The Role of Personality on Early Alliance Formation in the Context of Clinical Supervision

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Abstract

The literature suggests that working alliance is an important predictor of clinical supervision outcomes. However, little is known about the individual factors that influence the development and maintenance of the working alliance. This study aims to explore the role of supervisor and supervisee personality factors on the development of early working alliances, as well as supervisor and supervisee concordance rates in the context of clinical supervision. This study used the NEO-PI-3 measure to assess personality traits and the Working Alliance Inventory-Supervisor and Trainee Versions (WAI) measures to assess working alliance ratings. Results suggest that supervisors rate the strength of their alliances as significantly stronger than supervisees ($p < .05$). While no supervisee personality traits were found to predict their perception of the early alliance, the openness and agreeableness domains were found to be significantly associated to supervisor's self-reported ratings of alliance. Implications of these findings are discussed.

Keywords: Personality, Working Alliance, Clinical Supervision

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Clinical Supervision

Background

The origins of clinical supervision can be traced back to the 1950s as a practice used primarily amongst psychoanalysts in psychiatric units. The practice of supervision has steadily increased and it is now recognized as a key component of clinical training (Watkins, 2014). Consequently, during the 1980s and 1990s, there was a significant increase in empirical research and publication on clinical supervision (Hyrkäs, Appelqvist-Schmidlechner & Haataja, 2006) supporting the importance of supervision in both training contexts and continued professional development.

To date, studies have focused on demonstrating the effects of clinical supervision on supervisees' knowledge base, competency, and professional and personal growth (Hallberg, Hansson & Axelsson, 1993; Arvidsson, Lofgren & Fridlund, 2000; Hyrkäs, Appelqvist-Schmidlechner & Haataja, 2006), as well as on professional identity (Segesten & Ed, 1993). Other positive outcomes of clinical supervision relate to the quality of care for clients/patients (Hallberg, 1994; Edberg, Hallberg & Gustafson, 1996; Hyrkäs & Paunonen-Ilmonen, 2001) and the quality of written documentation (Hallberg, Hansson & Axelsson, 1993).

The aforementioned studies demonstrate the influence of clinical supervision on supervisees' personal growth and professional practice (Hyrkäs, Appelqvist-Schmidlechner & Haataja, 2006). Little is known however about the impact of individual characteristics on the process or outcomes of supervision. Some research in the workplace setting has linked personality to working alliances and outcomes (Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003). For instance, Ackerman and Hilsenroth (2001) explored how personality characteristics

could negatively affect a working alliance, suggesting it may be relevant to study the role of personality in the context of clinical supervision.

Definition of Clinical Supervision

Throughout the literature, many definitions for clinical supervision have been proposed. Bernard and Goodyear (1998, 2014) and Milne (2007) suggest it is an intervention from a senior member of a profession provided to a junior member, with the purpose of promoting professional development and gatekeeping the profession. Falender and Shafranske (2017) also note that clinical supervision is a distinct professional activity by which education and training are used to develop science-informed practices through a collaborative interpersonal process. This suggests that the key component of supervision is its collaborative nature.

In his article, *Clinical Supervision: A Concept Analysis*, Gordon (2000) discusses three different definitions for clinical supervision found in the literature: (1) Butterworth and Faugier (1992) define supervision as an exchange between practising professionals intended to assist in the development of professional skills; (2) Minot and Adamski (2009) describe it as a process by which a supervisor reviews and analyses a trainee's ongoing clinical work; and (3) the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) (1996) defines it as a practice-oriented relationship where a supervising practitioner reflects on the supervisee's practice. In reviewing these definitions of clinical supervision, three components emerge: the presence of an experienced member of the profession, the importance of feedback in promoting professional development, and the need to gatekeep the profession of psychotherapy. These clinical supervision needs are considered a necessity to ensure trainees develop the skills and knowledge required for effective professional practice (Milne, 2007; Friedman & Marr, 1995; Gordon, 2000; Bernard & Goodyear, 2014; Falender & Shafranske; 2017).

For the purpose of this study, the concept of clinical supervision will be defined as a relationship between a supervisor and a supervisee in the field of psychotherapy, with the purpose of offering feedback to encourage the development of professional skills, while ensuring protection of the public.

Importance of Clinical Supervision

Recent studies (Barnett & Molzon, 2014; Golia & McGovern, 2015; Dawson, Phillips & Leggat, 2013; Milne & Reiser, 2012) demonstrate the importance of clinical supervision for positive therapeutic outcomes and in support of trainees' professional development. This is done by promoting skill development, introducing supervisees to professional values and ethics, and gauging supervisees' readiness to begin their careers (Bernard & Goodyear, 2014). Not only is clinical supervision crucial to supervisee professional development, it is also critical for client care and ensuring service quality (Bernard & Goodyear, 2014).

In the practice of psychotherapy, supervision is identified as the primary means through which trainees develop professional competence (Hall, Kasujja & Oakes, 2015). In their study of clinical psychology students in Uganda, Hall et al. (2015) note that supervision was identified as the most importance factor in students' learning and development of self-awareness. Furthermore, clinical supervision was found to support students' emotional well-being through supportive alliances. It is therefore important to expand our understanding of what may or may not affect these alliances between supervisors and trainees (Hall, Kasujja & Oakes, 2015).

On the other hand, some studies have focused on the negative effects of bad or harmful supervision. Ellis et al. (2013) distinguish between bad or inadequate and harmful supervision to clarify potential harm to supervisees. Their study focused on describing two types of negative clinical supervision experiences; inadequate supervision and harmful supervision. Inadequate

supervision arises when the supervisor is unable or unwilling to increase trainees' professional performance, to observe the quality of the services offered to trainees' clients, or to serve as gatekeepers of the profession. The effects of such inadequate clinical supervision include the development of poor-quality supervisory relationships and harm to supervisees' clients due to improper training.

Harmful supervision, however, occurs when there is psychological, emotional, and/or physical harm or trauma is inflicted on supervisees: "harmful supervision may result from the supervisor acting inappropriately or with malice, supervisor negligence, or the supervisor clearly violating accepted ethical standards and standards of practice and care" (Ellis et al., 2013, p. 440). Harmful clinical supervision may cause symptoms of psychological trauma, such as feelings of mistrust, fear, shame, guilt, and/or self-derogation, thereby considerably decreasing the self-confidence of supervisees, functionally damaging their professional or personal lives, and causing deterioration in their general mental or physical health.

To fully understand the link between poor supervision and such negative effects on the supervisory relationship, it is imperative to understand the underlying mechanisms of supervisory alliances in order to apply them appropriately.

Supervisory Models

This subsection will examine the different supervisory models outlined in the literature. Bernard and Goodyear (2014) separate these models into three categories: psychotherapy models, developmental models, and process models, which will be discussed.

According to Bernard and Goodyear (2014), psychotherapy models refer to transposing the application of theoretical perspectives used when working with clients to working with their own supervisees. Learning how to deliver specific treatment theory is the main objective of the

psychotherapy models. One example of a psychotherapy-based model of supervision is Cognitive-Behavioural Supervision (CBT), which involves a formal structured approach as typically found in the CBT model (Liese and Beck (1997). For example, homework can be assigned and the supervisees' negative thought patterns can be assessed. Assessing thought patterns involves looking at affect and their impacts on supervisees' goals (Liese & Beck, 1997). By developing an in-depth understanding of the theoretical structures, the psychotherapy models allow supervisees to apply skills in psychotherapy, thus being an advantage of this model. This is due to the continued and direct exposure to their supervisor's theoretical perspective. Contrarily, being solely exposed to a single supervisor approach and theoretical model can limit the extent of the learning in regards to other therapeutic orientations. Furthermore, supervisees whose personal values do not match their supervisors' could also be limited in the development of their personal theoretical and therapeutic orientation (Bernard & Goodyear, 2014).

Developmental supervision models focus on supervisees' specific needs in relation to their skill level (Bernard & Goodyear, 2014). These were developed after recognizing the need for supervisors to form several styles and approaches with their supervisees in mind (Page & Woskett, 2001). Developmental models employ either psychosocial developmental theory, cognitive learning theory, social learning theory, motivation theory, and human development theory, or a combination (Bernard and Goodyear, 2014).

The developmental model involves categorizing supervisees according to three developmental levels: the first level of development represents the initial phase of training, where supervisees have limited knowledge, experiences, and skills; supervisees at level 2 have developed basic skills and show more confidence in making decisions; and supervisees at level 3 demonstrate an understanding of the use of self in therapy and have formed their personal therapeutic style. The

main advantage of the developmental model is that it focuses on supervisees' professional and personal needs by incorporating learning and motivation theories, for example (Watkins, 2012). However, a lack of understanding of supervisees' learning style may cause difficulties in understanding cultural differences (Bernard & Goodyear, 2014).

The process models encompass educational and relational supervisory processes. An important process model is known as the discrimination model, which comprises three supervisee skills and three supervisor roles (Bernard & Goodyear, 2014). The three skills are interventions, conceptualization, and personalization: interventions skills are used in therapeutic sessions with clients; conceptualization skills refer to supervisees' understanding of what is happening in terms of the therapeutic process; and personalization skills are the supervisees' personal style. The three supervisor roles include teacher (by means of direct feedback), counsellors (to enhance supervisee's reflective skills), and consultants (to promote an equal relationship). Supervisors can jump between these roles as needed over the course of the clinical supervision of their trainees.

Dawson and colleagues (2012) have also proposed a variety of supervisory models, including the Proctor's model, the CLEAR (or integrative) model, and the Growth and Support model. The Proctor's model covers three aspects: restorative, formative, and normative. The restorative component refers to supervisors' responsibility to offer support by identifying work-related distress, looking for signs of burnout, and referring supervisees to appropriate resources as needed. The formative grouping involves observing interactions and clinical interventions between supervisees and their clients, which creates the opportunity to address necessary skill development and encourages the use of evidence-based practice. The normative category addresses issues regarding ethics, norms, and the quality of services offered by trainees (Best, 2008; Winstanley, 2010; Dawson, Phillips & Leggat, 2012).

The CLEAR model proposes five steps to be followed in clinical supervision. First, contracting is the process by which supervisors and supervisees negotiate the terms and conditions of their relationship to achieve the desired outcomes. Second, active listening is needed on the part of supervisors. Third, exploring encourages the perpetuation of insights through questions. Fourth, action involves matching the appropriate therapeutic style to encourage the progress of clinical interventions. Finally, reviewing actions taken allows for correction and adjustment (Cutcliffe, Butterworth & Proctor, 2001). This model provides a prescribed structure that facilitates the process of clinical supervision session (Dawson, Phillips & Leggat, 2012).

