” (p. 35).

FSIA ratings were made on the amount of time supervisors and supervisees spent in initiation-based and response-based speech. Ratings for each variable were made on a 1 (none) to 5 (extensive) scale. The mean of the 4 Initiation items and the 3 Response items for each supervisor and therapist in the dyad was used in the analyses. Inter-rater agreement for the FSIA ratings was somewhat marginal for supervisor response-based speech (ICC = .68) and high for supervisor initiation-based talk (ICC = .80). However, we considered it reasonable to proceed to analyze these data with the caveat of marginal reliability for supervisor speech. Therapist–supervisee inter-rater reliability, however, was somewhat marginal to good for response and initiation-based speech (ICC = .67 and ICC = .85).

**Procedures**

Observational ratings of the variables in this study were made by a doctoral-level researcher and an advanced clinical psychology graduate student. Both raters were trained and had clinical experiences in conducting TLDP but were independent and had no direct involvement with the supervision and treatment of cases in the research sample. Raters practiced coding supervision and therapy sessions that were not used in the study. Once acceptable inter-rater reliability levels were attained, ratings for the present study commenced. The supervision session in which the supervisee received supervision for each of his or her patients’ third therapy sessions was identified (for 2 of the 40 cases, the 3rd therapy session was not available and the next closest session was selected).

Each coder listened to audio recordings of the relevant supervision session or therapy session. Observational ratings for both the FSIA and VTSS were based on the entire segment in which an individual therapy session (i.e., one patient’s third-session of psychotherapy) had been discussed (approximately
1 hr). All sessions were rated in random order and raters were blind to identifying information about the cohort, date, and session number. Each rater listened and made ratings to the audio-recorded supervision and therapy sessions in private so as not to be influenced by the presence of the other raters. Differences between the raters of greater than one point per item were discussed in order to maintain fidelity of future ratings. All sessions were rated by both raters and the mean of the raters’ codes was used for the final rating used in the analyses. Ratings for the therapy sessions that occurred immediately after supervision were used for measuring TLDP adherence in the therapy session.

Data analyses

The first hypothesis was examined the FSIA ratings using two 2 × 2 mixed design ANOVAs, where Supervisor (A vs. B) was a between subjects factor and FSIA learning style type (Initiation vs. Response) was a within-subjects factor. Speaker (supervisor vs. supervisee speech) was not included in the analysis because FSIA ratings are based somewhat on the total amount of talking that a speaker takes. Thus, one ANOVA was performed on supervisor speech whereas another was performed on supervisee speech.

Hypothesis 2 was tested with a 2 × 2 mixed design ANOVA, where Supervisor (A vs. B) was the main variable for comparison, but this analysis also included the two Training Years (training year versus booster year) as a within-subjects factor.

To test our third hypothesis that therapy session adherence on the VTSS would be higher for supervisees of Supervisor A when compared to those supervisees of Supervisor B, a 2 × 2 × 2 mixed design ANOVA was used. Similar to hypothesis 2, both supervisor group (A vs. B) and Training Year were factors in this analysis, however, this analysis included the supervisee’s therapy sessions that occurred before and after the supervision session as a within-subjects variable. Of interest was the therapy session VTSS adherence scores in these therapy sessions that juxtaposed the supervision session.

A final set of exploratory analyses tested whether the FSIA learning style variables predicted the supervisee’s technical adherence within therapy sessions. Four hierarchical linear regression analyses were conducted to examine whether the FSIA interactive learning style variables (supervisor initiation and response; supervisee initiation and response) predicted therapy VTSS in the therapy session after supervision. The first step in these models included the pre-supervision therapy VTSS as a predictor of post-supervision therapy VTSS. After controlling for the pre-supervisory level of TLDP adherence, the instructional style variable of interest was added.

Results

Because much of this large effect was due to the fact that supervisees had higher FSIA ratings for both initiation and response categories (they spoke more), it was decided that more meaningful understanding of the interaction should only be performed within supervisee and supervisor speech.

