

**EXPLORING PARALLEL PROCESS IN SUPERVISORY  
AND THERAPEUTIC PROCESSES:  
AN EXAMINATION OF RELATIONSHIP ALLIANCE  
AND THEIR PREDICTION OF OUTCOMES**

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Thesis submitted to Saint Paul University  
in partial fulfillment of the requirements for  
the Doctorate in Counselling, Psychotherapy, and Spirituality

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## Acknowledgements

This accomplishment is dedicated to my three children, Xander, Tatum, and Braysen.

I want to express my deepest gratitude to those who walked beside me through every step of this journey. To my family and friends—thank you for holding space for me during the late nights, the self-doubt, and the small victories. Your unwavering love, patience, and faith in me was a source of strength.

I would also like to express gratitude to my supervisors, Dr. Cynthia Bilodeau and Dr. Anne Thériault, for their unwavering support, insightful guidance, and encouragement throughout the course of this research journey. I am equally thankful to Dr. Christian Bellehumeur, Dr. Stephanie Wiebe, and Swathi Vepachedu for their valuable contributions, thoughtful feedback, and steadfast support as part of my academic team.

To the participants who trusted me, your openness gave this research life and meaning. This thesis holds not only my work but the love and support of every one of you.

## Abstract

This thesis project explored parallels between clinical supervision and psychotherapy processes, and the possible impact of those parallels on client outcomes. This monograph includes a comprehensive literary review that illustrates the background against which the research was conducted. It also sets out the components on which the researcher focused, with an emphasis on whether relationship is a primary predictor of outcomes in psychotherapy.

The research included two major areas of consideration: (a) to determine whether there is an association between the relational variables of alliance, autonomy, and affiliation at independent time points in the supervisory and therapeutic relationships, reflecting the possible presence of parallel process; and (b) to examine whether the relationship between therapeutic relational variables and client outcomes are moderated by supervisory relational variables.

The association between the relational variables of alliance, autonomy, and affiliation at independent time points was inconsistent, and the first hypothesis was therefore only partially supported. The most significant finding of this study was that the relationship between the supervisory alliance and the therapeutic alliance was significantly associated with client outcomes. Specifically, results showed that supervisory alliance may play a moderating role in the relationship between client-rated therapeutic alliance and client outcomes, wherein poor therapeutic alliance was associated with poor client outcomes, particularly in the presence of a poor supervisory alliance. In contrast, when the supervisory alliance was high client outcomes were relatively better both when the therapeutic alliance was high and when it was low. Interestingly, this suggests that strong supervisory alliance may serve to buffer the negative effects of poor therapeutic alliance on worsening client outcomes, and that strong supervisory alliance may in fact enhance the relationship between high therapeutic alliance and better client outcomes.

The relationship between clinical supervision and client outcomes has been the subject of various studies, yielding mixed results. While it is agreed that supervision is essential for the professional development of therapists, the limited previous research has not been able to solidify its direct influence on client outcomes. This study is one of the few that link supervision to positive client outcomes, and it connects with previous research in highlighting the need to leverage the potential benefits of parallel process. This requires that we gain greater understanding of parallel process and its impact on clinical work with clients.

Ultimately, the results of the present study underscore the need for robust training programs that emphasize the development of strong supervisory and therapeutic alliances. In particular, this study highlights the importance of the supervisory alliance. This supports several previous studies that link strong supervisory alliance to better outcomes for clients, and suggests that leveraging parallel process to provide more fulsome training programs may ultimately lead to more effective services being delivered to clients and, ultimately, to better client outcomes.

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## **Introduction**

The purpose of this research project was to explore the parallels between supervisory and therapeutic relationships, and to look at which processes might impact client outcomes. Specifically, the phenomenon of parallel process was explored through the lenses of the relationship variables of alliance, affiliation, and autonomy, examining their role in predicting client outcomes. It is hoped that this study will inform the field of clinical supervision with particular impact on supervisee development, ultimately contributing to the enhancement of professional services and client outcomes.

## **Background**

### ***Clinical Supervision***

Clinical supervision is identified as the signature pedagogy in the professional development of psychotherapists and is recognized as the instructional strategy that characterizes a profession's preparation of its practitioners (Bernard & Goodyear, 2019). Clinical supervision is a foundational aspect of psychotherapy practice and is most notably a critical element of training that serves to maintain the standards of the profession (Holloway & Neufeldt, 1995). It has a pivotal role in counsellor development for the duration of professional practice, from novice student to senior professional (Borders et al., 2017). In fact, an extensive body of research has focused on understanding supervision and how it impacts client outcomes.

Clinical supervision is a complex process within which an intricate, three-part relationship system exists between the supervisor, the supervisee (therapist), and the client (Freud, 1937; Bordin, 1983). All parts of this relationship triad are important in the duality of care and potential client outcomes.

Clinical supervision serves two main functions: (a) it supports supervisee development and learning outcomes; and (b) it provides the basis for gatekeeping (Overholser, 2004). It is, “individualized and responsive to what the supervisee brings to sessions with the supervisor,” (Hill & Knox, 2013, p. 776), and is a critical component to building effective and competent analytic practitioners (Watkins, 2013). Bernard and Goodyear (2019) provide the following working definition of supervision:

It is an intervention that is provided by a more senior member of a profession to a more junior colleague; it is evaluative and hierarchical; extends over time; monitors the quality of professional services offered to clients; and serves as a gatekeeper for the profession. (p.9)

In addition to outlining the two primary functions of supervision, this view also alludes to the complexity of the triadic process. Each member of the triadic relationship contributes uniquely to, and can affect, the dynamic of the supervision (Frawley-O’Dea & Sarnat, 2001), which is also subject to many other variables (Bordin, 1983; Ladany & Leharman-Waterman, 1999; Ladany & Melincoff, 1999; 2012).

Other research has further emphasized the triadic nature of supervision with a *double matrix model*, wherein the supervisor tends to the supervisory relationship and the therapeutic relationship using different modes, which helps to navigate both relationships along with the dynamics inherent in each (Hawkins & Shohet, 2012).

### ***Parallel Process***

In its current conception, parallel process is understood to be a multi-directional process that involves and affects all three participants of the clinical supervision triad; that is, the client, supervisee, and supervisor (Frawley-O’Dea & Sarnat, 2001). Considered by some to be an integral part of supervision (Caligor, 1981) and a powerful supervision intervention (Morrissey & Tribe, 2001), parallel

process serves as a tool that supervisors can utilize to help supervisees gain insight into their clinical work with clients (Jacobsen, 2007), and into the therapeutic relationship (Carroll, 1996).

The concept of parallel process is grounded in psychodynamic theory as a phenomenon unique to supervision. It was originally believed to arise when processes that occur in the supervisee-client dyad are reenacted in the supervisor-supervisee dyad (Searles, 1955). However, this is an abstract concept that is challenging to measure due to lack of consensus on how it is observed and described, as well as the lack of appropriate empirical measures (Zetzer et. al., 2020). While there is no universally accepted definition of parallel process, one area of consensus is that relationship plays a key role in the phenomenon. The definition used to inform the present research was taken from Frawley-O'Dea & Sarnat (2001):

Parallel process refers to the means by which key relational patterns of one dyad come to influence the relational configurations of the other dyad. Parallel processes are most likely set into motion when the transference-countertransference matrix in play in the first dyad involves nonverbal, unsymbolized relational constellations that are central to relational functioning of that dyad but have not yet been consciously processed or linguistically encoded by the members of the dyad. (p. 173-174)

Building on this definition, the present study measured perception of interpersonal processes with an emphasis on transference and the relational aspects of parallel process. A special focus was placed on the underlying relationship variables of alliance, affiliation, and autonomy, and whether and how those variables impact client outcomes. The present study also examined the relationship between the supervisory and therapeutic alliances, and the importance of supervision in shaping client outcomes.

### **Relevance of Clinical Supervision in the Context of this Study**

The relevance of clinical supervision is deeply rooted in its influence on the therapeutic process. Clinical supervision is integral not only to the development of effective therapeutic skills, but also for guiding therapists through the therapeutic process itself (Bernard & Goodyear, 2019). The relevance of clinical supervision extends beyond the immediate benefits for supervisees. It also has profound implications for client outcomes, making it a crucial component of the therapeutic process.

The therapeutic process involves a dynamic interaction between the therapist and client, and the supervisory process involves a dynamic interaction between the supervisor and the supervisee. Both alliances are continuously negotiated and refined. The present study therefore underscored the importance of clinical supervision in shaping and supporting therapeutic processes, and consequently, client outcomes.