The Growth and Support model of clinical supervision offers a framework allowing supervisors to reinforce the professional development of novice practitioners. This model encourages supervisees' growth and support by making supervisors mindful of the model's central features, namely, generosity, reward, openness, willingness to learn, thoughtfulness, humanity, sensitivity, uncompromisingness and personalization (Dawson Phillips & Leggat, 2012; Dawson et al., 2013).

Friedman and Marr (1995) highlighted three major components of the supervisory model: development of supervisees' professional, clinical, and educational skills; support, encouraging openness to share clinical experiences; and empowerment through the development of accountability, which functions as a preventative measure for research and practice development and offers a third-party point of view (Friedman & Marr, 1995). According to Friedman & Marr (1995), supervision aimed at skill development, support, and empowerment ensures continued professional development and improved performance.

Although many models and approaches are used in clinical supervision, Edwards et al. (2005) have shown that there is no significant difference in the effectiveness of supervision as

perceived by supervisees in relation to the type of clinical supervision received. Rather, research has begun to look at individual factors pertaining to supervisees and supervisors that may better explain variances in the process and outcomes.

Supervisors' Roles, Competencies, and Characteristics

Multiple factors have been found to affect the perceived quality of supervision, including the ability to choose an acting supervisor, the location in which supervision is received, and the length and frequency of supervisory sessions (Butterworth and al., 1996; Edwards et al., 2005; Hyrkäs, Appelqvist-Schmidlechner & Haataja, 2006; Dawson, Phillips & Leggat, 2012). Clinical supervision's primary role in training supervisees is to ensure the improvement of professional knowledge and clinical skills: "But how supervision is conducted can significantly affect the quality of the learning process for the supervisee and can greatly affect outcomes such as the quality of clinical services provided by supervisees to their clients" (Barnett & Molzon, 2014, p. 1059). This is why supervisors need to be competent in clinical care and providing clinical supervision (Barnett & Molzon, 2014, Olds & Hawkins, 2014). It can be difficult, however, to ascertain supervisor competency as there is no consensus on who should become a supervisor or on the required level of clinical, research, or supervisory experience one must have to assume such responsibilities (Robiner & Schofield, 1990).

Several studies have attempted to identify the characteristics of a good supervisor. Scanlon and Weir (1997) report that most supervisees agree that having a trustworthy supervisor is important, as is their competence and possession of the necessary knowledge and skills. Hyrkäs et al. (2006) also found that supervisor perceived competency was of high importance to supervisees, particularly in forming a working alliance. Furthermore, Bishop (1998) reported that supervisees

expected supervisors to have good listening skills, the ability to give constructive feedback, and a willingness to assume the role and responsibilities of a supervisor.

Clinical supervisors also must compose with different roles and the ease with which they adapt to these significantly influences trainees and the supervision's outcomes (Barnett & Molzon, 2014). As clinical supervisors guide trainees in their professional development, the way in which they conduct themselves may shape how supervisees form and develop their professional identity (Barnett & Molzon, 2014). Similarly, clinical supervisors mentor trainees, focusing on shepherding them through career decisions and planning, addressing finances, getting involved in the profession, and work-life balance, as well as becoming engaged as academic and professional references (Barnett & Molzon, 2014).

Thus, as clinical supervision is a vital component in training competent practitioners, studying successful individual factors will help provide a better understanding of the necessity of clinical supervision and factors affecting the working alliance between supervisors and supervisees.

Supervisory Relationship

Many studies have outlined the beneficial outcomes of clinical supervision for both personal and professional development (Horvath & Symonds, 1991, Bernard & Goodyear, 2014). Increased benefits, including greater supervisee satisfaction, skills development and greater confidence, have been found when supervisees perceived the relationship as safe, non-judgmental, and supportive of thoughts, ideas, and feelings (Dawson, Phillips & Leggat, 2012; Rousmaniere & Ellis, 2013; Barnett & Molzon, 2014). Conversely, poor supervisee satisfaction has been linked to supervisors not being open to personal debriefing (Dawson, Phillips & Leggat, 2012; Edwards

et al., 2005). Evidently, being able to discuss sensitive issues in a confidential manner lowers the risk of burnout, emotional exhaustion, and depersonalization (Edwards et al., 2005).

In their study, *Attachment Style and Its Relationship to Working Alliance in the Supervision of British Clinical Psychology Trainees,* Dickson et al. (2010) focused on the relationship between attachment style and alliance in clinical supervision. Their results indicate that supervisees' perception of a secure attachment with their supervisor significantly influenced the strength of the working alliance (Dickson et al., 2010). Furthermore, studies have found that the supervisee-supervisor fit leads to trusting relationships, which, in turn, leads to greater self-disclosure, increasing the working alliance and professional development (Dawson, Phillips & Leggat, 2012; Winstanley, 2000; Edwards et al., 2005; Golia & McGovern, 2015).

While these clinical relationships have been examined for decades, unanswered questions remain, specifically regarding influence exerted by numerous variables on the quality of the relationship and working alliance (Robiner & Schofield, 1990). An important component of the supervisory relationship is the working alliance, which is crucial in a psychotherapeutic clinical supervision context (Bordin, 1983; Bernard & Goodyear, 2014).

Working Alliance

Emergence of Working Alliance in the Literature

Working alliance first emerged in the literature over a century ago and has since continued to be a topic of interest amongst psychological researchers. In 1913, Sigmund Freud, the father of psychoanalysis, was the first to explore the concept of therapeutic working alliances by studying the different aspects of clients' attachment through observation of pleasant feelings clients developed towards their therapists (Horvath & Symonds, 1991). Following Freud, Gitleson (1962) explored client-therapist relationships and openness for transference as key elements to the

foundation of the therapeutic alliance. It was only in 1967, however, that the term "working alliance" was coined by Greenson (Horvath & Symonds, 1991). He stated that a positive working alliance between client and therapist is vital for successful therapeutic outcomes (Horvath & Symonds, 1991).

Carl Rogers (1957), pioneer of the person-centered approach, contributed to the body of research on working alliance by suggesting that a strong working alliance is based on therapists' abilities to convey empathy and congruence to their clients. Rogers thought that therapists should adopt a position of unconditional positive regard and acceptance toward their clients and that this was indispensable for client progress (Horvath & Symonds, 1991).

Barrett-Lennard (1978, 1985) extended these findings by pursuing further research on unconditional acceptance (Horvath & Symonds, 1991). In 1985, he explored the concept of empathy in the context of therapeutic relationships, describing this concept as unconditional positive regard, which had been previously established by Carl Rogers (1957). Barret-Lennard (1985) argued that empathy in therapy requires construct validity of the measured variables to allow valid research on alliance in therapy. Despite these findings, some studies have found that therapists' role in working alliance was only a partial factor in predicting therapeutic outcomes (Gelso & Carter, 1985; Horvath & Symonds, 1991).

Bordin established a model of working alliance in a therapeutic context. His tripartite model empahised the mutual agreement on goals and taks as well as a strong emotional bond (Bordin, 1986). Specifically, Bordin focused on the importance of building a strong working alliance between a person seeking change and the change agent (Bordin, 1986). He also indicated that the goals established need to be mutually agreed upon. Thus explaining that no goals can be reached without some basic understanding and agreement between the participants involved

(Bordin, 1986). Furthermore, Bordin also explained that the strengths of the therapeutic working alliance depend on a clear mutual understanding by the participants about the tasks involved to reach the goals (Bordin, 1986). Although Bordin's model of working alliance has been conceptualized in a therapeutic setting, it was later expanded to a variety of contexts, including clinical supervision (Bordin, 1986).

Working Alliance as a Predictor of Therapeutic Outcomes

Therapeutic working alliance was first explored by Horvath and Symonds in 1991 in a meta-analysis based on twenty working alliance studies. This meta-analysis concluded that there is evidence supporting a correlation between working alliance and therapeutic outcomes, no matter the approach, the interventions, or the therapeutic context. Their results suggest a large effect between working alliance and therapeutic outcomes.

During the following decades, researchers continued to explore working alliance to provide a better understanding of its role and impact in therapy. Numerous studies have outlined the importance of therapeutic alliance in predicting positive outcomes. In fact, some researchers suggest that the quality of the alliance is more important than the type of treatment in predicting therapeutic outcomes: "The direct association between the alliance and outcome identified in this empirical review is supportive of the hypothesis that the alliance may be therapeutic in and of itself" (Martin, Garske & Davis, 2000, p. 446). Write and Lussier (2008) elaborate on the central role of working alliance in therapy by stating that it is a non-negotiable component, because it is the best predictor of therapeutic success, more so than the initial level of distress. However, "Despite the robust relationship with outcome across a number of different contexts, establishing causality is difficult as the alliance cannot be experimentally manipulated" (Flückiger et al., Re, Wampold, Symonds & Horvath, 2012, p. 643).

An association between treatment outcomes across different moderating variables has also been shown to be significant in predicting alliance and outcomes (Horvath & Symonds, 1991; Re et al., 2012). Indeed, Martin et al.'s (2000) results support this idea, having found an alliance-outcome correlation with the use of various techniques.

Other studies have used various treatments and psychotherapeutic approaches as variables to analyze the effect of working alliance. In their study, *The Association Between Patient Characteristics and the Therapeutic Alliance in Cognitive-Behavioural and Interpersonal Therapy for Bulimia Nervosa*, Constantino et al. (2005) explored the association between alliance and outcome amongst patients diagnosed with eating disorders, using data from a large-randomized clinical sample, comparing two types of therapeutic interventions. Across both interventions, results showed a positive correlation between working alliance and therapeutic outcomes in the early and middle phases of treatment (Constantino et al., 2005).

Similarly, in their study, *How Central Is the Alliance in Psychotherapy? A Multilevel Longitudinal Meta-Analysis*, Flückiger et al. (2012) examined the moderating effects of research design, type of treatment, and researchers' adherence to specific therapeutic approaches on alliance and outcome. They found a strong correlation between alliance and outcome, as well as study design and commitment to disorder-specific manual usage. Their results indicate a significant association between alliance and outcome in all conditions and do not support the perspective that it is diminished in specific contexts, such as evidence-based treatments or specific disorders (Flückiger et al., Del Re, Wampold, Symonds, and Horvath, 2012). This confirms the importance of the alliance in several different contexts and populations.