For the first hypothesis, each supervisor and supervisee speech were analyzed separately as noted. For supervisor speech, the Supervisor (A vs. B) × FSIA (initiation vs. response) interaction resulted in a highly significant cross-over interaction, $F(1, 38) = 43.95, p < .001, \eta^2_p = .54$. As illustrated in Figure 1, this interaction was due to Supervisor A’s higher use of FSIA initiation-based speech than Supervisor B, $t(38) = 8.46$; whereas Supervisor B was significantly more likely to use a response-based interactive style with his supervisees, $t(38) = 3.03, p = .004$. In regard to supervisees’ speech, there was also a Supervisor (A vs. B) × FSIA categories (initiation vs. response) interaction, $F(1, 38) = 6.44, p = .015, \eta^2_p = .15$. This interaction was almost entirely due to supervisees using more response-based speech with Supervisor A than was used by Supervisor B, $t(38) = 5.25, p < .001$, whereas there was no difference in the supervisees’ use of initiation-based speech, $t(38) = 0.00$, ns (see Figure 1).

It is noteworthy that supervisee initiation-speech was near the ceiling of the 5-point scale regardless of the assigned supervisor.

The two supervisors also differed in their focus on TLDP techniques during the supervisory sessions (as measured by the VTSS). A main effect was found for Supervisor, indicating that Supervisor A had higher
supervision VTSS, and hence discussed more specific strategies in supervision sessions \((M = 2.15; SD = 0.42)\), than Supervisor B \((M = 1.80; SD = 0.39)\), \(F(1, 36) = 7.44, p = .01, \eta^2_p = .17\). The model also found a main effect by the year of training since more specific strategies were discussed by both supervisors during the first training year \((M = 2.14; SD = 0.40)\) than in the following year of booster training \((M = 1.87; SD = 0.43)\), \(F(1, 36) = 4.71, p = .04, \eta^2_p = .12\). However, the Supervisor X Training Year interaction was not significant.

Tests of the supervisee’s therapy session adherence yielded a significant supervisor group main effect. Therapists in Supervisor A’s group displayed significantly higher therapy VTSS \((M = 2.04; SD = 0.11)\) than did therapists from Supervisor B’s group \((M = 1.70; SD = 0.11)\), \(F(1, 27) = 4.24, p < .05, \eta^2_p = .14\). However, there were no other significant interaction or main effects in this model. Thus, there were differences between the supervisory groups in therapy VTSS adherence, but these differences could not be specifically linked to the influence of, or occurring after, supervision.

The hierarchical regressions of the supervisor and supervisee FSIA interactive learning styles as predictors of post-supervisory therapy session adherence found one significant prediction. FSIA supervisee initiation-speech during supervision predicted post-supervision in-session TLDP adherence (after controlling for pre-supervision TLDP adherence), \(\Delta R^2 = .18, \beta = -.43, p = .01\). That is, higher levels of supervisee initiation predicted lower TLDP adherence (and lower levels of supervisee Initiation were associated with higher TLDP adherence). Further analysis examined this effect separately for each supervisory group. Supervisee initiation for those therapists in Supervisor B’s group predicted therapy VTSS \((\Delta R^2 = .48, \beta = -.71, p = .006)\). However, an analysis of therapists from supervisor A revealed that supervisee initiation did not predict therapy VTSS \((\Delta R^2 = .00, \beta = -.06, ns)\). FSIA responsive speech, however, did not predict TLDP adherence in the post-supervisory session, \(\Delta R^2 = .02, \beta = .15, ns\).

Neither supervisor Initiation or Response speech behaviors predicted TLDP adherence in the post-supervision therapy session (Supervisor Initiation \(\Delta R^2 = .01, \beta = -.04, ns\); Supervisor Responsive \(\Delta R^2 = .01, \beta = -.04, ns\)).

**Discussion**

Findings from this study provide empirical evidence for unique supervision styles and supervisee learning. Supervisees demonstrated rates of learning and retention of TLDP strategies that were differentially related to supervisor that they had been assigned to at the beginning of the project. Specifically, therapists supervised by Supervisor A adhered to TLDP-specific strategies more than therapists supervised by Supervisor B. Therapists in Supervisor A’s groups maintained these relatively higher levels of adherence through the two years of the training program. However, these differences could not be linked to immediate effects of a supervision session on technical adherence within the subsequent therapy session. It would appear, then, that the overall differences (by supervisor) in therapy adherence could have been due to a number of other reasons. The most parsimonious explanation for therapy adherence differences would be found across many supervisory sessions during training (i.e., since the experimental treatment within the Vanderbilt II study was the training). Not only did Supervisor A focus more on TLDP content, but he also demonstrated a significantly different teaching style and supervisees responded to both supervisors in the expected complementary manner. Because we did not experimentally control for differences in TLDP content and FSIA instructional styles across supervisors, we cannot determine with certainty the extent to which supervisor differences affected adherence. However, it’s also reasonable that supervisor differences in adherence could have been due to additional influences, including the didactic instruction at the beginning of training, the personality of the supervisors, or individual differences among the supervisees.