### ***Enhancing Therapist Competence and Confidence***

One of the primary functions of clinical supervision is to enhance the competence and confidence of therapists in training (Bernard & Goodyear, 2019). This is achieved through strong therapeutic and supervisory alliances, also referred to as working alliances. Bordin's (1979) definition of the therapeutic working alliance is one of the most widely cited and foundational in psychotherapy and supervision literature. With this definition, Bordin introduced a tripartite model that describes the therapeutic working alliance as the collaboration between the therapist and the client which involves three components, including: (1) agreement on goals; (2) assignment of tasks; and (3) the development of bonds (Bordin, 1979).

The supervisory working alliance refers to the collaborative and purposeful relationship between supervisor and supervisee. Bordin's (1983) conceptualization of the therapeutic working alliance was expanded to other helping relationships, including supervision. The definition of therapeutic alliance was adapted to reflect the involvement of three key components: (1) agreement

on the goals of supervision; (2) consensus on the tasks to achieve those goals, and; (3) the development of a positive emotional bond between supervisor and supervisee (Bordin, 1983). Through a strong supervisory alliance, supervisors provide guidance, feedback, and support that help supervisees develop essential skills. This not only improves the therapeutic techniques of the supervisee but also contributes to the formation of a robust therapeutic alliance.

By experiencing a supportive and collaborative supervisory alliance, supervisees learn how to create a similar dynamic with their clients (Ladany et al., 2005). This modeling effect is crucial, as it helps supervisees internalize the principles of effective alliance-building, which they then apply in their therapeutic work (Bernard & Goodyear, 2019). As a result, clinical supervision becomes a key factor in ensuring that clients receive high-quality care (Falender & Shafranske, 2004).

### ***Implications for Client Outcomes***

Supervisors who prioritize the development of a strong supervisory alliance contribute not only to the growth of the supervisee but also to the well-being of the clients they serve (Bernard & Goodyear, 2019). By fostering an environment of support, trust, and collaboration, supervisors help supervisees develop the skills and confidence they need to build strong therapeutic alliances, leading to more effective and meaningful therapeutic outcomes for clients (Ladany & Melincoff, 1999). However, as discussed in the literature review below, these findings are based on research that is lacking in empirical evidence.

### ***Supporting the Therapeutic Process through Supervision***

The therapeutic process is complex and multifaceted, involving the establishment of trust, the negotiation of goals, and the execution of therapeutic tasks (Bordin, 1979). These elements are mirrored in the supervisory process, where the supervisor and supervisee engage in a parallel relationship (Watkins, 2011). The supervisory alliance serves as a model for the therapeutic alliance,

providing the supervisee with a framework for building and maintaining a strong therapeutic alliance with their clients (Bernard & Goodyear, 2019).

Supervisors play a critical role in helping supervisees navigate the therapeutic process by offering guidance on how to manage the various stages of therapy (Bernard & Goodyear, 2019). For instance, supervisors may provide strategies for establishing rapport, setting appropriate goals, and maintaining client engagement (Watkins, 2011). This guidance is particularly important in difficult or challenging cases where the therapeutic process may stall or regress (Ladany & Melincoff, 1999). By drawing on the supervisory alliance, supervisees learn how to sustain the therapeutic process even when faced with obstacles (Bordin, 1983). Moreover, supervision offers a space for supervisees to reflect on their therapeutic interactions, identify areas of strength and weakness, and explore alternative approaches (Falender & Shafranske, 2004). This reflective practice is essential for maintaining the integrity of the therapeutic process, ensuring that it remains client-centered and responsive to the evolving needs of the client (Koltz et al., 2012).

### ***Integrating Supervision and the Therapeutic Process***

Supervision not only shapes the development of therapeutic skills but also supports the ongoing process of therapy. By fostering a strong supervisory alliance, supervisors equip supervisees with the tools and confidence needed to navigate the complexities of the therapeutic process, ultimately leading to improved client outcomes (Beinart & Clohessy, 2017; Ladany et al., 1999). This underscores the importance of viewing clinical supervision as an integral component of the therapeutic process, with far-reaching implications for both supervisees and their clients. The related research and associated findings are discussed in the literature review below.

## **Parallel Process as a Powerful Supervisory Tool**

Clinical supervision is a dynamic process that significantly influences the development of therapeutic competence and the quality of client outcomes (Falender & Shafranske, 2004). One crucial concept in understanding the effectiveness of clinical supervision is the notion of parallel process. This phenomenon is particularly important because it provides a powerful tool for supervisors and supervisees to explore and address issues that may be affecting the therapeutic process (Doehrman, 1976). Reflecting the relational dynamics that occur between the supervisee and their client, parallel process can happen unconsciously, with the supervisee acting out the client's behaviour, emotions, or relational style within the supervisory relationship. Alternatively, the supervisee may internalize the supervisor's approach and unconsciously replicate it with their client (Doehrman, 1976).

Parallel process offers a unique lens through which supervisors can gain insight into the therapeutic challenges that a supervisee is facing. For instance, if a supervisee begins to exhibit feelings of frustration or helplessness within supervision, these feelings may reflect the emotions being experienced in the therapy room with their client. Recognizing this parallel allows supervisors to address these feelings within supervision, thus helping the supervisee manage and understand these emotions in their clinical work (Tracey et al., 2012). Overall, parallel process is considered a “powerful way to apprehend the dynamic intersection of therapy-supervision processes” (Watkins, 2017, p. 506).

### ***The Role of the Supervisor in Addressing Parallel Process***

Supervisors play a critical role in identifying and addressing parallel process (Watkins, 2011). When parallel processes are recognized, they can be used as a diagnostic tool to explore deeper issues within the therapeutic relationship. For example, if a supervisee is defensive or resistant during supervision, a supervisor might explore whether the supervisee's client is exhibiting similar behaviour in therapy (Doehrman, 1976). By discussing these parallels, the supervisor can help the supervisee develop strategies to work through resistance or other therapeutic impasses (Ladany et al., 2005).

Addressing parallel process requires a high level of self-awareness and reflection on the parts of both the supervisor and the supervisee (Bernard & Goodyear, 2019). Supervisors must be attuned to the emotional and relational dynamics within supervision, recognizing when these dynamics may be mirroring those in the therapy room (Watkins, 2011). This requires supervisors to be not only skilled in clinical techniques, but also adept at managing the supervisory relationship (Falender & Shafranske, 2004).

The exploration of parallel process can deepen the supervisee's understanding of the therapeutic relationship (Bernard & Goodyear, 2019). It encourages the supervisee to reflect on their own emotional responses and behaviours, both in supervision and in therapy, and to consider how these might be influencing their clients. This reflective practice is essential for the supervisee's professional growth and the effectiveness of their therapeutic interventions (Watkins, 2011).

### ***Parallel Process as a Learning Opportunity***

Parallel process provides a rich learning opportunity in clinical supervision, allowing supervisees to gain a deeper understanding of the relational dynamics that influence both supervision and therapy (Bernard & Goodyear, 2019). By exploring these dynamics, supervisees can develop greater self-awareness and refine their therapeutic skills (Ellis & Ladany, 1997).

For example, if a supervisee notices that they feel particularly anxious or inadequate in supervision, and these feelings mirror those that arise in sessions with a specific client, the supervisor can help the supervisee explore the underlying causes of these feelings. This exploration might reveal that the client is evoking transference reactions, which are then being played out in the supervisory relationship (Searles, 1955). By addressing these reactions in supervision, the supervisee can gain valuable insights that will help them manage similar dynamics in therapy (Tracey et al., 2012).

The process of working through parallel dynamics in supervision can model for supervisees how to manage similar processes in therapy. Supervisors who effectively address parallel process

demonstrate how to navigate complex relational dynamics, providing supervisees with a template for managing such dynamics with their clients (Borders & Brown, 2022). This modeling is particularly important in helping supervisees develop the skills needed to manage difficult or challenging therapeutic relationships (Falender & Shafranske, 2017).

### ***Implications for Supervisee Development and Client Outcomes***

The exploration of parallel process in clinical supervision has significant implications for both supervisee development and client outcomes. For supervisees, understanding and addressing parallel processes can lead to greater self-awareness, improved therapeutic skills, and increased confidence in managing complex clinical situations (Bernard & Goodyear, 2019; Tracey et al., 2012). By working through these dynamics in supervision, supervisees can develop a deeper understanding of the relational aspects of therapy, which are critical for building strong therapeutic alliances (Borders & Brown, 2022; Searles, 1955).

