Some awkward questions about supervision – and maybe a few answers too

Dave Green

Supervisor's tasks

- Ensure safety and well-being of clients seen by supervisee
- Ensure safety and well-being of trainee
- Promote the effective treatment of clients
- Promote professional development of the trainee
- Function as a professional gatekeeper

The information you need and the information you typically get

- Pretty heavy reliance on self-report of the trainee – suspect source of evidence
- Some direct sampling of their clinical work – sitting-in; audio-recording; video perhaps
- Indirect feedback from colleagues
- Outcome measures if you are very lucky
- Some normative standards against which to judge the trainee's performance

Non-Disclosure in Supervision (Hess et al 2008)

- Trainees "wilful witholding" of information from their supervisors
- Happened in both "good" and "bad" supervisory relationships
- Keeping quiet about own emotional reactions to clients and feelings about the supervisor/placement
- Understandable but destructive…

A familiar story – Ladany (1996)

- Non-disclosure is a frequent and normative aspect of supervision
- Trainees tend to withold information related to both clinical material and their experience of supervision
- Reasons given are impression management and perceived negative consequences of disclosure (What you don't know won' hurt me – Kadushin 1966)

The latest (Mehr et al 2010)

- 214 trainees recruited from clinical and counselling psychology courses in USA
- Completed trainee disclosure scale; supervisory alliance measure; and trainee anxiety scale after a SINGLE supervisory session
- 84.3% reported they had withheld some information from their supervisors
- Predictable links with negative view of supervisor and trainee anxiety levels

Of course if they were as experienced as we are…

- Not only would they have overcome these juvenile tendencies towards reputation management…
- They would have learned to read their clients' experiences of therapy so much better
- Except the evidence suggests only a small minority of therapists (the effective ones!) are good predictors of their clients' feedback on progress (Hiatt and Hargrave 1995)

Hatfield et al 2010

- Surveyed outcomes at US university counselling service over a 5 year period
- About 8% met criteria for statistically reliable change in the *wrong direction*
- Chose 70/400+ such examples and checked case notes to see if therapist had noticed what was going on. Only 21% had!
- Restricted casenote analysis to 41 instances of sudden deterioration from one session to next. 32% now noticed!

Positive self-appraisal bias

- We are not generally as good as we think we are – The Lake Wobegon story
- The "above average effect" (Alicke 1995)
- The double handicap of being both "unskilled *and* unaware of it (Kruger and Dunning 2003)
- I used to be like that… "From chump to champ" (Wilson and Ross 2000)
- Applies to psychotherapists too…

Walfish et al (in Lambert 2009)

- Studied self-perceptions of 129 therapists of different disciplines in private practice
- Asked to compare own performance and skills with others in their profession
- Estimate typical outcomes for their clients
- No one reckoned they were below average; 27% rated themselves >90th percentile
- 47.7% reported that *none* of their clients had ever regressed during treatment

Honest answers?

- Would it be possible for a trainee on your placement to pass without ever making a positive difference to a client's life?
- Would it be possible for a trainee on your Course to pass without ever making a positive difference to a client's life?
- Would you know what the drop-out rate is for the trainees you have supervised?
- Would you know what the typical drop-out rate is in your specialty?

An unspoken shame

- Barrett et al's 2008 review entitled "Early Withdrawal from Mental Health Treatment: Implications for Practice" reckons
  - Of 100 prospective clients contacting a mental health clinic
  - Only 50 will attend the initial evaluation
  - 33 will attend the first treatment session
  - 20 will remain by session3
  - Fewer than 17 will remain by session 10
- Similar UK findings from CORE researchers (Connell et al 2006)

The Reverse Dodo judgement

- A recent meta of comparative outcome studies of psychotherapy for depressed adults (Cuijpers et al 2008) compared 7 interventions and found no overall differences in effect size
- Drop-out rates hard to assess with **completers only** not **intention to treat** analyses
- However on the data available CBT had a significantly higher drop-out rate than other therapies. Maybe a function of sample size
- Probably all as bad as each other! See Masi et al (2003) review on dropout in systemic therapy

So will EBP help?