Martin et al. (2000) suggest that clients tend to interpret the alliance as stable over time, whereas therapists and observers tend to perceive it differently at various points in time. Therefore,

establishing a working alliance early in the therapeutic process remains a crucial factor for positive therapeutic outcomes (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000). Specifically, studies continue to show the strong influence that early alliance in therapy has on clients' treatment (Martin, Garske & Davis, 2000; Nissen-Lie, Monsen & Rønnestad, 2010). In fact, Martin et al.'s (2000) meta-analysis demonstrates that the stronger clients rate the alliance early on, the greater the therapeutic outcomes. Because clients seem to rate the alliance consistently throughout therapy sessions, if the alliance is strong and positive at the beginning, it will have better effects on the overall treatment (Martin, Garske & Davis, 2000).

This led Keller, Zoellner, and Feeny (2010) to study the effects of early therapeutic alliance with clients suffering from post-traumatic stress disorder. Their results suggest that a strong early alliance is associated with better client-therapeutic-outcomes.

Another study explored if a strong early alliance will positively influence therapeutic outcomes for clients with substance abuse, with results indicating that early working alliance between client and therapist predicts retention in substance abuse treatment and has a significant influence on that treatment (Knuuttila, Kuusisto, Saarnio & Nummi, 2012).

Strauss et al. (2006) have also explored the contribution of early working alliance on therapeutic outcomes by focusing on the strength of the alliance and rupture-repair alliance processes. The participants were 30 outpatient adults diagnosed with various personality disorders and results showed that alliance might function on more than one level by facilitating change and offering opportunity to correct behaviour, namely within a context of cognitive therapy (Strauss et al., 2006). Consequently, some researchers have proposed that therapists who build a strong client-alliance with ease generally achieve better therapeutic outcomes (Re et al., 2012).

Some studies have explored the degree of influence therapists may have on alliance-outcomes, suggesting therapists' contributions may be more critical than clients' (Baldwin, Wampold & Imel, 2007; Dinger et al., 2007; Re et al., 2012). For example, Baldwin, Wampold, and Imel (2007) focused on modelling the alliance-outcome relationship to distinguish between therapists' and clients' views of the alliance. They report that there are different predictors of outcomes when therapists rate the alliance versus when clients do. The results of this study indicate that therapists who build stronger alliances with their clients showed statistically significant better outcomes than therapists who did not build good alliances (Baldwin, Wampold & Imel, 2007).

Contributing Factors to Working Alliance in Therapy

Research over the past thirty years has provided support of the predictive role of working alliance on therapeutic outcomes (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Flückiger & Symonds, 2011; Flückiger et al., Del Re, Wampold, Symonds & Horvath, 2012). Many factors have been found to influence working alliance, including client or therapist features, changes in clients functioning, and client-therapist interactions (Derubeis, Brotman & Gibbons, 2005; Re, Horvath, Symonds & Wampold, 2012).

Derubeis et al. (2005) explored factors possibly influencing the therapeutic alliance and found that symptom improvement, the therapist, the client, and their interaction are important factors in developing and maintaining the therapeutic alliance (Derubeis, Brotman & Gibbons, 2005). By symptom improvement, they mean that the alliance-outcome correlation may be a result of clients' symptom improvement, rather than the alliance causing the symptoms' improvement. Therapists' abilities or tendencies to participate actively in building strong alliances is another major contributor for the alliance (Derubeis, Brotman & Gibbons, 2005).

In fact, Re et al. (2012) investigated the moderating effect of client-therapist ratio on the strength of the alliance-outcome relationship by postulating that an increased number of clients would correlate negatively with alliance-outcome. The results of their meta-analysis revealed that therapists' contribution to the alliance is predictive of the outcome; furthermore, they found that some therapists are better at developing therapeutic alliances than others and that their clients tend to achieve better therapeutic outcomes (Re, Flückiger, Horvath, Symonds & Wampold, 2012). Similarly, Dinger, Leichsenring, Wilmers & Schauenburg (2008), studied inpatients and found significant therapist effects in the alliance-outcome correlation. Conversely, therapists with difficulty building alliances may not have the same outcomes with their clients (Derubeis, Brotman & Gibbons, 2005). Derubeis, Brotman and Gibbons (2005) suggest that this ability may not be teachable; rather, it is hypothesized that specific personality traits may facilitate therapists' investment in building strong alliances. As such, therapists play an important role in the alliance–outcome relationship.

As for clients' role in establishing the therapeutic alliance, some clients may be better than others at forming alliances (Derubeis, Brotman & Gibbons, 2005). Thus therapists' and clients' personality traits and their interactions are important in building strong alliances. Theses factors could play a role in establishing the alliance, since the interaction of personality traits could determine alliance-outcome (Derubeis, Brotman & Gibbons, 2005). Therefore, "certain types of [clients] may interact particularly well with certain types of therapists, for various reasons (gender, personality traits, socioeconomic backgrounds, political viewpoints, etc.)" (Derubeis, Brotman & Gibbons, 2005, p. 179).

Working alliance comes from the contributions of clients and therapists (Frieswyk & Al, 1986; Horvath & Symonds, 1991). Moreover, Frieswyk and al. (1986) found that attitudes about

client involvement is key when creating an alliance, thus it is important to evaluate clients' level of collaboration early on. Furthermore, Re et al. (2012) note that clients with good attachment histories and well-developed social skills form better alliances and show better therapeutic outcomes than their counterparts. Mallinckrodt, Coble, and Gantt (1995) found that social competencies such as adult attachment and self-efficacy accounted for 14% of the variance in clients' working alliance ratings. Further studies suggest that other factors contribute to the alliance, such as duration of treatment (Flückiger et al., Del Re, Wampold, Symonds, and Horvath, 2012).

Nonetheless, the overall level of working alliance has been shown to be a better predictor of therapeutic outcomes than single measures of alliance during a given session (Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011). It could be argued that working alliance would be a better indicator of outcomes in long-term treatment than in brief therapy. Regardless, it is apparent that working alliance in therapy is central for better therapeutic outcomes. That being said, working alliance between supervisors and supervisees in clinical supervision remains a rarely studied subject.

Working Alliance in Clinical Supervision

Bordin (1975) states that working alliance makes it possible for clients to receive and follow the therapeutic process (Bordin, 1975; Horvath & Symonds, 1991). Bordin (1983) was amongst the first to generalize the model of therapeutic working alliance to clinical supervision. According to his body of work, working alliance in clinical supervision is necessary for easing and improving trainees' professional development. He defined supervisory working alliance as the collaboration between a senior and novice practitioner to promote change within the supervisee.

The process of working alliance in clinical supervision is founded on a mutual agreement, based on goals, tasks, and strong emotional bonds. Mutual agreement consists of a contract, either explicit or implicit, outlining goals and learning outcomes of supervision, with tasks expanding on these set goals to identify the role each individual must take to achieve them. The bonds are the various levels on which individuals relate to one another, such as liking, caring, and trusting one another. According to Bordin (1983), a strong supervisory working alliance is crucial for the process in which counsellor supervisees experience professional and personal growth (Burns, 1958; Robinson, 1949; Ackerman & Hilsenroth, 2001,; Ackerman & Hilsenroth, 2003; Kadushin & Harkness, 2014). Working alliance is a description of the change process itself, therefore, the working alliance is a process of change (Bordin, 1983). It is important to explore how specific personality traits affect this change, because the body of research has revealed that supervisory alliance predicts supervisory outcomes (Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003).

Personality

Background

In attempting to understand human nature, psychologists attempted to conceptualize the complex phenomenon that is personality. Many researchers have devoted their careers to identifying, understanding, and developing a unified theory of personality (Larsen & Buss, 2014). Over a century ago, Sigmund Freud made his contributions to this effort by stating that at the core of a unified theory of personality lies the universal human nature, specifically, the universal instincts of sex and aggression played out by the id, the ego, and the superego throughout the psychosexual stages of development (Larsen & Buss, 2014; Feist & Feist, 2009).

In 1913, one of his disciples, Carl Gustav Jung developed a distinct theory of personality. Jung's perspective of personality entails that motivation comes from emotional experiences inherited from our ancestry – the collective unconscious. Jung's theory suggests that a person can be both introverted and extroverted, rational and irrational, pushed by past events, while also being drawn by future ones (Feist & Feist, 2009); thus, he illustrated the dichotomous relationship within individuals, pulling them in opposite directions.

Thereafter, Alfred Adler added to the body of research by presenting a new take on personality, opposing Freud's precepts (Feist & Feist, 2009). Adler believed that people are motivated mostly by social influences and by their striving for success. Likewise, he maintained that people are responsible for their characteristics and identity, whereas Freud assumed that personality was largely predetermined and that individuals have little control in shaping their identity. Adler also hypothesized that present behaviour is formed by personal expectations for the future, whereas Freud thought that present behaviour was a result of past experiences. Adler further opposed Freud in regards to the unconscious, suggesting that healthy people are usually conscious of their actions and the reasoning behind them (Feist & Feist, 2009).

In the 1950s, Karen Horney elaborated the psychoanalytic social theory of personality, arguing that personality is shaped around social and cultural conditions, especially childhood experiences, with unmet childhood needs and difficult experiences during this crucial period of development leading to basic anxiety, resulting in one of three possible responses: moving toward people, moving against people, or moving away from people. Whereas individuals not afflicted with such unmet needs or difficult experiences balance all three in a healthy manner, those suffering from basic anxiety rely on only a single response mode (Feist & Feist, 2009). For

instance, a child having suffered physical neglect could adopt the response of moving against people.

Erik Erikson suggested a post-Freudian theory of the personality, instead of agreeing or opposing Freud, Erikson came up with an entirely new way of conceptualizing personality. He proposed a lifelong process of development by introducing eight stages of psychosocial development spanning from childhood to adulthood, noting that each stage is marked by a psychosocial struggle shaping individuals' personality. Erikson emphasized adolescence as a fundamental period in weakening or strengthening personality depending on the ease with which the phase is surmounted. Although his theory of personality is based on Freud's psychosexual theory of development, it was extended and modified by taking social and historical influences into account (Feist & Feist, 2009).

In reaction to these psychoanalytic perspectives came the humanistic existential movement, advanced by such pioneers as Maslow, Allport, Rogers, and May. Contrary to other approaches, which perceive motivation as a reaction to a deficit, humanists consider the need for growth as the root of motivation. (Feist & Feist, 2009).