With respect to clients, the exploration of parallel process in supervision can lead to more effective therapy. When the supervisee can recognize and address the dynamics that are influencing their work with clients, they are better equipped to help their clients navigate similar issues (Borders & Brown, 2022; Ellis & Ladany, 1997; Falender & Shafranske, 2017). This can lead to more meaningful and impactful therapeutic outcomes, as the client is able to work through relational difficulties with the support of a therapist who is attuned to these dynamics (Gnilka et al., 2012).

### **Focus of the Present Study**

The present study explored the interpersonal nature of supervisory and therapeutic alliances, with a focus on the relational variables of alliance, affiliation, and autonomy. This research looked at the interaction of the relational variables in the supervisory and psychotherapy processes and whether and how that interaction is associated with client outcomes. It was hypothesized that these relational

elements would be present in a similar way in both the supervisory and therapeutic relationships, and that the interaction of relational elements would be associated with client outcomes.

Two hypotheses were tested in the present study. Hypothesis 1 (H1) was that there would be an association between the relational variables of alliance, autonomy, and affiliation at independent time points in the supervisory and therapeutic relationships, reflecting the possible presence of parallel process. Hypothesis 2 (H2) was that the relationship between therapeutic relational variables and client outcomes would be moderated by supervisory relational variables.

### **Literature Review**

This review examines the theories about and research into parallel process and its role in clinical supervision and client outcomes across more than 68 years, from 1955 through 2023. This exploration has evolved from theoretical propositions through short-term research projects conducted by individual researchers, to more recent team-led extended longitudinal studies. The applicable literature is organized below into three main categories, including parallel process (general theories to date), parallel process and alliance, and studies addressing how parallel process impacts client outcomes.

#### **Parallel Process: General Theories to Date**

Parallel process has been explored in analytic literature as a phenomenon that occurs in the unconscious when the supervisee is experiencing an impasse, treatment difficulty, or resistance with the client (Bromberg, 1982). It has been theorized that these challenges are expressed behaviourally because of the supervisee's inability to communicate them (Bromberg, 1982), which reflects Freud's (1914) assertion that what is repressed is reproduced behaviourally.

Searles (1955) was the first to describe a phenomenon that he termed *reflective process*, putting forth a bottom-up theory that the phenomenon manifests when the supervisee-client relationship is reflected in the supervisory relationship. He theorized that parallel process serves to

communicate unconscious content from the therapeutic relationship into the supervisory relationship as a shared identification. Characterizing the broad spectrum of emotions felt by the supervisor as informative reflections that offer insight into the supervisee's relationship with the client, Searles (1955) proposed that the reflective process, "fosters a self-awareness that contributes to the advancement of both the supervisory relationship and the therapeutic relationship" (p. 136).

An alternate theory then described a *process-centred supervision* model that focuses on the interactions among the supervisor, the supervisee, and the client. This model proposed that the supervisor utilizes the emotional experiences and challenges of the supervisee in both supervision and psychotherapy to facilitate an awareness and understanding of the client's presenting issues (Wagner, 1957). The phenomenon previously referred to as reflective process and process-centered supervision was subsequently relabeled as parallel process (Ekstein & Wallerstein, 1958).

Multiple researchers have since agreed that the supervisee acts as a conduit between the supervisor and the client, unconsciously presenting to the supervisor in the same way the client presents to the supervisee (Bromberg, 1982; Friedlander et al., 1989). A case study of a single triad applied the social psychological theories of self-presentation and interpersonal influence to examine the theoretical model of parallel process (Friedlander et al., 1989). This study collected self-report and verbal communication data to examine process and outcomes. Both supervisor and supervisee rated their respective experiences favorably, with parallel measures of satisfaction and agreement on the value and depth of supervision that carried over to the therapeutic sessions.

In a separate study to track the development of parallel process over time, the interpersonal processes of a single triad of supervisor, supervisee, and client were explored across 25 supervised, short-term, dynamic psychotherapy sessions. One finding of this study was that, contrary to Wagner's (1957) theory, parallel process does not occur in the individual's consciousness but is generated from dynamics involving conflict, autonomy, grandiosity, power, and control (Alpher & Freedheim, 1991).

Parallel process has also been found to provide meaningful information that can help guide treatment planning and interventions, and the exploration and utilization of this phenomenon contributes to the supervisees' professional growth by helping them to gain a deeper insight into their client's experience (Goren, 2013). In addition, parallel process is credited with allowing the supervisor to join with the supervisee to make the supervisee aware of reflected matters of treatment importance that they may not readily see. The supervisor can then use this lens to encourage the supervisee to consider the implications of those reflected matters for their functioning as therapists, and how they can, "constructively apply those insights to the treatment situation" (Watkins, 2017, p. 509). In this sense, parallel process supports the supervisor's objective to help guide the supervisee to become skilled at using the self as an instrument (Aponte & Kissil, 2016).

Research to date has looked at parallel process from a variety of perspectives that often overlap to some extent across and between studies. The following portion of this review separates the research into seven primary sections, or areas of focus: (a) the directional nature of parallel process; (b) the potential triggers for parallel process; (c) the influence of developmental factors on parallel process; (d) the development of parallel process over time; (e) interpersonal behaviours and relationship variables in parallel process; (f) the common aspects of parallel process; and (g) challenges to the concept of parallel process. A summary of the given research is provided at the end of each section.

### ***The Directional Nature of Parallel Process***

Research into parallel process was initially based on the premise that it was a bottom-up event that begins in the supervisee-client relationship. Then, as understanding began to grow, it was seen instead as a top-down phenomenon that is initiated in the supervisor-supervisee relationship. The current paradigm has now evolved to viewing parallel process as being bi-directional and impacted in unique ways from both sides of the supervision triad.

The first researcher to bring forth the bi-directional nature of parallel process refuted the earlier bottom-up conception by providing credence for the occurrence of a top-down process that is generated by the supervisor and brought into the supervisee's relationship with the client (Doehrman, 1976). This conclusion was based on the results of a clinical analysis of repeated interviews with two supervisors, four supervisees, and eight clients at a psychological training institution that specialized in long-term, intensive psychoanalytic psychotherapy. It involved observing eight sets of concurrent supervisor-supervisee-client interactions, focusing on process rather than outcomes. The goal was to examine what challenges in a supervisee-client relationship might be related to challenges in the respective supervisor-supervisee relationship. In this study, the researcher observed that an impasse in the supervisory relationship was replicated in the therapeutic relationship. Further observation, revealed that once the supervisory relationship impasse was resolved, the impasse in the therapeutic relationship was also resolved. This was found to provide evidence of the bi-directional nature of parallel process, whereby what was mirrored in one dyad was brought into the other dyad (Doehrman, 1976). Additional studies concluded that parallel process is a bi-directional process that can transfer conflict, emotional affect, behaviours, or thought content from clinical supervision to psychotherapy, or from psychotherapy to clinical supervision, or both (Watkins, 2017).

Revisiting the view of parallel process as a bottom-up phenomenon, one team of researchers conducted a study in which the participants were nine psychodynamic supervisors of doctoral supervisees, and each participant was asked to report on one supervisory case from the previous two years. These researchers concluded that parallel process originates in the therapeutic relationship, is enacted in the supervisory relationship, and is addressed by supervisor with the subsequent intervention impacting both supervisee outcomes and client outcomes (Zetzer et al., 2020). These researchers further proposed that it would be beneficial to the field of supervision research to understand the conditions that promote awareness of parallel process and how it can be utilized as a

supervision tool. They also highlighted the importance of considering how parallel process is affected by the duration and strength of the supervisory alliance.

The insight gained from the above-noted exploration suggests that, when utilized in a meaningful and therapeutic manner, parallel process can benefit supervisee development, supervision outcome, the therapeutic alliance, and client outcomes. Supervisees were found to value parallel process as a useful intervention tool that contributes to progress in both supervision and therapy (Zetzer et al., 2020). This finding suggests that there is an immediate need to further understand parallel process in order to leverage its benefits with respect to promoting insight, understanding, and skill development for the supervisee. In addition, addressing parallel process in a timely manner may mitigate the risk of issues festering and impacting both the supervisory and therapeutic relationships, and ultimately supervision outcomes, client outcomes, and client care.

A strength of the above-noted study was that the participating supervisors were skilled psychodynamic supervisors familiar with parallel process, who had an average of 21 years of clinical experience and 16 years of supervisory experience. However, this strength also poses a potential limitation, in that the participants' familiarity with parallel process may have introduced an inherent bias in their assessment and reporting. An additional confound may have been introduced by the fact that rather than collecting real time or otherwise more immediate data, the study asked supervisors to report retrospectively as to whether parallel process had occurred in any of their supervision cases.