- You could up your supervisory game by applying EBP principles and tutoring your trainee in a manualised intervention then checking regularly that they are not straying "off piste"
- Evidence that research protocols can be transferred to clinical settings with comparable levels of efficacy but
  - Effect size achieved in TAU may be comparable as ther seems to be little evidence that treatment outcomes are enhanced (Addis and Waltz 2002)
  - Optional level of adherence to protocol is not at all clear (Perepletchikova and Kazdin 2005)
  - There are always variations in client response to even the most effective therapies (Morley et al 2009)
  - Some therapists are much more effective than others (Okiishi et al 2006) - even in controlled therapy trials
- EST does not equal EBP (Westen et al 2005)

Lambert et al (2003)

- Meta-analysis of 3 studies examining effects of tracking patient outcome on therapist performance (>1k participants)
- Progress measured using OQ45
- Statistical definitions of reliable change plus clinical cut-off scores provide an expected recovery trajectory
- Traffic light feedback system: white (discharge); green (OK); yellow (slow); and red (danger of dropout)

Lambert et al (2003)

- Provision of "signal-alarm" feedback (ie yellow and red status) reduced level of deterioration (13% v 21%)
- Partly due to staying in therapy longer but overall costs comparable
- Trainees benefitted from feedback on all their cases but qualified staff just profited from signal-alarm data

Harmon et al (2007)

- Large study comparing effectiveness of 3 feedback conditions against no feedback archival data as control
  - Outcome feedback to therapist
  - Outcome feedback to therapist and client
  - Outcome feedback plus use of clinical support tool to therapist for signal-alert client cases
- CST consists of one-off questionnaire assessment of client's view of (1) therapeutic alliance (2) motivation to change and (3) current support system

Results

- All groups showed significant improvement
- All feedback conditions had better outcomes than no feedback control
- Adding client feedback provided no significant extra benefit (unexpected)
- Strengthening feedback using the CST significantly enhanced outcome for the signal-alarm clients (no data on others)

Other tools for obtaining feedback

- Shorter versions of CORE - CORE 5 & CORE 10
- IAPT recommends sessional administration of GAD -7 and PHQ-9
- Designed for use each session but focus on outcome not therapeutic relationship
- Ideographic approaches such as PQRST, semantic differential and repertory grids
- Short from of Vanderbilt therapeutic alliance scale (Shelef and Diamond 2008)

The CDOI approach

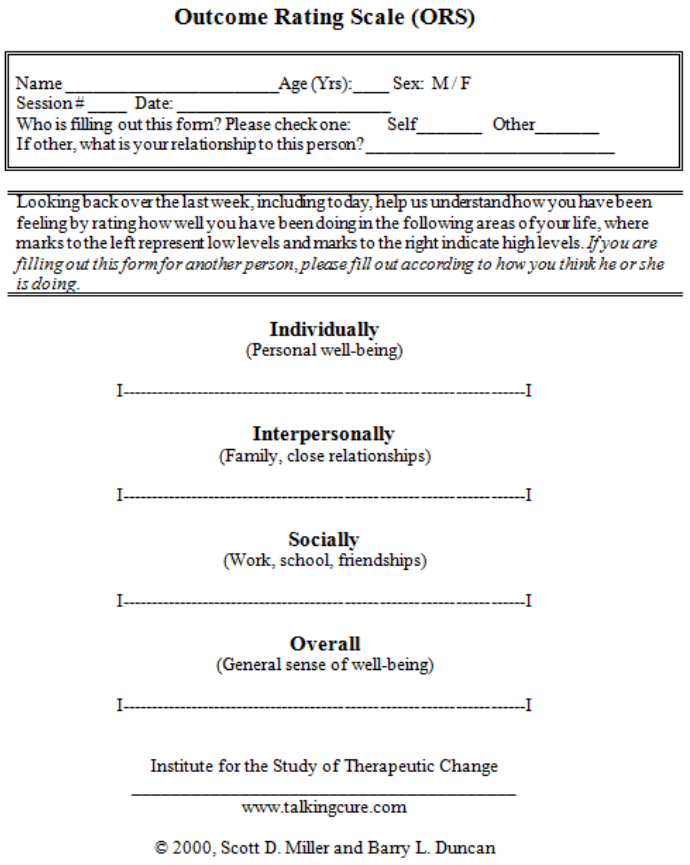
- Promoted by Miller and Duncan (2000) from the Institute for the Study of Therapeutic Change in Chicago
- **C**lient-**D**irected **O**utcome-**I**nformed
- Advocate use of session-by-session client feedback on progress towards outcomes (ORS) and experience of each consultation (SRS)