The present study also identified evidence as to what occurred during supervision that might have influenced these adherence differences. The FSIA instructional style differences between Supervisor A and Supervisor B were rather apparent. Supervisor A’s instructional style represented a more directive supervisory approach, whereas Supervisor B’s non-directive approach was evidenced by his significantly higher scores on FSIA responsive communication. Findings of Supervisor B’s response-based approach are consistent with descriptions from the field of teacher education as involving less direction and more student discovery (Weimer, 2002).

Moreover, this is the first known study in which distinct interactive learning styles predicted the retention of technical skills in post-supervision therapy sessions (with pre-supervision levels of adherence removed). Specifically, supervisees that communicated with relatively more initiation-speech within supervision were significantly less likely to adhere to TLDP techniques in actual therapy sessions (and lower supervisee initiation was likely to have higher adherence). However, it is notable that only supervisees’ FSIA initiation was a significant predictor of
adherence and the supervisors’ FSIA variables did not predict their supervisees’ post-supervision adherence.

Limitations and Future Directions

A number of limitations to this study should be mentioned. For example, the relatively low power of this study may have contributed to why supervisors’ instructional style did not specifically predict therapy session adherence. Other limitations include the choice to rate the amount of time spent discussion TLDP and interactive communication, which provides an inexact measurement, which in turn may have contributed to two FSIA variables that were somewhat marginal in inter-observer reliability. More precise timing of specific types of communication or the use of other precise forms of unitizing might have been advantageous (though these choices would also have required further modification of the original forms of these scales). Even with these limitations in mind, it seems plausible that suggest that the differences in the supervisors’ teaching styles were integrally related to differences in their respective supervisees’ tendency to introduce new topics, which in turn had an impact on their acquisition of technical adherence. It is also possible that differences in technical acquisition occurred earlier, even during the initial 12-week long didactic training, than the supervision sessions that were analyzed for this study.

A limitation of this study was that psychotherapy competencies involve highly complex, interactive behaviors that extend beyond the narrow criterion of technical adherence that was used in this study. Although this study included both technical and instructional style measures, attaining real-world mastery with these skills is an interactive process and involves real-world applications. Thus, supervision is probably more analogous to the teaching involved in other complex performances (e.g., music, dance, sports). In most psychotherapy supervision, the supervisee is already embedded within a real-world setting and attempting to apply declarative knowledge (e.g., from course readings) and transform it into procedural knowledge. Ericsson (2006) described this unique learning situation as one in which “deliberate practice” is the most effective strategy for developing such complex, real-world skills. As mentioned above, deliberate practice involves structured practice with feedback that is specific and immediate. However, the risk of deliberate practice is that the supervisor must be extraordinarily sensitive to the supervisees’ experience since there is increased risk for the supervisee to feel controlled and criticized.

For example, Supervisor A’s style was relatively more directive and structured. He tended to focus on how his supervisees were systematically thinking about patients and then engaged supervisees in decision-making about which TLDP-specific strategies to choose for any given situation. (Binder, 1999). By contrast, Supervisor B’s supervisory style was relatively more non-directive and student-centered in that he non-assertively guided his supervisee toward TLDP-specific strategies and allowed his supervisees to struggle with conceptualizing their unique understanding of their patients first before adding some TLDP notions as possibilities. Supervisor B’s focus was to help clarify what his supervisees were thinking rather than to guide their thinking and decision-making toward specific TLDP actions. We believe that further understanding of these two basic supervisory styles, directive and student-centered supervision, are not mutually exclusive and worthy of further study. Future study of the discretionary use of these basic approaches and how they might optimally match to supervisee development might aid in developing more comprehensive models and evidence for effective supervision. For example, more directive approaches may be more effective for advanced (e.g., post-doctoral) supervision as it may be a more effective method in facilitating the achievement of technical adherence. However, for beginning therapists a more directive approach may streamline early technical adherence, but perhaps at the cost of neglecting to nurture the development of novice therapists’ critical thinking when grappling with clinical material and relational process issues.