Another limitation was that data was collected in semi-structured interviews with the instructions that each supervisor give only a bottom-up account of parallel process occurring. This accounting was to include: a description of the client and the therapist; the supervisor's view of the quality of the supervisory relationship; the supervisor's second-hand interpretation of the psychotherapy relationship based on supervisee reports; any parallel processes that occurred; and the impact of supervisor interventions on supervision, psychotherapy, and the client. This is a considerable

amount of information for the supervisors to recall about each member of the triad in a case that might be as much as two years old, raising the potential for inaccuracies. Also, focusing only on a bottom-up view potentially fails to capture the full enactment of parallel process, which may include important top-down elements (Doehrman, 1976).

The (Zetzer et al., 2020) study was further limited by the fact that case examples were selected based on whether they met the researchers' operationalized definition of parallel process, and all nine reports were focused on supervisor interventions that were associated with positive results. This further introduced a bias towards positive outcomes.

In the interest of continuing to evolve our understanding of any parallels that might help further the goals of both supervisee development and client outcomes, the present study expanded upon the evidence of the bi-directional nature of parallel process and how it is related to relationship variables and client outcomes.

### ***Potential Triggers for Parallel Process***

Historically, there have been many explanations offered as to what triggers the occurrence of parallel process. The debate continues and studies have been conducted to gain further insight into what causes it and the impact it has on supervision and on psychotherapy. Some of the key studies into parallel process triggers are discussed below.

Based on their analytic review of the literature, McCue & Lane (1995) proposed various mechanisms as possible triggers for parallel process including: (a) intrapsychic, focusing on alternating roles and identification; (b) historical, focusing on countertransference; (c) interpersonal, focusing on empathy and reciprocity; (d) experiential, focusing on projective identification; and (e) epidemiological, focusing on shared situational factors. Some researchers view parallel process as a process of non-verbal communication (Sachs & Shapiro, 1976), some as a vehicle for learning (Ekstein & Wallerstein, 1972), and others as a form of concealment of supervisee anxiety; that is, a

reenactment of their challenges in working with the client (Bromberg, 1982). Wolstein (1984) echoes this explanation, proposing that the supervisee unconsciously recreates the client's defensiveness in supervision to regulate anxiety in the supervisory relationship.

Supervision and therapy have both been established as helping processes that involve self and rely on identificatory processes, with these factors working together to prime interactions for parallel process to occur (Gediman & Wolkenfeld, 1980). These researchers also concluded that parallel process can be triggered by any member of the triad and can be experienced by both novice and experienced supervisees, reinforcing the concept that parallel process is a multi-directional phenomenon.

### ***The Influence of Developmental Factors on Parallel Process***

Two key similarities have been highlighted between new therapists and new clients: (a) doubt and anxiety often accompany those acting in either new capacity; and (b) the novice therapist is faced with the additional challenge of needing to learn to recognize and apply the areas where they identify with the client when difficulties (resistances) arise that the therapist cannot resolve, and the client can experience resistance to the changes that treatment introduces (Sachs & Shapiro, 1976). These researchers concluded that some novice therapists have a fear of exposing their inadequacies and identify with their clients who hold the same fears. According to this view, the therapist and the client hold a shared burden of re-experiencing these feelings of inadequacy in the face of each other.

In addition, while parallel process can occur at any level of supervisee development, it might be most pronounced for novice supervisors because they are more likely to identify with their supervisees due to the similarity of their developmental level (Stoltenberg & Delworth, 1987). Entering into any new relationship is expected to entail a period of adjustment, and the emotions and uncertainty that accompany acting in a new capacity may have an impact on all facets of the

supervisory and therapeutic relationships. It can be expected that new supervisors or new supervisees will likely experience some hesitancy, and the same would seem to apply to a client new to therapy or starting a new therapeutic relationship. It might also be expected that any member of the triad could project these emotions onto their respective dyad. While the capacity in which each member of the triad is functioning will likely be different, there is a shared experience of the anxiety that comes with being new to a role (Stoltenberg & Delworth, 1987).

### ***The Development of Parallel Process Over Time***

The way the supervisee engages with the supervisor has been found to parallel the pattern of interaction between the supervisee and the client. These are referred to as *interdependent transactions* that occur across dyads (Alpher & Freedheim, 1991). These researchers found that the perception of interdependence in supervision is associated with similar perceptions in psychotherapy, supporting the notion that parallel process occurs and that what is experienced in the supervisory relationship manifests itself in the therapeutic relationship. However, the researchers noted that because this study was specific to short-term dynamic psychotherapy, generalizations to other forms of supervision and therapy may not apply. Also, as with Friedlander et al., (1989), the fact that this was a single case study of one triad further limits its usefulness with respect to generalized application of the results.

While the present study also collected data over a relatively short term, it did not focus solely on any specific theoretical, supervisory, or therapeutic approach and it was based on a larger sample of dyads, making the results more useful for generalization. Also, in further contrast to the singularity of the Alpher & Freedheim (1991) case study, the present research collected data from all participants on similar elements using equivalent measures.

### ***Interpersonal Behaviours and Relationship Variables in Parallel Process***

One of the foundational premises of parallel process is that it emerges within either the therapeutic or supervisory relationship and is subsequently transferred across dyads through the supervisee, who unconsciously reproduces interpersonal dynamics from one context in the other (Ekstein & Wallerstein, 1972). This conceptualization has been supported by supervision literature emphasizing the supervisee's central role in carrying affective and relational material between these two relational systems (Doehrman, 1976; Searles, 1955).

Parallel process is thought to occur when unresolved transference-countertransference patterns or relational constellations in the therapeutic relationship are enacted in supervision, or conversely, when dynamics from supervision influence the therapist's clinical engagement (Frawley-O'Dea & Sarnat, 2001; Friedlander et al., 1989). This bidirectional and recursive nature of the phenomenon highlights that both the supervisory and therapeutic alliances are necessary preconditions for parallel process to unfold. Consequently, scholars have stated that parallel process must be studied within the interdependent framework of both supervisory and therapeutic relationships, rather than in isolation, to fully understand its mechanisms and implications for clinical training and client outcomes (Tracey et al., 2012; Watkins, 2017). As such the exploration of the occurrence of parallel process is through relational variables, that are present within the supervisory and therapeutic relationship. And, as noted above, key relational variables include alliance, affiliation, and autonomy.

A number of studies have specifically explored whether and how interpersonal behaviour and relationship variables fit into the parallel process phenomenon. Some key research into these aspects, such as focus, affiliation, alliance, and autonomy, is discussed below, along with some of the ways in which that research influenced the present study. The nature of parallel process involves the repetition or transfer of relational patterns between the supervisee-client dyad and the supervisee-

supervisor dyad, and assessing these interpersonal behaviors provides empirical traction for identifying when such mirroring has occurred (Henry et al., 1994; Friedlander et al., 1989).

In the study of parallel process within psychotherapy supervision, measuring affiliation and autonomy offers a valuable lens for understanding the interpersonal dynamics that may be unconsciously mirrored across the therapeutic and supervisory relationships. These two relational dimensions capture fundamental aspects of how individuals relate to one another in dyadic interactions (Benjamin, 1974; Benjamin et al., 2006).

Affiliation refers to the degree of warmth, friendliness, positive regard, and cooperation in interactions expressed in interpersonal behaviours. High levels of affiliation are associated with warmth, kindness, acceptance, and a desire to maintain close, cooperative relationships. Conversely, low levels of affiliation are marked by hostility, criticism, rejection, and distancing from others (Benjamin, 1996). This dimension plays a crucial role in determining the emotional tone of social interactions, in that it influences whether relationships are characterized by closeness or conflict.

Autonomy refers to the level of independence or control that an individual expresses in their interactions. Autonomy ranges from behaviours that promote independence and self-determination to those that involve control and restriction of another individual. In the interpersonal focus, autonomy manifests in behaviours such as directing, guiding, or exerting control over others (Benjamin, 1996). On the opposite end, it includes behaviours that encourage others to act autonomously or to make decisions for themselves, and relates to how individuals regulate their own behaviour, make decisions, and take responsibility for their actions. Autonomy is therefore central to self-regulation, personal agency, and the development of healthy interpersonal boundaries (Benjamin, 1996).

Looking at affiliation and autonomy is an ideal approach for capturing the subtle enactments that occur when unresolved dynamics from the therapeutic relationship are carried into supervision,

or vice versa (Benjamin, 1974; Benjamin et al., 2006). Specifically, when the therapist's interpersonal stance with the client closely resembles their stance with the supervisor along the dimensions of affiliation and autonomy, it may suggest the presence of parallel process (Henry et al., 1994). Furthermore, the dimensions of affiliation and autonomy provide a structured framework for understanding how individuals interact with others and how they perceive themselves. However, affiliation and autonomy have not been studied extensively in the context of parallel process (Alpher & Freedheim 1991; Henry, 1996).