Outcome Rating Scale

- 4 item scale administered at the beginning of each session
- Correlates strongly (.7) with OQ-45 Lambert's longer outcome measure
- Test-retest reliability = >.8
- <1 minute to complete and score
- See replication study Bringhurst et al 2006
- Decent correlations with full scale CORE scores on Yorkshire data from Human Givens

The Outcome Rating Scale (ORS)

- Given at beginning of every session
- Assesses individual, relational, & social functioning.



Outcome Rating Scale (ORS)

Name _____ Age (Yrs):____ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

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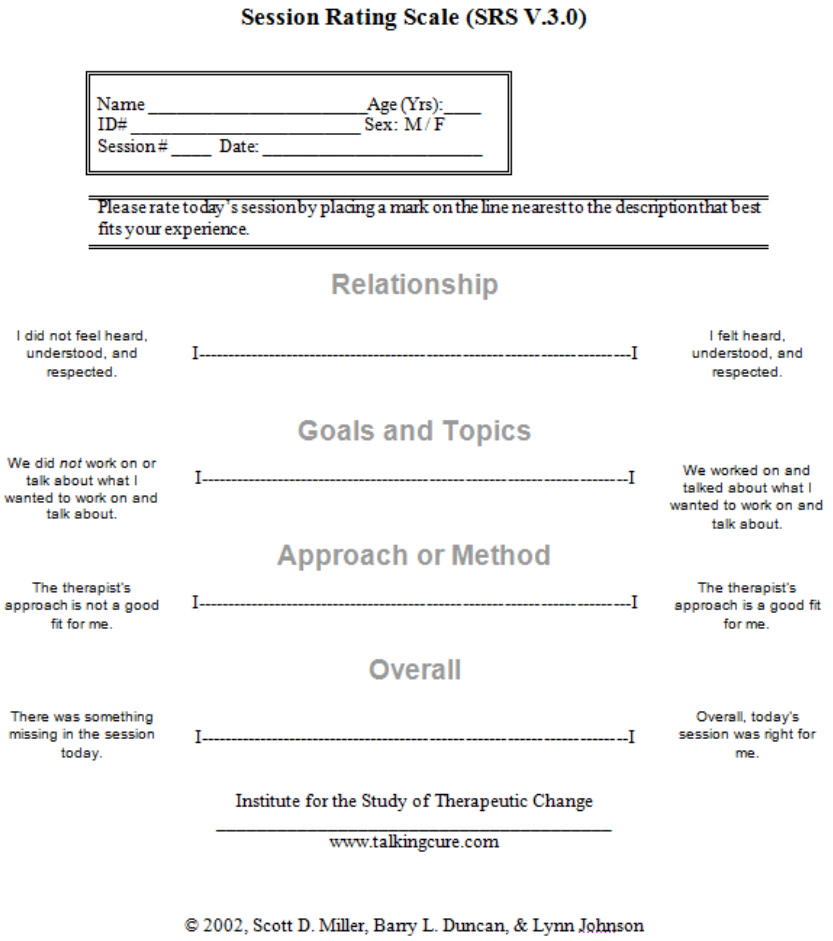
Session Rating Scale

- 4 item alliance scale administered just before the end of each session
- Test-retest reliability = .7
- Correlation with HAQ-11 = .48
- <1 minute to complete and score
- Scores of <36 are unusual and warrant discussion – not easy to interpret as complaint is a good sign!
- No obvious alternatives – HAT perhaps

The Session Rating Scale (SRS)

- Given at end of every session
- Assesses perceived relationship with therapist, extent worked on shared goals and topics, whether the approach/method was a good fit and overall assessment.