Gordon Allport perceived motivation as a process of consciousness by which individuals undertake actions and behaviours knowingly. He concentrated on the uniqueness of the individual and believed this concept was lost by labelling personality characteristics, maintaining that it reduces individuals to a sum of its parts or traits rather than the whole (Feist & Feist, 2009).

Rogers elaborated his person-centered theory based on personal-professional experiences as a psychotherapist. The client-centered theory of personality, a non-directive approach, involves being genuinely concerned for the client and converging all attention on the client for better therapeutic outcomes. He advanced two principles on which lay the foundations of his approach:

formative and actualizing tendencies. Formative tendencies refer to the concept by which information and matter develop from simple to complex; whereas actualizing tendencies refer to the achievement of one's potential. The process of self-actualization stems from the evolution brought about by the formative tendencies, which in turn lead to the development and progression of personality (Feist & Feist, 2009).

Rollo May, the father of existential psychology, suggested that a person is fully responsible for who they become; nevertheless, he deemed running away from responsibilities, a problem affecting many, as indicative of a lack of courage to accept their destiny, leading to anxiety or guilt. According to May, anxiety stems from the breakdown of a personality's defining factors. As such, an individual, unable to achieve his potential, will be afflicted by anxiety. Guilt arises when people fail to perceive and acknowledge their potential or others' needs (Feist & Feist, 2009).

George Kelly's theory of personality is unique, in the sense that it is unrelated to any of these aforementioned theories. Kelly suggests that people create their own world by means of personal constructs (Feist & Feist, 2009). For him, "[p]eople exist in a real world, but their behavior is shaped by their gradually expanding interpretation or construction of that world." (Feist & Feist, 2009, p.548). His psychology of personal construct suggests that personality is formed by personal interpretations of the world, subject to change to avoid victimization (Feist & Feist, 2009).

Over the past half-century, several researchers have attempted to measure personality traits and have argued about how many exist. Although some authors disagree, the five main personality domains, also known as the Big Five theory, have gathered much scientific support. The Big Five model was first researched using a combination of lexical and statistical approaches. In the 1930s, Allport and Odbert (1936) elaborated the first lexical approach by identifying 17,953 personality

traits. From this, four trait categories were identified: (1) stable; (2) temporary states, moods, and activities; (3) social evaluations; and (4) metaphorical, physical, and doubtful terms.

Following their work, Cattell (1943) used stable traits to establish a lexical analysis of personality. He reduced the 4,500 stable traits into 35 personality traits clusters.

In 1949, using some traits identified by Cattel, Fiske discovered a five-factor solution through factor analysis: “Fiske is noted as the first person to discover a version of the five-factor model, but he is not credited with having identified its precise structure” (Larsen & Buss, 2014, p. 77).

Following Fisk’s work, the Big Five model continued evolving through several researchers’ revisions, including Tupes and Christal (1961), Norman (1963), and Rammstetd (2010). Today, the Big Five is the most validated personality instrument. In fact: “the Big Five taxonomy has achieved a greater degree of consensus than any other trait taxonomy in the history of personality trait psychology.” (Larsen & Buss, 2014, p. 77). Many studies have supported the structure of the five-factor model and concluded that it is a “biologically based human universal” that transcends language and cultures (Bouchard & Loehlin, 2001; McCrae & Costa, 1997; Wiggins & Trapnell, 1997; Yamagata et al., 2006). Specifically, the Big Five has been tested in more than 50 societies across six continents and the results support the universal existence of the Big Five (McCrae, 2002; McCrae & Terracciano, 2005; Schmitt et al., 2007). Furthermore, the Big Five suggests a uniform covariance amongst human traits despite vastly different cultures, histories, economies, social lives, ideologies, and every other form of cultural and behavioural expression (Gurven et al., von Rueden, Massenkoff, Lero Vie, 2013). Although the Big Five theory is well supported, three main critiques have been identified in the literature. The first of which relates to the fact that the theory does not consider the influences of dynamic structures and

processes (Cervone & Pervin, 2014). Specifically, the big five theory is unable to specify how biological and psychological mechanisms relate to personality traits (Cervone & Pervin, 2014). The second critique is that despite some studies having demonstrated that cultural changes may lead to personality changes, social factors are not considered to affect the big five personality traits. (Twenge, 2002; (Cervone & Pervin, 2014). The last critique of the big five theory is that it supports the idea that every person presents all of the traits from each personality domains, only on different levels. As of today, this conclusion has not been supported (Cervone & Pervin, 2014).

Many authors have tried to establish theories of personality and pursued research in the field; however, as of today, there is still no unified theory of personality, though specific domains of personality have been identified (Feist & Feist, 2009). Personality is a vast topic of research, involving many different themes, such as "shyness, aggression, trust, dominance, hypnotic susceptibility, depression, intelligence, attributional style, goal setting, anxiety, temperament, sex roles, self-monitoring, extraversion, sensation seeking, agreeableness, impulsivity, sociopathic tendencies, morality, locus of control, optimism, creativity, leadership, prejudice and narcissism" (Larsen & Buss, 2014, p. 13). Specific domainsof personality have been found but there is no theory able to unify all of them. They remain distinct domains: dispositional, social and cultural, biological, intrapsychic, cognitive-experiential, and adjustment (Feist & Feist, 2009).

Personality in Supervision

Although personality is a popular research subject, it has not been explored in depth within the context of clinical supervision. Swanson and O'Saben (1993) studied the link between counsellors' and trainees' personality types and their needs and expectations from clinical supervision. The results indicate that trainees' expectations and needs varied according to their Myers-Briggs personality type. In fact, a need for support was identified more often by sensing

types, whereas behavioural monitoring and respectful confrontations were more often required by intuitive ones. Reciprocal confrontation, which consists of a confrontation directed at personal aspects of the supervisees' behaviour, was required more often by perceiving types (Swanson and O'Saben, 1993; Clingerman, & Gilbride, 2011). Other studies have also explored the effect of different personality types on supervisees in the field of psychotherapy (Lochner and Melchert,1997; Clingerman, & Gilbride, 2011). Lochner and Melchert's (1997) results suggest that highly sensing and judging type supervisees prefer a task-oriented approach to supervision, whereas highly intuitive and perceiving types prefer a strong alliance with their supervisor.

These studies demonstrate the influence that supervisee's personality types can have on clinical supervision (Clingerman, & Gilbride, 2011). Some studies have included supervisors' personality types as an independent variable of the research designs (Clingerman, & Gilbride, 2011). Handley (1982) examined the influence of supervisors' and supervisees' personality types on both supervisors' and supervisees' ratings of the supervisory relationship, satisfaction with supervision, and supervisors' evaluations of trainees. Handley's study shows that highly intuitive supervisees have more empathy, regard, and congruent responses from supervisors (Handley, 1982; Clingerman, & Gilbride, 2011). Additionally, supervisors showed greater satisfaction with the performance of intuitive supervisees and had the tendency to grade them significantly higher in counselling competencies than they did with sensing supervisees (Handley, 1982; Clingerman, & Gilbride, 2011). Consequently, results indicate that similarities in personality type between supervisors and trainees are related to greater supervisor rating of, and appreciation and affection toward, supervisees (Handley, 1982; Clingerman, & Gilbride, 2011). However, personality type similarities were not found to be related to supervisors' evaluations of trainees (Handley, 1982; Clingerman & Gilbride, 2011).

Carey and Williams (1986) continued Handley's work, but found no significant link between supervisees' personality types and supervisors' ratings of trainees' performance (Handley, 1982; Clingerman, & Gilbride, 2011). Therefore, the relationship between supervisees' personality traits and supervisors' perceptions or behaviours is still an important research question, particularly due to its possible impact on working alliance in clinical supervision.

Kitzrow (2001) attempted to understand supervisors' personality traits and how they can influence clinical supervision (Clingerman, & Gilbride, 2011). He found that intuitive supervisors are more likely to foresee potential issues that could arise instead of focusing on current problems or details. Another finding indicates that supervisors who are informed about personality types and their influence on clinical supervision may prefer specific supervision interventions for specific supervisees (Clingerman & Gilbride, 2011). Furthermore, Kitzrow's study indicates that supervisors who are familiar with their personality type and those of their supervisees, acknowledge their biases and the influence they may have on their choice of supervision intervention (Clingerman & Gilbride, 2011).

In comparison, Moore et al. (2004) explore learning preferences based on supervisees' personality types, as indicated by the MBTI personality inventory, and found that preferences differ from one type to another. Their results showed that extraverts showed a preference for activity, interaction, and external stimulation, whereas introverts showed a preference for pause, isolation, and introspection; (Moore et al., 2004). Sensors showed a preference for details and experiences, whereas intuitives showed a preference for the big picture and creativity; (Moore et al., 2004). Thinkers demonstrated a preference for principles, logic, fairness, and analysis, whereas feelers demonstrated a preference for personal impact, values, empathy, and meaning; (Moore et al., 2004). Judgers showed a preference for planification, anticipation, routine, and tasks, whereas

perceivers preferred reactions, openness, spontaneity, and the process (Moore et al., 2004). Moore et al. (2004) support the idea that personality type has influences on supervisors and supervisees. It would, therefore, be beneficial to explore these concepts using a different type of personality assessment, such as the Big Five, underscoring the contributions that this study will bring to the field.

Clingerman and Gilbride (2011) followed Kitzrow's and Moores's research by analyzing supervisors' personality types and their supervisory interventions, finding that supervisors conducted intuitive interventions even if their own personality type was not intuitive and that supervision was mainly based on perceiving processes. Therefore, "t[he] study found that regardless of supervisors or supervisees personality types or gender, clinical supervision interventions were primarily reported as *Intuitive* and *Perceiving"* (Clingerman, & Gilbride, 2011, pp. 166-167).

Analytical and Clinical Perspective of Personality

Current studies relating to personality support the importance of considering clients' personalities when evaluating and diagnosing psychopathology in order to better understand and analyze their situations (Hopwood, Zimmermann, Pincus, & Krueger, 2015). According to Hopwood et al. (2015), rather than focusing solely on diagnostic criteria, personality traits should be considered when it comes to posing a diagnosis. In fact, they suggest that knowing about a client's personal dispositions facilitates clinical processes: "Thus, connecting the basic building blocks of personality structure with the dynamics that characterize patient presentations is a pathway to increasingly effective clinical formulation." (Hopwood et al., 2015, pp. 434-435). Additionally, Hopwood and al. (2015), demonstrate that integrating personality structure and

dynamics by using various methods of assessment and sophisticated analyzes is indispensable for proper diagnosis, as well as clinical and personality assessments.