The case study by Alpher and Freedheim (1991) employed the long-form Benjamin (1974) Structural Analysis of Social Behaviour (SASB) survey, which evaluates dyadic relationships through real time self-reporting to illustrate that interaction patterns within the supervisory relationship frequently parallel those observed in the therapeutic relationship. Notably, that study revealed correlations between the relational dynamics that supervisees exhibit with their supervisors and those they enact with clients. This suggests that supervisory interactions may both influence and reflect therapeutic processes, which underscores the systemic and relational continuity between supervisory and therapeutic contexts. Focusing their study on exploring parallels in the interpersonal processes of the supervisory and therapeutic relationships that would support the existence of parallel process, Alpher and Freedheim (1991) noted that, "the relationships themselves are the units for observation" (p. 219).

One study of psychodynamic-interpersonal psychotherapy assessed moment-to-moment relational exchanges, highlighting the ability of the SASB model to capture interaction patterns such as reciprocal warmth or hostility (Henry, 1996). The findings emphasized the importance of therapist responsiveness and the ways in which client behaviour often mirrors longstanding relational schemas.

Other research into the interpersonal behaviours and relationship variables in parallel process have looked at bi-directional repetition, and at the importance of the supervisor's ability to effectively

manage the effects of parallel process when they see it occurring. Looking at parallel process as the bi-directional repetition of aspects exhibited in the supervisory and therapeutic relationships, one group of researchers designed a Parallel Process Survey to collect data from 300 participants, including supervisors and supervisees in psychoanalytic and non-psychoanalytic groups at a postdoctoral-level institute (Raichelson et al., 1997). Participants were asked to respond in general terms rather than on specific interactions. The survey included 33 Likert scale items divided into sections to collect data about: the degree of awareness of parallel process; the degree to which parallel process was used in supervision; and the degree of importance of parallel process in supervision. It also assessed the effects of parallel process and presented open-ended questions to gain feedback about supervisor and supervisee experience with completing the survey. The conclusion was that parallel process occurs and is utilized in both psychoanalytic and non-psychoanalytic supervision, with a higher level of occurrence and utilization of intervention reported in the psychoanalytic orientation group. This was found to provide empirical support that parallel process is present in various theoretical orientations.

These researchers designed the Parallel Process Survey because at that time there were no known measures to assess the occurrence and effects of parallel process. However, a fundamental limitation of the survey approach is that it provides no opportunity to probe, and there is no clear method to capture nuance without the appropriate scaling properties. The Parallel Process Survey needs further study to obtain validity and reliability data on its scale properties before it can be applied to future studies. Another limitation of the study was that although both supervisors and supervisees were given the same survey, the participants were from various postdoctoral institutes in New York and not from the same graduate training facility. Therefore, there were no matched dyads.

The Raichelson et al., (1997) study was further limited by the fact that data collection excluded client experience and client outcomes. Also, when a participant is retrospectively answering general questions about overall experience, reporting may potentially have some inaccuracies and may be less

consequential than reporting drawn from more immediate measures. In contrast, the present study focused on recruiting matched dyads from the same educational institution and used measures with established reliability and validity scores. For more meaningful results, the present study also explored real time feedback from the perspectives of therapist and client to collect data on their perceived relationships based on their specific and immediate shared experience. This included collecting data regarding both client experience and client outcomes.

Observations of recorded psychotherapy sessions and subsequent supervision sessions found that better outcomes are achieved when the supervisor, upon recognizing that parallel process has occurred, contains the anxiety of the supervisee and then addresses what has arisen as a result. With the goal of exploring the bi-directional nature of parallel process, one researcher conducted a single case study of a single triad based on two randomly chosen psychotherapy sessions and one intervening supervisory session. The researcher selected video-recorded therapy sessions five and six for a single client from many years previous. In this study, the client defended against anxiety, the anxiety was projected onto the supervisee, and the supervisee identified with it and brought it into supervision. The supervisor contained the anxiety, interpreted what transpired, and helped the supervisee work through the process by modeling intervention techniques for the supervisee. The researcher concluded that better outcomes are achieved when the supervisor, upon recognizing that parallel process has occurred, contains the anxiety of the supervisee and then addresses what has arisen as a result (Jacobsen, 2007).

Two limitations are noted with respect to the Jacobsen, (2007) study. The first was that the researcher may have brought an inherent bias to the appraisal of the videos in looking specifically for evidence of parallel process. Although an effort was made to address this confound by having a co-examiner conduct an independent analysis, that individual was also primed to watch for parallel

process. As with Alpher and Freedheim, (1991), the second limitation of the Jacobsen (2007) study was that a single case study of one triad does not provide for generalized application of study results.

When parallel process is addressed in supervision the interaction is brought into the supervisee-client relationship, positively impacting treatment and client outcomes. This insight was drawn from an examination of the relationship between parallel process and client outcomes over the course of treatment by following 17 supervision triads across 12 supervision and therapy sessions (Tracey et al., 2012). For example, the observers noted that when the supervisee was exhibiting resistant behaviour in supervision that mirrored that of the client in therapy, the supervisor re-enacted a portion of that behaviour with the supervisee, then demonstrated alternative behaviour to achieve a more responsive therapeutic approach. This provided a behavioural model that the supervisee could bring into the therapy session, with the desired result of improving both supervisee competency and client outcomes. These researchers concluded that the increase in behavioural similarity between supervisor and supervisee is associated with positive client outcomes. When the supervisor models how to address and engage with the client's resistance, the supervisee is learning, both verbally and experientially, how to modify their behaviour and bring it into the therapy session. This in turn helps the client shift and develop adaptive ways of coping (Tracey et al., 2012). These findings confirmed the earlier findings of Friedlander et al., (1989) that there is migration of interpersonal dynamics from one dyad to the other, and that there are similar relational aspects and behavioural features in the supervisory and therapeutic relationships.

### ***Theoretical Orientation***

In psychotherapy, theoretical orientation refers to the foundational framework that informs a therapist's understanding of client concerns and guides their selection of appropriate interventions. "The purpose of a theoretical orientation is to present a framework through which to understand, organize, and predict human behaviour," (Boettcher et al., 2020, p. 53). This orientation incorporates

the therapist's personal philosophy, academic training, and clinical experience, serving as a lens through which they conceptualize cases, understand client narratives, and implement treatment strategies. It ultimately ensures both consistency and intentionality in the therapeutic process (Boettcher et al., 2020).

The development and application of a theoretical orientation is widely regarded as a foundational aspect of supervisee training and professional identity formation. While historically viewed as a critical element in structuring therapeutic work, recent research has taken a more nuanced view of its influence, particularly in the early stages of supervisee development.

One study by Raichelson et al., 1997 explored whether theoretical orientation was a factor in the presence of parallel process. It was specifically through the lens of the supervisor's orientation, not the supervisee. The conclusion was that parallel process occurs and is utilized in both psychoanalytic and non-psychoanalytic supervision, with a higher level of occurrence and utilization of intervention reported in the psychoanalytic orientation group (Raichelson et al., 1997).

Theoretical orientation has not been widely examined as a potential confounding variable in existing literature on parallel process counselling orientation. However, while it was not directly analyzed within the scope of the present study, it was included as a potential confound using the Counseling Orientation Scale (COS) (Loesch and McDavis, 1978). Specifically, it was thought that understanding the supervisees' counselling orientation might help identify whether this might be a contributing factor in the potential occurrence of parallel process and client outcomes.

### ***Common Aspects of Parallel Process***

Two common aspects of parallel process are power and intimacy (Doehrman, 1976; Grey & Fiscalini, 1987). Power and intimacy are also present in the context of both the therapeutic relationship and the supervisory relationship (Iman, 2006; Soheilian et al, 2014; Watkins, 2017; Zetzer et al. 2020). Supervision, especially in training contexts, is a ripe ground for parallel process because of its dual roles (educational and evaluative), making it a complex relational space (Gnilka et al., 2012). In addition, there is a power dynamic which is inherent due to the evaluative nature of the supervisory relationship (Gazzola & Thériault, 2007) and the professional helping nature of the therapeutic relationship, which is also hierarchical (Doehrman, 1976; Frawley-O’Dea & Sarnat, 2001; Searles, 1955).

Several researchers have looked for the mirroring of relational variables in the context of the therapeutic relationship and the supervisory relationship to suggest the occurrence of parallel process (Alpher & Freedheim, 1991; Friedlander et al., 1989). For example, one study explored similarities of dominance and affiliation of communication patterns in the supervisory and therapeutic relationships, working from the hypothesis that parallel process would be indicated by greater similarity between the interpersonal behaviours (Tracey et al., 2012).