Session Rating Scale (SRS V.3.0)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. I---I I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I---I We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. I---I The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. I---I Overall, today's session was right for me.

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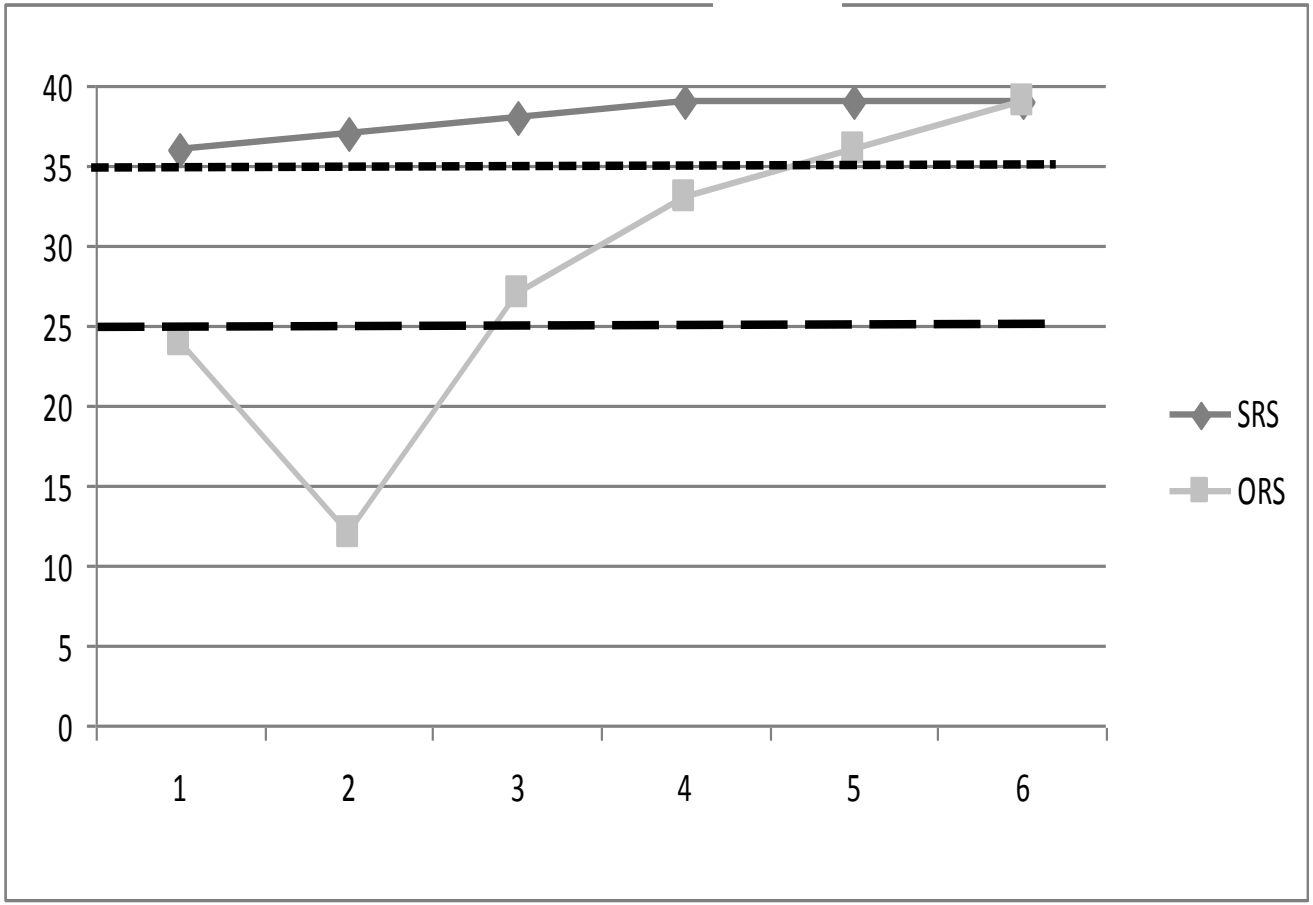
Creating a "Culture of Feedback"