Characteristic and personality traits analysis can also be used in clinical practice to adjust and customize interventions, which may result in better working alliance and therapeutic outcomes (Chapman & Talbot, 2009; Stauffer et al., Perdrix, Masdonati, Massoudi, Rossier, 2013). The use of instruments to assess client dispositions allows therapists to develop adequate therapeutic programs and offer better guidance by identifying underlying strengths, weaknesses, and emotional intelligence (Rossier, 2005). Stauffer et al. (2013) found that when controlling for client characteristics, no significant effect was found for their satisfaction with therapists' clinical interventions. Hence, alliance is a key component for clients' satisfaction of therapeutic outcomes rather than the interventions themselves and personality may play an important role in establishing a strong working alliance in therapy or supervision.

Developmental Perspective of Personality

The development of personality is characterized by change within the individual, while maintaining continuity, consistency, and stability over time (Larsen & Buss, 2014). It is important to note that not all changes entail the development of personality. Development implies modifications to individuals' internal workings, rather than a change in external environment or context. Moreover, personality development does not include all aspects of internal change, because change must persist over time, as described by Larsen and Buss (2014):

> When you get sick, for example, your body undergoes important changes: your temperature may rise, your nose may run, and your head may ache. But these changes do not constitute development because the changes do not last — you soon get healthy, your nose stops running, and you spring back into action. In the same

> way, temporary changes in personality — due to taking alcohol or drugs, for example — do not constitute personality development unless they produce more enduring changes in personality (p. 129).

Enduring modification to personality may result from serious illness or accidents having caused permanent internal physical changes. A noteworthy example is the well-documented case of Phineas Gage, who, while working as a foreman on a railway construction site, suffered a severe accident during which an iron rod impaled his frontal lobe through his left cheek, leaving him with permanent and dramatic personality changes (Larsen & Buss, 2014).

Continuity vs. Stability.

Based on a psychodynamic perspective it was believed that personality was developed and solidified during childhood, implying that it remains static thereafter and cannot change after childhood (Caspi & Roberts, 2001; Larsen & Buss, 2014). As explained by Caspi and Roberts (2001), subsequent theorists suggested that personality is established in childhood, but continues to evolve during the period of adolescence. This perspective has evolved to support the idea that personality can change at any phase of life, but is less likely to change during adulthood due to stabilization in core values and beliefs (Glenn, 1980; Caspi & Roberts, 2001):

> Thus, the range of changeability declines as people grow older. The increasing stability of ontogeny results from a shift in the allocation of resources at different times in the life course (Baltes, 1994) […] Life-span theories do not specify the age at which personality or other psychological constructs stop developing. Rather, they put forward the notion that as we age, we become more constituent, yet we retain the potential for change. (Caspi & Roberts, 2001, p.51).

Some factors have been found to moderate the continuity or stability of personality, such as biosocial transitions – significant events in individuals' lives, such as marriage, having children, and puberty, which can lead to changes in personality – and historical factors – era- or period-specific influences, such as war, which could affect the progression of personality (Caspi & Roberts, 2001; Larsen & Buss, 2014).

The evidence that personality can change overtime demonstrates the need to include it in therapy, as well as in clinical supervision. The inclusion of personality in this study will help with the understanding and analysis of the effects different personality traits have on supervisory outcomes. Such findings will yield practical clinical and research applications.

Consistency of Personality.

Following the debate on whether the development of personality is continuous or stable, the matter of consistency began to face debate and this debate, as it pertains to the extent of personality consistency, continues (Larsen & Buss, 2014). The consensus regarding consistency has to do with the stability of personality traits overtime: for example, a highly agreeable individual will remain relatively constant in his levels of agreeability throughout his lifetime. This precept is mainly applicable to biologically based traits; thus, attitudes, interests, and opinions, which are not genetically anchored, may vary over time. While biologically based personality traits are generally consistent through time, their means of manifestations, such as behaviours, are subject to change with time and circumstances (Larsen & Buss, 2014). Larsen and Buss (2014) describe an example of a disagreeable individual, who, as a child, would have fits and temper tantrums, which later developed into difficulties in sustaining personal relationships and maintaining jobs.

Furthermore, consistency over situations is widely debated within personality psychology. Trait psychologists maintain that personality remains consistent across various situations (Larsen

& Buss, 2014), while other researchers, such as Mischel (1968), propose that personality may vary as a function of situational context.

Early research suggested that personality is based on behavioural consistency, as it is reflective of internal motivations, cognitions, and emotions (Allport, 1937). However, subsequent studies in the field found limited support (Mischel, 1968). Consequently, the exploration of personality as a study topic faded out of mainstream psychological development research (Swann & Seyle, 2005; Fleeson & Noftle, 2008). However, recent studies are trying to push for the reintegration of personality into psychological research with alternative arguments being proposed to advocate for the revival of interest in this subject "[t]hese alternative conceptions were intended to save personality by suggesting that behaviour may be consistent in an alternative way even if not consistent in ways previously examined" (Fleeson & Noftle, 2008, p. 1360). This study will help direct future clinical supervision by defining and analyzing different supervisory outcomes when matching supervisors' and supervisees' personality traits in clinical supervision.

The literature on personality in a therapeutic context focuses on clients' personality traits more than on therapists', although it has been shown that the latter's personality traits play an important role in the therapeutic process (Mallinckrodt & Nelson, 1991; Nelson & Taylor, 1993; Dunkle & Friedlander, 1996). Mallinckrodt & Nelson (1991) suggest that a strong alliance between therapists and clients has more to do with interpersonal styles than with therapists' skills or intervention techniques.

Some studies have focused on how certain characteristics may affect the therapeutic process: for example, Dunkle and Friedlander (1996) identified several personality characteristics that are predictive of the bond component of the alliance in therapy. Specifically, clients with less hostility and increased social support were more likely to report a stronger alliance with therapists

early in the process. Interestingly, these finding suggest similar outcomes when considering therapists' characteristics, indicating that therapists' personality traits are equally as important in predicting alliance (Dunkle & Friedlander, 1996).

Likewise, Ackerman and Hilsenroth (2001) reported similar results, stating that therapists' personal attributes play a role in alliance, either negatively or positively. These authors focused on factors negatively affecting the therapeutic alliance. Their results suggest that such characteristics as rigidity, uncertainty, a tendency to exploit, criticism, distance, tenseness, indifference, and distraction deteriorate the alliance (Ackerman & Hilsenroth, 2001).

When it comes to the exploration of personality aspects in a therapeutic context, most studies focus on personality disorders or extreme expressions of personality, such as catatonia or mania (Coleman, 2006). It is important for researchers not to forget, what is referred to as normal personality, as it may influence the process and outcomes of therapy (Coleman, 2006): "When we speak of the individuality of a person, we are to a certain extent talking about personality. Personality is such a basic element of human experience that it often goes unnoticed, like the air we breathe." (Coleman, 2006, p. 83-84). The lack of literature on aspects of non-extreme personality highlights the importance of this study and its focus on personality as a whole.

Purpose of the Study

Clinical supervision is the primary means of training in psychotherapy, meaning that supervisors must have an in depth understanding of the processes and outcomes of supervision to optimize their training styles and objectives. Research suggests that working alliances are crucial in predicting positive supervision outcomes, thus a deeper understanding of these alliance is needed. Importantly, personality may be an important factor in supervision and the attending working alliance.

Specifically, this study maintains that there is a need for quantitative empirical understanding of the important individual factors that foster or hinder the development of early alliance formation in a clinical supervision context and for understanding the nature of perceived alliance strength according to both supervisors' and supervisees' experiences. Additionally, research on the impact of different personality traits on the working alliance in clinical supervision is lacking.

This study intends to help rectify this deficit by contributing to the much-needed knowledge base of effective counsellor education and the impact of individual factors on early alliance formation in clinical supervision. The following research questions will be addressed: (1) What is the impact of supervisors' personality on their experience of their alliance? (2) What is the impact of supervisees' personality factors on their experience of their alliance? (3) Do supervisees and supervisors differ in terms of how they perceive their alliance?

Methodology

Participants and Recruitment

The body of participants consisted of 50 supervisees and their 13 supervisors. Supervisee participants were second year counselling students enrolled in the counselling and spirituality program at a Canadian University and were seeing clients at a Counselling Centre during a 12-week session. Supervisor participants were psychotherapy professionals hired by the Centre to supervise students for weekly, group supervision sessions over the course of the 12 weeks.

As part of their course requirements, trainees met with their clients on a weekly basis. Modalities used in supervision were videotapes of all trainees' sessions with their clients and trainees' progress notes. Trainees were asked to complete a working alliance questionnaire following the fourth, eighth, and twelfth supervisory sessions.

Participants were recruited through advertisement posters at the university and through e-mails sent to eligible supervisors and supervisees. To be eligible for the study, supervisors had to be currently supervising trainees, while supervisees had to be second-year students completing their practicum. The institutional review boards approved the study (REB# 1-1360.10/14 R3) and written informed consent was obtained from all participants. Participants did not receive any compensation for their participation in this study.

Procedure

The data used in this study are part of a larger ongoing study. Prior to the first supervision session, researchers or trained research assistants met with participants (supervisors and supervisees) individually to obtain informed consent and have the participants complete a short Demographic Questionnaire, detailing their age, gender, ethnicity, theoretical orientation, and contact information. Participants were also asked to complete the NEO Personality Inventory-3 (NEO-PI-3) (McCrae & Costa, 2010), among other measures included in the research and described further below.

Early alliance measures were collected following the fourth of 12 weekly supervision session. A research assistant was responsible for tracking the progress of sessions and for emailing the Working Alliance Inventory – Trainee and Supervisor versions (WAI) to be completed by participants following session 4. These forms were pre-coded to ensure confidentiality. Participants were instructed to complete the questionnaires as soon as possible following the supervision session and to drop them off in a locked and confidential box at the counselling centre. Interviewers were clinicians and trained research assistants.

Measures

Demographic Data. Baseline demographic information was obtained during the intake interview. Data about age, gender, ethnicity, and education/degree, as well as supervision and therapy experience were obtained from the supervisors who participated in the study. Likewise, data about age, gender, ethnicity, therapy experience, and theoretical orientation were obtained from the supervisees.