The researchers examined whether parallel process is present in supervision and looked at the possible relationship between parallel process and client outcomes. Data was collected from 17 master’s-level supervisory triads over the course of one semester at a university counseling training clinic. The results confirmed the presence and the bi-directional nature of parallel process in supervision as found by Doehrman (1976), concluding that parallel process is consistently present, unconsciously replicated, and generated from the supervisee-supervisor dyad to the therapist-client dyad and vice-versa (Tracey et al., 2012).

This was one of the only parallel process investigations that was not based on a case study. Instead, to explore whether there were similarities between the triad segments, this study specifically looked at two of the eight interpersonal communication types: dominance and affiliation. The researchers hypothesized that similarities between these communication types would indicate that parallel process had occurred.

Based on the results of the Strong et al., (1988) Interpersonal Communication Rating Scale (ICRS), and the Lambert et al., (1996) Outcome Questionnaire-45 (OQ-45), this study was found to support, "...the existence of bidirectional parallel processes at the level of interpersonal interaction," (Tracey et al., 2012, p. 330). Results indicated that increasing similarities of dominance and affiliation on the parts of the supervisor and the supervisee were associated with positive client outcomes, and there was a similarity in supervisee and client behaviour over time.

One limitation of the Tracey et al., (2012) study was that it narrowly focused on only two types of interpersonal communication. Also, although the study recorded and rated the full supervisory sessions, data was collected only from the middle 20 minutes of each fully recorded therapy session. This may have impacted the results as entire therapeutic interactions were not captured. Another limitation of the study was that many of the client participants started therapy sessions mid-way through the semester and others ended therapy before the semester was over. In addition, there were several gaps in the data set due to inaudible tapes, missed recordings, or not having both the supervision session and therapy session for the same week, all of which led to an irregular pattern of data collection across time.

In contrast, the present study considered a broader scope of process and outcome measures to identify whether parallel process was occurring, and then went a step further and collected feedback directly from participants based on the full experience of the therapist and the client. While

use of the Interpersonal Communication Rating Scale was beyond the scope of this research project, the OQ-45 was used to examine client outcomes.

### ***Challenges to the Concept of Parallel Process***

Parallel process can be difficult to research because one cannot predict when it will be expressed in supervision or in the therapeutic setting. Another challenge is related to the validity of data collection, in that it has historically been based largely on anecdotal evidence (Watkins, 2017). Criticism of parallel process research includes: (a) reliance on self-report measures; (b) lack of specificity for ethnic groups; (c) small sample size; (d) lack of comparison cases; (e) lack of formalized data analysis; (f) observer-confirmation bias; (g) lack of independent raters; (h) studies focused on graduate student participants; and (i) varied definitions of parallel process (Mothersole, 1999; Watkins, 2015).

The continued lack of consensus regarding the definition of parallel process suggests that its intangible nature can make it difficult to distinguish from the power dynamic or the tension and anxiety around evaluation that is associated with the supervisory relationship. This issue, along with the controversy amongst supervisors and researchers regarding what parallel process is, how it is identified, and how it should be addressed in supervision continues to raise questions (Zetzer et al., 2020). Some theorists query whether parallel process is actually a process in supervision and urge cautious consideration, claiming that the concept is misused, overused, or loosely applied (McNeil & Worthen, 1989; Miehl, 2010), and another view is that parallel process is illusory (Lesser, 1983). Yet another hypothesis is that what is reported as parallel process may in fact be the result of a conflation of factors, including: (a) the evaluative nature of supervision; (b) the power dynamics that are inherent in the respective dyads; and (c) the development level of the supervisee. If this is the case, it would seem to follow that a supervisor assuming that parallel process is occurring when in fact it is not could lead to strain on the supervisory relationship and confusion for the supervisee, while leaving the real

issue(s) unresolved (Watkins, 2017). If the sole assumption is that parallel process has occurred, then the factors that may actually be generating the issue, such as the competence or skill of supervisee, may be overlooked (Schimel, 1984). Also, the supervisor perceiving that parallel process is occurring and then assuming that the supervisee is being resistant could possibly have a ripple effect, all of which has the potential to get carried into the therapeutic relationship. Assuming that parallel process is always what is transpiring can lead to overlooking how the supervisee's or supervisor's own dynamic may be affecting the relationships (Feiner, 1994).

Multiple researchers have gone so far as to propose that using the label of parallel process where it does not apply can potentially lead to rupture in the supervisee-supervisor relationship, which in turn can compromise client care (Feltham & Dryden, 1994; Watkins, 2017).

#### ***Summary of the General Theories of Parallel Process to Date***

Parallel process has generally been found to arise when processes that are occurring in one dyadic relationship (supervisor-supervisee) are reenacted in the other dyadic relationship (supervisee-client). This phenomenon is currently understood to be a multi-directional process that involves and affects all three triad participants; that is supervisor, supervisee, and client (Alpher & Freedheim, 1991; Gediman & Wolkenfeld, 1980; Stoltenberg & Delworth, 1987).

As a tool to help the supervisor in guiding the supervisee, it has been proposed that awareness of and effective response to parallel process can work towards preventing conflict, proactively resolving issues before there is a detrimental impact on the supervisory alliance (Koltz et al., 2012; Mueller & Kell, 1972). At the same time, while supporting the existence of parallel process, research to date also raises a strong argument against arbitrarily presuming the occurrence of parallel process at the risk of overlooking the presence of other factors. Overall, the findings have helped to frame parallel process as a potentially powerful phenomenon that merits further study.

### **Parallel Process and Alliance**

Extensive research has explored the mechanisms of supervisory and therapeutic alliance and their impact on outcomes. This has provided the foundation for an important focus of the present study, which was to explore whether parallel process occurs across and/or between the two types of alliance. For example, when supported by a strong supervisory alliance, the supervisor has been found to be able to switch focus between the supervisory and therapeutic alliances, which facilitates tending to parallel process (Ladany et al., 2005). Also, a previous exploration of the relationships between the personality congruence of supervisee and client, therapeutic alliance, and treatment outcomes, concluded that personality congruence was associated with the bond, but that it was not associated with client outcomes, goals, or tasks (Taber et al., 2011). This association is relevant to the present study in that it suggests evidence that supervisee and client congruence on alliance is associated with outcomes.

Describing alliance as a dominant and influential factor in both therapeutic and supervisory relationships, multiple researchers have agreed that the relational bonds are fostered as the supervisee and supervisor work on agreed upon tasks that support the realization of the shared goals of supervision (Falender & Shafranske, 2017; Watkins, 2014). This view is supported by the findings of a longitudinal study of novice supervisees who were providing long-term psychodynamic or cognitive-behavioural therapy (Ybrandt et al., 2016). These researchers found that the supervisee ratings of the supervisory alliance varied in quality over time compared to the therapeutic alliance as rated by the supervisee. In this case, the supervisees received clinical supervision in a group format only, and supervisees rated their experience of the alliance with their supervisors and their clients at five time points.

The usefulness of leveraging parallel process as a meaningful resource was further endorsed by a study which confirmed that the supervisor's ability to role model an intervention that is

congruent with what needs to be translated into the therapeutic relationship is effective in supporting both the supervisory alliance and the therapeutic alliance. Building a solid supervisory alliance before addressing parallel process with a supervisee was found to have a significant beneficial impact on both relationships (Zetzer et al., 2020).

### ***Therapeutic Alliance***

Psychodynamic theorists introduced the concept of therapeutic alliance (also known as the working alliance) when Freud referred to patients as *collaborators* in the process of therapy and described the alliance as a two-sided *analytic pact* between therapist and patient (Freud, 1937). Providing a conceptual framework that emphasizes the need for consensus between the client and the therapist based on the principle of mutuality, Bordin (1979) then identified three factors that contribute to the strength of the therapeutic alliance. These include: (a) the degree to which the client and therapist agree on therapeutic goals; (b) the degree to which the client and therapist agree on the tasks necessary to reach the agreed upon goals; and (c) the quality of the bond between client and therapist.

Building on this concept, Kanzer (1981) proposed that the two-sided analytic pact is built on the “oldest and most consistent technical precept in psychoanalysis” (p. 71), also commonly referred to as the *fundamental rule* that describes the flow of associations and interactions between therapist and client. Freud (1937) described the analytic pact as operating on a continuum between the inner and outer reality of both the therapist and the patient, and as holding a place in the context of therapy. Kanzer (1981) concurred, holding that the analytic pact is formed as a result of, “mutual tasks imposed by standard conditions” (Kanzer, 1981, p. 74).