- When scheduling a first appointment, provide a rationale for seeking client feedback regarding the alliance.
- Work a little differently;
  - "Want to make sure that you are getting what you need"
  - Take the "temperature" at the end of each visit
  - Feedback is critical to success
- Restate the rationale at the beginning of the first session and prior to administering the scale.


40
35
30
25
20
15
10
5
0
1
2
3
4
5
6
SRS
ORS

RCT of CDOI approach

- Anker et al (2009) conducted a Norwegian RCT comparing outcomes of CDOI informed marital therapy with TAU controls
- Initially 453 couples randomly assigned to 2 conditions but 211 couples opted out or just did not turn up for the first session
- 205 couples attended at least 2 therapy sessions and completed post-therapy measure
- 74 couples completed 6 month FU measures

Anker et al contd

- 10 therapists participated in study
- All described themselves as eclectic
- 2 days initial training plus 3x3 hours follow-up with focus on interpretation of ORS scores
- Light touch oversight with minimal checking of how therapists used feedback data with clients, or therapeutic approach adopted
- Same therapist in both conditions
- Outcome measures – ORS at pre-post treatment and 6 month follow-up

Results

- No pre-treatment differences between groups
- Overall treatment worked. Mean effect size d =.76
- Some variability between therapists in outcome (4%)
- ORS scores in the feedback group on average 4.89 higher than TAU group at end of treatment
- Difference maintained but reduced at 6 month follow up (now mean ORS score 3.97 points higher)
- Some real world differences too. 18.4 % of couples in feedback group had divorced or separated at follow-up versus 34.2 % of TAU group
- Some suggestion that the relatively less effective therapists benefitted more from feedback condition

Implications for supervision

- Lambert and Hawkins (2001) remarked that "It is surprising and even ironic that supervision is frequently conducted in the absence of systematic monitoring of patient progress"
- Recommended routine use of "patient tracking" in supervision
- Provide a case vignette where the traffic light system alerted supervisor and supervisee of need to change tack in therapy

Use of client feedback in supervision

- Reese et al (2009) conducted an exploratory study with 9 supervisors; 28 2nd year therapy trainees and 110 clients
- Half the group had supervision as usual and collected unanalysed and undiscussed sessional outcome data (ORS) from clients
- The other half collected sessional outcome (ORS) and alliance (SRS) data from clients which they used in therapy and supervision

Interesting results…

- Noticeable differences in client outcome
  - Both groups improved but significantly more movement in feedback group
  - Clear therapist differences (range of mean effect size for outcome group = 0.43 to 1.72 compared with control group = -0.22 to 1.02)
- Noticeable improvement over time
  - Both groups more effective in 2nd semester
  - Feedback group improved more (from 0.70 to 0.97 mean effect size) than control group (from 0.30 to 0.37) from 1st to 2nd semester

However…

- No differences between groups on measures of either quality of supervisory alliance (SWAI) or supervisee satisfaction (SOS)
- No differences between groups on measure of Counsellor Self-Efficacy (COSE)
- But for trainees in outcome group their sense of efficacy was strongly correlated with aggregate outcome scores at the end of the study (.51) while no such relationship existed in the control group (-.38) !!!

Limitations of study

- Small numbers and not fully randomised
- Client factors bound to influence outcome
- The big question remains unanswered. Does using sessional outcome and alliance feedback data in supervision improve client outcomes for trainees on top of the benefits of using that data directly with their clients? And what is the respective contribution of ORS and SRS to outcome in both of those two conditions?