Working Alliance Inventory: Supervisor and Trainee Versions (Bahrick, 1990). Early working alliance between supervisors and supervisees was assessed using a modified version of the 36-item WAI. The WAI is a self-report instrument that was developed as a measure for Bordin's conceptualization of working alliance. The measure used for this study has been slightly modified from the original Working Alliance Inventory – Counsellor and Client versions (Hovarth, 1982) to reflect the supervisory context of this study. The WAI results in three 12-items subscale scores for goals, tasks, and bond, as well as an overall working alliance total. Items were rated on a 7-point Likert-scale, with 1 representing almost never and 7 almost always. The WAI has been used in many studies, with high internal consistency in a variety of counselling settings, ranging from 0.87 to 0.93 (Horvath & Greenberg, 1989; Holmqvist, Philips, & Mellor-Clark, 2015; Perdrix et al., de Roten, Kolly & Rossier, 2010).

NEO-Personality Inventory. The NEO-PI-3 is a measure of personality dimensions, based on the Five Factor Model, designed to provide a general description of normal adult personalities for clinical, counselling, and educational scenarios, consisting of 240 items answered on a 5-point Likert scale. The five main categories of personality as outlined in the NEO-PI-3 are neuroticism, extraversion, openness, agreeableness, and conscientiousness. Each category consists of six personality trait subscales. The NEO-PI-3 is one of the most commonly employed measures of personality used in scientific research, having been applied to a wide

range of personality traits, having demonstrated good reliability and validity (Benson & Kluck, 2014).

Data Analysis

Data analyses were conducted using SPSS v23.0. Missing data was handled through list-wise deletion. Bivariate correlations were conducted to explore the relationship between personality domains and early working alliance ratings. A series of follow-up multiple regressions were conducted based on the significant correlations found between personality domains and early working alliance to explore the predictive role of individual personality facets in the creation of early working alliance.

Results

Preliminary analyses were conducted to see if age and gender influenced results from any of the working alliance subscales and all of the NEO-PI-3 personality domains. The results of these preliminary analyses indicated no influence ad these variables were not controlled for in subsequent analyses.

Mean Scores of Supervisors and Supervisees Neo Personality Domains and Working Alliance Ratings

The supervisors who participated in this study are situated in the average range for the neuroticism, extraversion, and conscientiousness personality traits. The supervisors in this study obtained a mean score of 132.73 (T-score = 69), a high level, for the openness personality trait, suggesting high levels of openness. They also are situated just above the average range for agreeableness with a mean of 135.52 (T-score = 62), which suggests high levels of agreeableness. Results are summarized in Table 1.

The supervisors who participated in this study have a mean score of 216.93 (*SD* = 14.63) for their total alliance ratings, whereas the supervisees obtained a mean of 198.19 (*SD* = 33.59).

Table 1

Mean Scores and Standard Deviations of Supervisors' and Supervisees' NEO Personality Domains Compared to NEO-PI-3 Average Range Scores

NEO personality traits domains	Supervisors		Supervisees		NEO-PI-3
	M	*SD*	*M*	*SD*	Average range scores
Neuroticism	71.04	20.84	77.7	21.26	67-88
Extraversion	111.81	20.60	116.12	17.62	97-117
Openness	132.73	20.17	134.92	20.01	94-113
Agreeableness	135.52	6.24	137.72	13.36	104-122
Conscientiousness	122.63	18.30	124.16	18.43	112-132

Correlations Between Personality Domains and Their Alliance Ratings for Supervisors and Supervisees

Bivariate correlations were conducted to investigate the relationship between supervisors' five personality domains and their perceived working alliance. Analysis revealed significant negative correlations between supervisors' openness (-0.33) and agreeableness (-0.29) and their early total alliance rating scores, indicating a significant link between these factors. These results suggest a negative correlation between supervisor level of agreeableness and their perceived alliance ratings. Bivariate correlations were conducted to investigate the relationship between supervisees' five personality domains and their perceived early working alliance rating scores. While there were associations between supervisees' personality domains and their perceived early

working alliance rating scores, results remained non-statistically significant. Results are summarized in Table 2.

Table 2

Bivariate Correlations of Personality Domains and Perceived Early Total Alliance Scores

Outcome Variables	Agreeableness	Neuroticism	Extraversion	Openness	Conscientiousness
Supervisors' Total Working Alliance	-0.29*	-0.12	-0.00	-0.33*	0.24
Supervisees' Total Working Alliance	0.04	0.11	0.09	0.08	0.04

* $p < .05$

Sample Characteristics

Personality and working alliance data were available for 13 supervisors and 50 supervisees. The sample of participating supervisors consisted of 9 females and 4 males, with a mean age at the onset of the study of M = 46.2 years (SD = 10.01). The sample of participating supervisees consisted of 43 females and 7 males, with a mean age of M = 39.6 years (SD = 12.3).

Predicting Supervisors Perceived Alliance from Domain Traits Using Multiple Regressions

Based on the significant correlations found between supervisors' personality domains (agreeableness and openness) and their ratings of early working alliance, multiple regression analyses were conducted to identify which personality facets of the personality domains predicted early alliance. Table 3 displays the multiple regression results for the openness personality domain and Table 4 displays the multiple regression results for the agreeableness personality domain.

For the openness personality domain, the *feeling* facet significantly predicted supervisors'

early total alliance ratings. Increased scores on feelings negatively predicted supervisors' ratings of their early working alliance ratings. Results are summarized in Table 3.

Table 3

Multiple Regression of Supervisor Perceived Total Early Alliance Ratings of Their Openness Personality Facets

	Predictor Variables	B	SE	R^2	*F*	*T*	*p*
Total Working Alliance			13.29	0.28	2.70		0.02*
	Fantasy	-0.09	1.04			-0.34	0.73
	Aesthetics	0.55	0.94			1.55	0.13
	Feelings	-0.47	0.81			-2.20	0.03*
	Actions	0.27	0.87			1.21	0.23
	Ideas	-0.15	1.05			-0.47	0.64
	Values	-0.03	1.06			-.09	0.93

* $p < .05$; ** $p < .01$

For the agreeableness personality domain, the *modesty* facet significantly predicted supervisors' early total alliance ratings. Increased scores on modesty negatively predicted supervisors' ratings of their early working alliance ratings. Results are summarized in Table 4.

Table 4

Multiple Regression of Supervisor Perceived Total Early Alliance Ratings of Their Agreeableness Personality Facets

	Predictor Variables	B	SE	R^2	*F*	*T*	*p*
Total Working Alliance			11.85	0.43	5.20		0.00**
	Trust	0.17	0.69			1.21	0.23

Straightforwardness	0.03	0.93	0.17	0.86
Altruism	-0.21	1.09	-.87	0.39
Compliance	-0.56	1.38	-1.76	0.09
Modesty	-0.93	0.93	-3.40	0.00**
Tender-Mindedness	0.27	1.11	1.20	0.23

* $p < .05$; ** $p < .01$

Differences Between Supervisor and Supervisee Alliance Ratings

Independent sample t-tests were conducted to explore possible differences in strength of perceived alliance ratings between supervisors and supervisees. Supervisees and supervisors were significantly different in their early total alliance ratings, with supervisors reporting significantly higher early perceived alliance ratings (M = 216.93, SD = 14.63) than supervisees (M = 198.19, SD = 33.60), $t(43.50) = -3.16$, $p = .003$.

Discussion

This thesis examined the associations between supervisors' and supervisees' personality traits and their perceived quality of early supervisory working alliance. In addition, this research examined whether supervisors and supervisees differed in the strength of their perceived early working alliance. The analyses led to three important findings. First, personality facets from two of the NEO-PI-3 five-personality domain (openness: $p < .05$; and agreeableness: $p < .01$) significantly predicted supervisors' early alliance ratings. Second, supervisees' personality traits did not impact their early alliance ratings. Third, a significant difference between supervisors' and supervisees' perception of their alliance was observed, where supervisors rated their early alliances significantly higher than that of their supervisees. Implications of these findings are explored further in the following section.

Personality as Predictors of Alliance Ratings

Results suggest that supervisees' alliance ratings were not significantly related to their personality traits; however, some supervisors' personality traits were found to be significant predictors of their alliance ratings.

Previous research suggests that supervisors' higher levels of self-awareness could explain why their personality traits influenced their ratings of alliance, but not those of supervisees' (Williams, 2008; Kadushin & Harkness, 2014). Specifically, these studies suggest that self-awareness is an important personality trait for both supervisees and supervisors in a clinical supervision context (Williams, 2008; Kadushin & Harkness, 2014). Self-awareness involves the ability to perceive one's behaviour objectively and to have free access to one's own feelings without excessive guilt, embarrassment, or discomfort, as well as to self-examine and self-reflect (Kadushin & Harkness, 2014). This highlights the importance of self-awareness in enhancing therapists' ability to act in a deliberate, disciplined, and conscious manner with clients (Kadushin, 2014).

Moreover, studies have found a relationship between self-awareness and practice competence, supporting the need for supervisors to have higher levels of self-awareness to educate their supervisees about the importance of self-awareness (Epstein & Hundert, 2002; Kadushin, 2014). It can, therefore, be inferred that supervisors in this study may have had a higher level of self-awareness, due to their expertise and experience in the field, as well as having the ability to self-reflect and examine their alliance with their supervisees (Kadushin & Harkness, 2014).

Conversely, supervisees in this study may not yet have fully developed this ability, possibly explaining why their personality traits did not affect their alliance ratings. Supervisors' higher levels of self-awareness makes them more objective and introspective during self-reflection or

analysis, specifically being more aware of their reactions towards clients and supervisees (Kadushin, 2014).

A reason for this difference could be that supervisors may have concerns about the influence that their personality traits may have on the working alliance with their supervisees, thus, affecting ratings of the alliance. For instance, one study found that supervisors were concerned about some aspects of their personality that affected supervision outcomes, such as being hyperverbal, too rigid, perfectionist, demanding, or communicating unrealistic expectations (Kadushin, 1992; Kadushin & Harkness, 2014). These findings also support the argument that supervisors tend to have higher levels of self-awareness, as they tend to be more conscious of their personality traits and of how their personality traits could affect their working alliance. As such, Kadushin (1992) also found that supervisors identified personality characteristics that acted as strengths in developing a working alliance with their supervisees, such as being fair and well organized. Moreover, Kadushin (1992) found that supervisors were aware of their difficulties as supervisors, including administrative duties, such as reviewing or evaluating. This internal dynamic could also have been present with the supervisors who participated in the present study.