Various treatment objectives in psychotherapy have been found to require distinct types of therapeutic alliances (Bordin, 1979). For instance, therapy aimed at altering deep personality structures relies heavily on a strong emotional bond between therapist and patient to create a sense

of safety, allowing the patient to engage in the emotionally challenging aspects of the therapy. In contrast, exposure therapy for a phobia may place greater emphasis on task agreement, such as the patient consenting that gradually confronting a snake is an effective approach to addressing their fear of snakes (Bordin, 1979).

The therapeutic alliance is a dynamic construct that can change throughout therapy, responding to shifts in the therapeutic relationship, the client's emotional state, and the nature of the issues being addressed. Unlike traditional views of rapport, which emphasize a general sense of liking or comfort, the therapeutic alliance involves active collaboration and a shared commitment to therapeutic work (Horvath & Luborsky, 1993). Bordin's (1979) model is significant because it emphasizes the flexibility of the alliance across various therapeutic frameworks, suggesting that its development is central to all forms of psychotherapy.

The therapeutic alliance has also been shown to be a robust predictor of client outcomes. Meta-analyses have demonstrated a moderate to strong positive correlation between the strength of the therapeutic alliance and successful therapy outcomes across different theoretical approaches, such as cognitive-behavioural therapy (CBT), psychodynamic therapy, and humanistic approaches (Horvath et al., 2011). One widely cited meta-analysis reviewed 79 studies and found an average correlation of 0.22 between alliance strength and treatment outcomes, suggesting that a stronger alliance consistently leads to better outcomes for clients (Martin et al., 2000).

The quality of the therapeutic alliance is widely recognized as a strong predictor of client outcomes in psychotherapy (Horvath et al., 2011), and the strength of the alliance between therapist and client significantly influences the effectiveness of treatment (Horvath & Bedi, 2002; Norcross, 2011; Wampold & Imel, 2015). These findings suggest that fostering a robust therapeutic alliance should be a primary focus for practitioners aiming to improve client outcomes (Horvath et al., 2011).

Interestingly, the therapeutic alliance has been found to have predictive power beyond specific therapeutic techniques. For instance, one study concluded that the therapeutic alliance is a common factor across various therapeutic modalities, contributing to positive outcomes regardless of the specific interventions used (Wampold & Budge, 2012). This suggests that the relational elements of therapy, such as collaboration and trust, may be more important than the specific techniques or approaches applied in therapy sessions.

However, researchers have criticized the lack of focus on the timing of alliance measurements in relation to psychotherapy outcomes. In many studies, the therapeutic alliance is measured after some improvement has already occurred, which complicates understanding the true relationship. A key concern is the unclear direction of causality (Barber et al., 2000; DeRubeis et al., 2005; Falkenström et al., 2013). Specifically, it is argued that symptomatic improvement, often attributed to specific therapeutic techniques, may actually lead to a stronger alliance rather than the alliance driving the improvement (Falkenström & Larsson, 2017).

### ***Supervisory Alliance***

Extending the concept of therapeutic alliance to include the supervisory context, Bordin (1983) described alliance as a pantheoretical construct that applies to both supervision and therapy as a, “collaboration for change...a change process itself” (p. 35). In a study that further established alliance as a significant component of the change process, Bordin (1983) emphasized that the extent to which positive shifts occur is a reflection of the strength of the supervisory alliance and the “power of the tasks that are incorporated into the alliance” (p. 35), putting forth the theory that it is the strength of the supervisory alliance that determines outcomes.

In fact, numerous studies have found the supervisor-supervisee alliance to be a crucial mediator that affects supervision interventions (Goodyear, 2014; Horvath & Greenberg, 1989). The supervisory alliance is noted for its power to influence the trajectory of the supervision experience for

both the supervisor and the supervisee (Watkins, 2014), and the quality of the supervisory alliance is considered to be the foundational basis of quality supervision (Ellis, 2010). Also, awareness of and effective response to parallel process has been found to work towards preventing conflict as well as resolving any issues before there is a detrimental impact to the supervisory alliance (Koltz et al., 2012; Mueller & Kell, 1972).

Several factors influence the development of a strong supervisory alliance, with one of the most significant factors being the supervisor's interpersonal and relational skills. Supervisors who can demonstrate empathy, respect, and genuineness are more likely to establish a strong bond with their supervisees (Ladany et al., 2001). A strong supervisory alliance is cultivated when supervisors foster an environment that invites supervisees to openly explore the supervisory relationship, including power dynamics, personal reactions to supervision, and the intersecting identities of the supervisor, supervisee, and client (Inman, 2006; Soheilian et al., 2014). Additionally, supervisors who are open to feedback and willing to adapt their supervisory style to meet the needs of the supervisee tend to foster a more positive and collaborative relationship (Bernard & Goodyear, 2014).

The supervisee's characteristics also play a role in the development of the supervisory alliance. Supervisees who are open to learning, self-reflective, and willing to engage in the supervision process are more likely to form a strong alliance with their supervisor (Patton & Kivlighan, 1997). However, supervisees with high levels of anxiety or insecurity may struggle to trust their supervisor or to feel comfortable discussing their challenges, which can hinder the development of the alliance (Ladany et al., 1999).

Research conducted by Hutman and Ellis (2020) concluded that in order to encourage supervisee disclosure, support professional development, and safeguard client welfare, supervisors must possess the knowledge, skills, and attitudes necessary to work effectively with diverse supervisees and client populations. Additionally, building a strong supervisory working alliance is

essential to fostering this environment (Ladany et al., 1996, 2013; Mehr et al., 2010, 2015). A recent study by Taylor and Ellis (2023) demonstrated that supervisors who were perceived as relationally humble significantly enhanced both the strength of the supervisory working alliance and the level of supervisee disclosure. These results highlight the critical role of relational qualities such as humility in promoting trust, openness, and psychological safety within the supervisory relationship.

More recent research has highlighted the prevalence and patterns of supervisee nondisclosure in clinical supervision. In a study by Cook et al., (2020), 95.3% of pre-licensed supervisees reported withholding some degree of information from their supervisors, with over half (53.3%) admitting to having completely withheld a concern. Notably, supervisees were more likely to withhold supervision-related content—such as negative perceptions of the supervisor, disagreements, or doubts about the supervisor’s competence—than client-related concerns like clinical mistakes or personal issues. These findings suggest that relational and evaluative dynamics within supervision can significantly inhibit openness, particularly when the supervisee fears negative repercussions or feels unsafe expressing criticism. The tendency to withhold issues directly related to the supervisor underscores the importance of fostering a supervisory environment characterized by trust, mutual respect, and psychological safety to facilitate full disclosure and enhance supervisory effectiveness (Cook et al., 2020). External factors such as the organizational or institutional context can also impact the supervisory alliance. Supervisors and supervisees working in settings with high caseloads, limited resources, or a lack of organizational support may find it more challenging to dedicate sufficient time and energy to the supervision process, potentially weakening the alliance (Milne, 2009). Conversely, organizations that prioritize supervision and provide adequate support for both supervisors and supervisees are more likely to foster strong supervisory alliances (Milne, 2009).

In a qualitative phenomenological study that explored the supervisee’s perspective of good supervision events, tape-recorded interviews were conducted with eight intermediate- to advanced-

level supervisees who were asked to recall good supervision events (Worthen & McNeill, 1996). In every interview, supervisees, "...referred to the quality of the supervisory relationship as crucial and pivotal," (Worthen & McNeill, 1996, p. 32). The researchers concluded that the supervisory relationship is what fosters development of supervisee skills and competency, and that the commitment to collaboration helps to provide direction and maintain focus while reinforcing the relational bond. Going a step further, Hawkins & Shohet (2012) put forward a model of supervision that highlights the fact that relationship matrices that exist in the context of supervision are impacted by broader social and organizational contexts.

Watkins (2014) has come to consider the supervisory alliance to be the "quintessential integrative variable" (p. 151) and, "the essential common factor" (p. 153) in the process of supervision. Furthermore, the quality of the alliance between the supervisor and supervisee has been found to impact the supervision process and outcomes (Faledender & Shafranske, 2017), and the quality of mutuality is considered to be one of the major factors that predict the effectiveness of the supervisory alliance (Bordin, 1980). Also, the supervisory alliance has been found to have a significant impact on supervisee learning (Ladany et al., 2013). Additional studies have confirmed that supervisory alliance as rated by the supervisee appears to have a direct impact on supervision processes and outcomes, such as supervisee satisfaction with supervision and symptom reduction for clients (Bambling et al., 2006; Bambling & King, 2014; Hill & Knox, 2013).