Nonetheless…

- This study suggests that outcomes for your trainee's clients will likely improve if you use ORS and SRS in their supervision
- You may not become a more popular supervisor as a consequence but you are unlikely to drop your ratings either
- Your trainees will probably not emerge any more confident after your placement but their self-appraisal of clinical competence should be more in touch with reality!

A wee exercise…

- Fill in ORS and SRS scores on behalf of one of the clients you have recently seen. If possible create a little ORS/SRS history of your work together on the graph
- Work in 3s as a supervisee-supervisor-observer triad.
  - 20 minutes each combination
  - 15 minutes feedback informed supervision
  - 5 minutes feedback from observer
- End with whole group discussion

Measuring the supervisory alliance

- If it makes sense for therapists to solicit regular consumer feedback from clients, doesn't the same principle hold for supervisors?
- What measures are available to enable supervisees to provide structured feedback to their supervisors?
- How practical might they be to use?

Longer measures of the supervisory alliance

- The Supervisor Working Alliance Inventory (SWAI) is the current proverbial gold standard but its factorial structure has been criticised by Ellis (1997)
- In the UK Palomo et al (2010) from the Oxford course have produced the Supervisory Relationship Questionnaire (SRQ) a 67 item scale designed to cover aspects of supervision identified by supervisees in Beinart's qualitative doctoral research. Comprehensive but unwieldy

Brief supervisory alliance measures

- Interestingly several simultaneous developments of shorter scales that can be used to collect sessional feedback
- In Germany Zarbock et al (2009) developed two parallel questionnaires to be used by supervisor and supervisee - with no great correlation between the two! 11 items covering 3 dimensions (relationship; problem coping; and clarifying)
- In US Ellis is working on a short version of the SWAI
- In Norway Ronnestad has just submitted a 12 item scale for journal review. The measure has already been endorsed by the newly formed Supervision Research Group run by Sue Wheeler in Leicester
- And in Yorkshire…

Nigel Wainwright's thesis

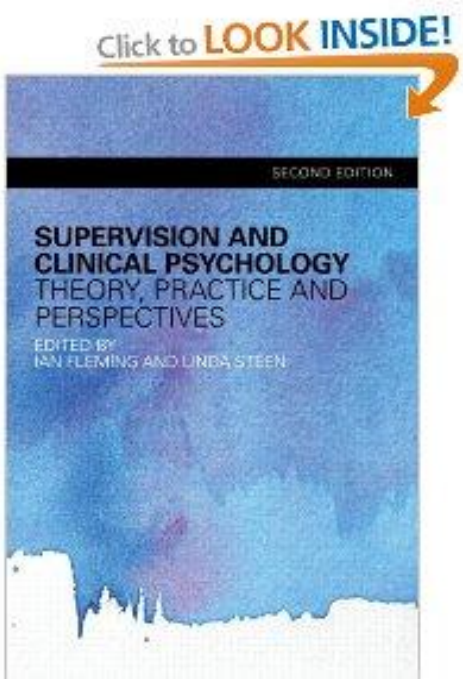
- Aim to produce a brief (shorter than other alternatives) measure of supervisory alliance akin to the SRS
- Aim to follow the same principles used by Miller and Duncan in producing the SRS
  - Sample items from existing supervisor alliance scales ; administer to >100 trainees; factor analyse results
  - Use this information to create a new, short form; validate against existing measures; get feedback on likely usefulness
- Only a single factor solution from regression stats – probably linked to frequency of high scores
- But some more differentiaion in cluster analysis

The LASS – Leeds Alliance in Supervision Scale

- Only 3 items covering supervisee's perception of the approach taken by supervisor; the supervisory working relationship: and how well the session met the trainee's needs
- Simple to use; plenty of supportive data; hot off the press and FREE
- Feedback to me, Nigel or Gary Latchford

A little light reading

Fleming and Steen 2011



Green and Latchford 2012