Another possible explanation for this difference is the concept of referent power in a clinical supervision context, which occurs when the supervisor has power that derives from the supervisees' desire to be liked by the supervisor and to be like the supervisor (Kadushin & Harkness, 2014). "Referent power has its source in the positive relationship between supervisor and supervisee, in the attraction the supervisee feels towards the supervisor." (Kadushin & Harkness, 2014, p. 61). This power is also known as a relationship power, whereby the supervisee wants to believe and behave as their supervisor does (Beinart, 2004; Frawley-O'Dea & Sarnat, 2001; Milne, 2009; Kadushin & Harkness, 2014). Milne (2009) also explains that supervisees tend

to let themselves be influenced by the referent power due to their supervisor's expertise and attractiveness.

In his study, Beinart (2004) found that perceiving supervisors as a good role model was an important condition for better supervision outcomes, from the supervisees' point of view (Beinart, 2004). From this perspective, if supervisees perceive their supervisor as a positive role model, the referent power may be stronger.

Furthermore, Frawley-O'Dea and Sarnat (2001) explain that "[…] it is human nature that supervisors should simply do to their supervisees as was done to them by their supervisors" (p. 270). This highlights the fact that humans learn by observing figures of authority. Since supervisors are the main figure of authority influencing supervisees' learning, it is more likely that trainees will adopt their supervisors' therapeutic and supervisory style, which guides. Thus, supervisees tend to see their supervisor as a model to guide their own professional development as a therapist and supervisor.

In light of our findings, the concept of the referent power may help explain why supervisees' personality traits did not influence their alliance ratings. That is, supervisees may have wanted to conform with their supervisor's personality traits instead of their own (Kadushin & Harkness, 2014). The concept of supervisees conforming with their supervisor's style is further supported by Kadushin & Harkness (2014) who found that referent power is associated with the type of relationship displayed between supervisor and supervisee. Specifically, once the relationship is established, it provides the supervisor with a basis of power with which to influence. The stronger the relationship, the stronger the supervisor's power to influence their supervisees' behaviours and attitudes (Kadushin & Harkness, 2014). Therefore, it is possible that the difference in personality traits and alliance ratings between supervisors and supervisees is explained by the

influence of the referent power. That is, supervisors' position of authority may prevent supervisees from letting their personality traits influence their alliance ratings because of a desire to conform. This difference between supervisors' and supervisees' personality traits and alliance ratings could also be explained by a positive relationship between supervisor and supervisee.

Personality Facets. The Feeling personality facet from the openness personality domain was found to be a significant negative predictor of the supervisors' early alliance ratings. The NEO-PI-3 suggests that openness to feelings involves receptivity to one's inner feelings and emotions and perceiving the evaluation of emotions as an important part of life (Costa & McRae, 1992). Since the supervisors in this study were found to have particularly high levels of Openness, it could indicate that supervisors are more likely to be open to their different emotions, explaining the negative correlation between their ratings of their early total alliance and the feeling personality facet.

Specifically, people showing higher levels of the Feeling on the facets may experience deeper, more distinguished emotional states and feel both happy and unhappy more intensely (Costa & McRae, 1992). For instance, Zillig, Hemenover, and Dienstbier (2002) found that when assessing the Openness personality traits with the NEO-PI-3, affect and cognitions are emphasized rather than behaviours, meaning that this domain focused on the "heart" and "mind" rather than the "intellect". Since the affect and cognition are the main components of the Feeling personality facet, as one's level of feeling increases, so might their ability to process affective and cognitive components, such as being inclusive in one's thinking and feeling (Zillig, Hemenover & Dienstbier, 2002). Therefore, being able to process and include affect and cognitions may lead supervisors to be aware and conscious, explaining the negative prediction of feeling on alliance ratings. Similarly, research suggests that individuals high on Feeling tend to be more

conscientious, exposing them to distracting thoughts, disturbing impulses, and cognitive inconsistencies (McCrae & Costa, 1997; Diseth & Martisen, 2009). Being more exposed to these negative thoughts or impulses could suggest that they would negatively influence the supervisors' alliance ratings. In sum, having a higher level of openness to feelings may also accentuate negative feelings.

Along the same lines, the Modesty personality facet from the Agreeableness domain was also found to be a negative predictor of the supervisors' early total alliance ratings. According to Costa, McRae, and Dye (1991), the Modesty personality facet refers to an aspect of self-concept. Hence, individuals scoring high on modesty are high in self-degradation and low in the need for exhibition, which also indicates that low scorers tend to be unassuming rather than arrogant (Costa, McRae & Dye, 1991).

Previous research on modesty has outlined its association with insecurity and dependent characteristics. In fact, the Neo-PI-3 suggests that people with high levels of modesty also tend to present symptoms of dependency (Costa & McRae, 1992). In addition, people presenting dependent personality traits tend to be unsure and insecure about themselves (Costa & McRae, 1985; Widiger & Costa, 2002; Lowe, Edmundson & Widiger, 2009). Widiger and Costa (2002) indicate that presenting excessive modesty is not beneficial and may in fact lead to pathological symptoms (Lowe, Edmundson & Widiger, 2009). Excessive modesty involves needing reassurance and advice from others to make everyday decisions (Widiger & Costa, 2002; Lowe, Edmundson & Widiger, 2009). Lowe, Edmundson, and Widiger (2009) support the idea that modest people tend to feel insecure, leading them to be unsure about themselves. Consequently, given that the supervisors in this study presented higher level on the Agreeableness personality domain to which the modesty trait is associated, they may have felt insecure about their alliance

with their supervisees, explaining the fact that modesty facet negatively predicts their early total alliance ratings.

Further, Furnham, Richards, and Paulhus (2013) explain that negative associations between the Modesty personality facet and narcissism personality traits or disorder are understandable since the NEO-PI-3 inventory's description of this domain (Costa & McRae, 1991) is wide, including traits such as "autocratic, selfish, stubborn, demanding, headstrong, impatient, intolerant, outspoken, hard-hearted, argumentative, and aggressive" (Furnham, Richards & Paulhus, 2013, p. 204). The evidence suggests a strong association between narcissistic traits and low scorers on modesty (Furnham, Richards & Paulhus, 2013). Having narcissistic personality traits usually involves presenting a grandiose self-appreciation and inflated self-image, which lead to selfish and indifferent behaviours (Furnham, Richards & Paulhus, 2013).

Considering this association, it could be suggested that high scorers on modesty may be more reserved and less pretentious (Furnham, Richards & Paulhus, 2013), allowing them to feel less secure about their working alliance ratings. As a result, high scorers on this facet tend to be able to self-reflect and be aware of their weaknesses. Taken together, this association could explain why as the supervisors' *modesty* level increases, their alliance ratings decrease, since they are better at self-reflecting, leading them to notice their weaknesses and perceive their working alliance with their supervisees as weaker.

To summarize, the negative prediction between the Modesty personality facet and the supervisors' early total alliance ratings could be explained by its association with insecurity and dependent traits. Lastly, another possible explanation could be that high scorers on modesty tend to have a better sense of self and have the ability to self-critique.

Concordance Rates

The results of this thesis suggest that supervisors have higher early alliance ratings scores than supervisees. This aligns with previous research by Bilodeau et al. (2010) and Fitzpatrick et al. (2005), which suggest that discrepancy between client and therapist could be caused by different conceptions counsellors and clients may have of the working alliance. Three possible concepts could help explain this result: supervisors' self-awareness, the concept of concordance, and the power of authority.

The results of this study somewhat align with previous research, which suggests that supervisors tend to have a higher level of self-awareness and tend to have the ability to facilitate the achievement of concordance (Williams, 2008; Kadushin & Harkness, 2014; Tusaie & Fitzpatrick, 2017). Tusaie and Fitzpatrick (2017) describe the concept of concordance as working collaboratively with a client to set goals and treatment strategies in the context of therapy, leading to a strong working alliance. To be able to achieve concordance, an awareness of the therapist's own thoughts and feelings is necessary; additionally, the use of counter-transfers is encouraged, as it involves becoming aware of feelings involving the client (Tusaie & Fitzpatrick, 2017). Although the concept of concordance was developed in a therapeutic context, it could explain why supervisors tend to have higher alliance ratings, since achieving concordance may be easier for supervisors than to supervisees, as the former have more experience, expertise, and possibly higher level of self-awareness, leading to the use of integrative thinking skills and feelings in order to develop concordance with supervisees and perceive their alliance higher.

Supervisors are not only more aware of their inner feelings, but also of the fact that their role implies satisfying both the requirements of their organization and of their supervisees. Having to deal with a job and human demands may lead them to tensions of conflicting demands and

expectations, such as handling complaints and imposing discipline (Kadushin & Harkness, 2014). Consequently, knowing that supervisors are aware that their role may influence their alliance with their supervisees may explain why the results of this study suggest they have higher alliance ratings than supervisees.

While supervisors' position of authority could also incite them to feel more secure about their role, giving their alliance higher scores than supervisees, supervisees' position of subordination, being closely observed and evaluated, could explain their lower alliance score (Kadushin & Harkness, 2014). In fact, formal evaluations, as used in clinical supervision, can cause anxiety, as well as fear of failure and rejection (Kadushin & Harkness, 2014).

Authors have explored the impact and consequences of ambiguity and role conflict within social services departments, including clinical supervision (Clare, 1988; Kadushin & Harkness, 2014). Subsequently, the power differential can have positive and negative consequences for the supervision process and outcomes (Clare, 1988; Kadushin & Harkness, 2014). Clare (1988) proposes that power, authority, and influence should be used to improve the working relationship between supervisees and supervisors. Specifically, "[o]ne possible strategy, in theory, would be to give greater emphasis to the professional autonomy of the practitioner-with delegated discretion to make assessments, formulate and negotiate an intervention strategy and to allocate resources for the achievement of agreed goals" (Clare, 1988, p. 492). Moreover, formal power has been shown to either increase or decrease relationships between superiors and subordinates (Clare, 1988). For instance, authority can be beneficial in supervision when supervisors have the ability to influence supervisees through credibility, interpersonal identification, and modelling of competence, knowledge, and skills (Clare, 1988, Kadushin & Harkness, 2014), promoting respectable values, such as leadership, improved self-image, confidence, and competence (Clare, 1988).

In his study Kakabadse (1982) focused on the different levels of authority and their impact on the supervisory relationship. The results of his study suggest that working alliance is influenced by the different beliefs about work held by people at different authority levels. Supervisees' lower ratings of the alliance could be explained by the fact that they can be confused and frustrated by clients' and supervisors' different expectations (Clare, 1988).