Another limitation of this study is that there were only two supervisors and thus the results have limited generalizability. This archival study of supervision was chosen because of the unique instructional differences in the supervisory styles that had previously been observed (Henry et al., 1993). These different styles were confirmed by the results of this study, which showed that each supervisor displayed unique FSIA styles. Greater generalization can be made about results involving a larger sample of supervisees and their therapy patients. As with most psychotherapy studies, the limited number of supervisors may create non-random variability. However, this relative disadvantage is balanced by the lack of research on the interpersonal processes within psychotherapy supervision. While it would not be appropriate to generalize to all usage of these instructional styles, this study provides practitioners of supervision some potential issues to consider while using either a more directive or a more non-directive supervisory style.

Conclusions and Future Directions

The results of this study provide a modicum of support for use of a relatively more directive and
structured instructional approach when teaching novice psychotherapists basic psychotherapy techniques. The relatively more directive style of Supervisor A and the higher adherence of his supervisees is consistent with findings from some related domains of complex performance (e.g., chess, sports, radiology). Namely, the most effective teaching methods involve (1) articulating clear performance benchmarks and goals, (2) providing specific feedback on trainee performance, and (3) orchestrating thoughtfully planned practice sessions (Binder, 1999; Ericsson, 2006). As psychotherapy is also a set of skills that are used in complex performance, we believe that these methods could be promising for future supervision and training in psychotherapy.

Future research on the interactive learning environment has the potential to improve our understanding of supervision. Because successful psychotherapy involves the acquisition of both technical adherence and interpersonal skills, the one-size-fits-all approach of traditional clinical supervision may not be effective for meeting competencies of contemporary practice. The supervision and training of this complex blend of technical goals, client–therapist relational issues, client contexts and supervisee needs might be enhanced through methods that match this complexity. For example, we have suggested elsewhere that future study might focus on the use of video-assisted feedback on simulated targeted psychotherapy situations as one component of psychotherapy training prior to supervision of actual therapy patients (Anderson et al., 2012; Binder, 1999). The targeted nature of such video-assisted training modules could keep interactive learning more focused on specific training goals, without the distractions of having to deal with actual patient–therapist interpersonal processes. Such a training setting would approximate Ericsson’s (2006) description of “deliberate practice.” Throughout this sequence of training experiences, supervisors would remain responsive to students’ learning needs. Such training strategies already have been successfully implemented in secondary education settings, using technologies that ground learning within specific, realistic video-assisted narratives (e.g., Biswas, Schwartz, & Bransford, 2001).

Finally, instruction in technical adherence is only one aspect of clinical supervision. At least equally important is the development of therapist interpersonal skills to a level where specific therapy techniques can be effectively implemented taking into consideration the exigencies of the immediate patient–therapist relationship. We raise this issue now because the original “Vanderbilt II” project (Strupp, 1993) was designed to train therapists to address problematic patient interpersonal styles. Yet one of the lessons learned from that study is that the therapists (all of who had been highly recommended by peers and teachers) were not able to implement the prescribed techniques with sufficient interpersonal skill (Strupp & Anderson, 1997). For therapists to be optimally effective, they must achieve an integration of technical adherence and interpersonal skills. So far, we have identified a supervisory approach that effectively fosters the acquisition and implementation of prescribed techniques. Our next challenge is to develop methods that effectively train therapists to implement their techniques with sufficient interpersonal skills.

Note

1 Analysis that included speaker (i.e., Supervisor × Speaker × FSIA categories) indeed resulted in a highly significant interaction, F(1, 38) = 26.88, p < .001, ηp² = .41. Because of differences talk-time might influence the FSIA analysis, all analyses were also conducted with the total amount of FSIA rating usage as a covariate (i.e., the combined rating of both FSIA initiation and response ratings). Findings with the covariate were highly similar in significance and ES and therefore this covariate was not included in final reporting.

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