Kadushin and Harkness (2014) differentiate between authority and power in clinical supervision, with the former being the right to direct, command, and punish and the latter being the ability to apply these with supervisees (Kadushin & Harkness, 2014). Kadushin and Harkness (2014) state that "[t]he supervisees' readiness to accept the supervisor as an expert and as an object of identification and emulation is subject to change." (p. 62). In fact, supervisors' power may decrease if supervisees conclude that the supervisor is not the expert he was initially perceived to be, which could explain their reduced alliance ratings (Kadushin & Harkness, 2014).

Further research would help to understand why supervisors tend to rate their alliance higher than do supervisees.

To conclude, the differences observed between supervisors and supervisees in how their personality traits affect the alliance ratings could be explained by supervisors' higher level of self-awareness and the concept of referent power. Additionally, the feeling personality facet from the openness domain as a negative predictor of supervisors' alliance ratings could be explained by supervisors' openness towards their feelings, including negative ones. This openness to feelings increases the likelihood that supervisors may feel more insecure about themselves. A negative association was also found for the modesty personality facet as a predictor of supervisors' early alliance ratings. Therefore, as the level of modesty personality trait increases, supervisors seemed to perceive their alliance as lower. Finally, the concept of power and authority might help explain

why supervisors have higher alliance ratings, leading supervisors to feel more secure about their alliance, whereas supervisees may feel more insecure because they are being observed and evaluated (Kadushin & Harkness, 2014).

Strengths and Limitations

As previously stated, studies support that the working alliance is the most predictive factor of therapeutic outcomes (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Flückiger & Symonds, 2011; Flückiger, Del Re, Wampold, Symonds & Horvath, 2012). Studies also suggest that working alliance in a clinical supervision context is important to promote better training for supervisees (Burns, 1958; Robinson, 1949; Bordin, 1983; Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003; Kadushin & Harkness, 2014). Research suggests that personality traits can be predictive of clinical supervision processes and outcomes (Handley, 1982; Clingerman, & Gilbride, 2011). Since this study focused on exploring how personality traits influence supervisors' and supervisees' working alliance ratings, it contributes to a better understanding of factors that can influence clinical supervision processes and outcomes. Moreover, as this study attempts to deepen the understanding of clinical supervision processes, it also aids in comprehending how clinical supervision impacts therapeutic outcomes, to protect clients and psychotherapy as a profession. Scales used throughout this study, such as the NEO-PI-3 and the WAI modified version for Trainees and Supervisors, are validated and applicable to diverse populations (Benson & Kluck, 2014), which increases the likelihood that the results are reliable and valid.

Sample Size. The relatively small sample size may have increased the risks of Type I or Type II errors. Further research should include lager sample sizes to continue to explore the differences in supervisors' and supervisees' alliance ratings in a clinical supervision context,

with personality traits as a predictive variables. As such, researchers would gain better understanding of supervisees' role in working alliance. To reduce the risk of Type I and II errors, this study recruited a minimum number of participants for the data to be extended and increase the validity of the results.

Self-Report Bias and Social Desirability Bias. Self-report bias may have been an issue, as this study used self-report questionnaires (NEO-PI-3 and WAI), relying on participants' honesty. "In general, research participants want to respond in a way that makes them look as good as possible. Thus, they tend to under-report behaviours deemed inappropriate by researchers or other observers, and they tend to over-report behaviours viewed as appropriate" (Donaldson & Grant-Vallone, 2002, p. 247). The degree to which self-report bias may be problematic varies according to the questionnaires' topic (Austin et al., Deary, Gibson, McGregor & Dent, 1998; Hoskin, 2012). Although this study used two valid questionnaires – personality and working alliance – the risk of deceit may still be present, specifically in relation to personality, due to the desire to present oneself in a better light (Austin, Deary, Gibson, McGregor & Dent, 1998; Hoskin, 2012).

Response Bias. "[Response bias] refers to individuals' tendency to respond a certain way, regardless of the actual evidence they are assessing" (Hoskin, 2012, par. 7). For example, participants may rate their alliance by only referring to their last supervision instead of comparing their last four. Response bias can be problematic when assessing the relationship between two questionnaires, as seen in the present study, which compares the results of the NEO-PI-3 and the WAI modified version for Trainees and Supervisors. This issue arises, because correlations between two questionnaires may only be reflective of the consistency of participants' response bias across questionnaires, rather than representative of an unaffected

relationship among the variables measured in the questionnaires (Hoskin, 2012). Although this is a possible limit of this study, we have tried to reduce this effect by taking data that was recruited over many years.

Rating Scales. Rating scales are typically used to allow participants to provide nuanced answers, rather than just yes/no ones. Although rating scales have their advantages, they can be problematic (Fan, Miller, Park, Winward, Christensen, Grotevant et al., 2006; Hoskin, 2012). One of these problems relates to how people interpret and use scales differently (Fan, Miller, Park, Winward, Christensen, Grotevant et al., 2006; Hoskin, 2012). Additionally, research suggests that people have different ways of filling out forms: some like to use the edges of the scales, while others prefer the midpoints (Fan et al., 2006; Hoskin, 2012). Different interpretations of rating scales yield considerably different scores that differ from the questionnaire's intended purpose (Fan et al., 2006; Hoskin, 2012).

Important Findings and Clinical Implications

The results presented have important implications for clinical supervision processes and outcomes. Personality traits were predictive of supervisors' early alliance ratings, but not of supervisees'. Increased awareness of this finding would allow supervisors and supervisees to understand the role their personality traits play in the processes and outcomes of supervision.

The results of this study are important when considering factors that may have affected supervisees' alliance ratings, such as fears and anxiety of being evaluated/observed and referent power. Supervisors could gain awareness of how their position of power can influence supervisees' interpretation of the working alliance, which could help inform their interactions by addressing the aforementioned barriers that could be at play.

Furthermore, supervisors' honesty about supervisees' potential insecurities could help ease supervisees' fears and anxiety of being evaluated/observed and desire to conform with supervisor. Supervisees' increased awareness of their potential insecurities/barriers could allow them to feel less pressure, due to transparency, and to feel like they can be authentic rather than conforming. These findings could help inform both supervisors and supervisees about the importance that their role may have on their alliance ratings and how addressing it in clinical supervision could reduce the level of influence these barriers have on the alliance ratings.

The predictive relationship between supervisors' personality traits and early alliance ratings may carry important implications for university training programs. Since personality traits seem to be predictive of working alliance ratings, clinical training programs could start assessing potential supervisors' personality traits in order to match them with appropriate supervisees and promote . Properly matching supervisees with supervisors based on personality traits would increase the likelihood of developing strong supervisor-supervisee working alliance. Personality matching between supervisors and supervisees could also prevent potential difficulties that may surface due to incongruences in personality traits.

If supervisor-supervisee matching is not possible due to constraints, such as limited budget or availability of supervisors, the results of this study could help increase supervisors' awareness of supervisees' needs. Developing training sessions geared to increasing supervisors' awareness of supervisees' personality traits and how to tailor appropriate interventions to cater to their various needs would allow supervisees to benefit from and be satisfied with their clinical supervision. For instance, with supervisees high in agreeableness and susceptible to being modest, supervisors would be aware of potential interventions to reinforce or reduce displays of modesty, allowing the supervisor to find a balance to promote adequate levels of the trait within supervisees.

Moreover, the results of this study highlight the importance of working alliance in clinical supervision for supervisees. As previously discussed, stronger working alliances may lead supervisees to fully benefit from their supervisors, who serve as professional models. Therefore, this study could have important implications for the practice of clinical supervision and the training of supervisees in suggesting that working alliance may be an important factor for consideration for all supervisees. This could help inform supervisors' training about possible influences that personality may play in a supervision context. Increasing supervisors' level of knowledge and understanding of how their personality traits and style may influence the working alliance with their supervisees and how they perceive and rate it could help supervisees be more objective in how they rate their alliance.

Another important finding was the differences in alliance ratings, specifically, supervisors had higher alliance ratings than supervisees. These results are important for clinicians to note, because supervisees are known to be better predictors of supervisory outcomes. As such, further research could examine what specific factors contribute to lowering supervisee alliance, which could help inform clinicians and supervisors with the ability to address it in clinical supervision when needed.

The results of this study also help inform and increase the awareness of mental health practitioners and society as to which personality traits tend to influence working alliance in clinical supervision. This may help health practitioners develop openness to exploring the importance of personality traits, their impact on working alliance, and using this knowledge to promote better supervisory outcomes.

Future Research

This research contributed to the small number of studies that have explored working alliance in a clinical supervision context. This is the first step to understand how early working alliance ratings can be influenced by supervisors' and supervisees' personality traits. Further research is needed to better understand the differences in alliance ratings between supervisors and supervisees and the impacts that personality traits have on supervisors' alliance ratings. As little is known about supervision training, future research should focus on how to increase working alliance and supervisory outcomes, for example, by making supervisors more aware of working alliance. Key areas that should be addressed in further research include supervisors' education and awareness about working alliance and the variables affecting supervisees' alliance ratings.

Future research should focus on larger samples, while exploring dyadic data and the influence of one participant's characteristic on the other's ratings, as this was outside the scope of the present study.

The results of this thesis are promising in terms of improving positive supervisory outcomes and have opened many avenues for further research. It is important to explore this area as it may inform mental health practitioners and supervisors regarding the variables and factors influencing working alliance in clinical supervision and promote better supervisory outcomes.

Conclusion

This study aimed to understand what personality traits from the NEO-PI-3's five personality domain predict supervisors' and supervisees' alliance ratings. The results suggest that facets from two personality domains (openness and agreeableness) significantly predicted supervisors' early alliance ratings whereas no significant results appeared for supervisees. Results also demonstrated that supervisors tend to have higher early alliance ratings than supervisees. This study contributed to a better understanding of how personality traits can predict

supervisors' early alliance ratings, while exploring which specific facets of personality positively or negatively predict the early alliance ratings. This study has contributed to the understanding of how supervisors view their alliance with their supervisees. It explored supervisors' and supervisees' experiences that can inform how to incorporate and process the use of working alliance in supervision. Although more research is needed in this area, specifically in regards to supervisees' alliance ratings, this research has highlighted the importance of supervisors' personality traits and how they predict their early alliance ratings as well as highlighted the need to better understand the differences between supervisors and supervisees in terms of how they perceive their early alliance.

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