Research indicates that the strength of the supervisory alliance is positively associated with supervisee development, learning, and satisfaction with supervision (Ladany et al., 1999). A robust alliance fosters an environment where the supervisee feels safe to explore their professional identity, share their challenges openly, and receive feedback constructively. Moreover, a strong alliance facilitates supervisee learning, promotes self-reflection, and helps the supervisee to integrate theoretical knowledge with clinical practice (Bernard & Goodyear, 2014).

A healthy supervisory alliance has also been found to have a positive impact on the supervisee's ability to explore and integrate training and to learn new skills. This increases the supervisee's level of trust in the supervisor and their tendency to model the supervisor's behaviours, and also reduces role ambiguity (Friedlander & Snyder, 1983; Hutt et al., 1983; Kennard et al., 1987; Olk & Friedlander, 1992; Patton & Kivilighan, 1997).

The supervisory alliance is considered a dynamic relationship that shifts over the course of time (Bordin, 1979). This has been attributed to the dynamic nature of the alliance, and to the positive and negative experiences throughout the supervision process that can contribute to the build-and-repair cycles (Bordin, 1983). Supervisor factors such as the modelling of openness to conflict and resolution, being developmentally orientated, and being willing to learn from mistakes, all support a healthy supervisory alliance (Nelson et al., 2008).

**The Effects of a Highly Rated Supervisory Alliance in Clinical Supervision.** A highly rated supervisory alliance has profound effects on both the supervisee's professional development and the quality of client care. The supervisory alliance, which encompasses the collaborative relationship between supervisor and supervisee, is built on mutual trust, agreement on goals, and shared tasks (Bordin, 1979). A strong alliance is associated with enhanced supervisee learning, satisfaction, and self-efficacy, supervisee self-disclosure, and it also positively impacts the supervisory process, leading to better outcomes for clients (Hutman & Ellis, 2020; Ladany et al., 1999; Taylor & Ellis, 2023).

One of the most significant effects of a highly rated supervisory alliance is the positive impact it can have on supervisee development. A strong alliance fosters a supportive and collaborative environment in which supervisees feel comfortable discussing their challenges and receiving feedback (Bernard & Goodyear, 2014). Research suggests that supervisees who perceive their supervisory alliance as strong tend to engage more fully in the supervision process, which in turn promotes deeper reflection on their clinical work and greater integration of theory into practice. This openness and

willingness to engage is crucial for developing clinical competencies, such as case conceptualization, therapeutic interventions, and ethical decision-making (Ladany et al., 1999).

Additionally, when supervisees perceive their supervisory alliance as strong, they are more likely to discuss challenging client cases and seek guidance on difficult therapeutic issues. This openness allows for more thorough exploration of complex clinical dynamics and leads to more thoughtful and effective interventions (Ladany et al., 1999). Conversely, a weak or conflicted supervisory alliance may hinder the supervisee's willingness to disclose challenges, leading to poorer client care. Therefore, a highly rated supervisory alliance not only benefits the supervisee but also contributes to better therapeutic outcomes for clients (Ladany et al., 1999).

The supervisory alliance can serve as a model for the therapeutic alliance that the supervisee develops with clients. Supervisors who demonstrate effective relational skills, such as empathy, active listening, and providing constructive feedback, can help supervisees develop these same skills in their clinical practice (Kilminster & Jolly, 2000). This modeling effect underscores the critical role that the supervisory alliance plays in shaping the supervisee's professional development and therapeutic approach.

One study looked at 75 supervisees and their clients across four supervision sessions to explore the supervisory working alliance and the therapeutic alliance as rated by the client (Patton & Kivlighan, 1997). The hypothesis was that the supervisory alliance would be related to the quality of the therapeutic alliance, as well as the supervisee's adherence to a treatment model. These researchers found that the supervisee's perception of the supervisory alliance is significantly related to the client's perception of the therapeutic alliance. They further concluded that the quality of the supervisory alliance affects the quality of the therapeutic alliance and the level of supervisee compliance with treatment protocols, and that fluctuations in the quality of the supervisory alliance predict variations in the therapeutic alliance.

It was hypothesized that these findings were due to the supervisees applying the knowledge they gained in supervision to foster both the supervisory alliance and the therapeutic alliance, and to select and provide treatment interventions (Patton & Kivlighan, 1997). However, there remains some consensus for the theory that neither the supervisee's theoretical orientation nor the client's presenting issue(s) necessarily impact the therapeutic alliance (Horvath & Bedi, 2002; Norcross, 2011).

Further research has found that the agreement between supervisee and supervisor regarding what constitutes helpful events and not so helpful events contributes to the collaborative nature of supervision (West & Clark, 2004). Research continues to consistently report that the quality of the alliance is a key predictor of supervision outcomes (Wampold & Budge, 2012), and that it affects the quality of supervision (Watkins, 2017).

Collecting data from graduate level supervisees to assess the emotional bond component of the supervisory alliance, one study found that the strength of the emotional bond between supervisor and supervisee impacts the quality of the supervisory alliance (Ladany et. al., 1999). A poor supervisory alliance was found to impact the willingness of the supervisee to be open and forthcoming and was associated with a negative supervisee perception of both supervisor and self. Conversely, a positive emotional bond was associated with the supervisee's positive perception of their supervisor's performance and personal qualities as well as the supervisee's self-efficacy. These researchers found that alliance is a critical factor in the, "change process of supervision," (Ladany et. al., 1999, p. 447), and that the emotional bond component is significantly related to supervision satisfaction.

Many variables have been found to interplay with the personal characteristics of the supervisor and supervisee, ultimately influencing the quality and trajectory of the supervisory alliance. These include, without being limited to: (a) the degree of agreement between and awareness of supervisor and supervisee perceptions regarding the quality of the alliance (Beinart & Clohessy, 2017;

Ladany et al., 1999); (b) the unique challenges that a novice supervisee faces (Lee & Chung, 2003); (c) the degree of supervisee and supervisor self-disclosure and the resulting bond or lack thereof (Clevinger et al., 2019; Milne, 2009; Spence et al., 2014); (d) maladaptive perfectionism, which includes intense self-doubt, self-scrutiny, and self-criticism and which is negatively correlated with both the supervisory alliance and the therapeutic alliance (Ganske et al., 2015); (e) the supervisee's ability to cope with stress (Gnilka et al., 2012); (f) the supervisor's ability to model effective stress reduction strategies (Gnilka et al., 2012); and (g) the supervisor's interpersonal skills and ability to interact and communicate (Bambling & King, 2014). Countertransference (Ladany et al., 2000) and unclear goals (Nelson et al., 2008) have also been found to affect the supervisory alliance.

**Impact of Supervisory Alliance on Client Outcomes.** Perhaps the most concerning consequence of a low-rated supervisory alliance is its potential impact on client outcomes. The primary goal of clinical supervision is to ensure that supervisees provide high-quality care to their clients, but a weak supervisory alliance can undermine this goal. Supervisees in poor supervisory alliances are less likely to seek guidance on difficult cases or to disclose mistakes, which can lead to errors in clinical judgment and treatment planning (Ellis et al., 2014). Without adequate supervision, these supervisees may struggle to navigate complex client dynamics or ethical dilemmas, resulting in suboptimal care for clients.

In extreme cases, a weak supervisory alliance can contribute to ethical violations or malpractice. When a supervisee feels unable to discuss ethical concerns or seek advice from their supervisor, they may be more likely to engage in unethical practices, either knowingly or unknowingly (Ladany et al., 1999). Given that ethical breaches can harm clients, this can have serious repercussions for the client.

Because of the possibility of a detrimental impact on supervisee development and client outcomes, it is important for the field of clinical supervision to understand the impact of the

supervisory alliance (Ladany et al., 2013). This is directly relevant to the second focus of the present study, which was to examine whether the relationship between the therapeutic and supervisory relational variables of alliance, affiliation, and autonomy is significantly associated with client outcomes. Research supports the notion that each member of the triad contributes to the dynamic felt in and between both the supervisory and therapeutic alliances. Furthermore, given that the above-noted research suggests that the supervisory alliance and the therapeutic alliance provide the framework from which collaboration and growth can occur, it would be difficult to study parallel process without considering the supervisory and therapeutic alliances.

### ***Fluctuations in Alliance***

The supervisory and therapeutic alliances can fluctuate within and between sessions (Falkenström et al., 2017; Patton & Kivlighan, 1997) and alliance ruptures can occur, potentially leading to rupture or rupture-repair patterns (Falkenström et al., 2017).

**Fluctuations in the Therapeutic Alliance.** The therapeutic alliance is not a static entity. It is subject to fluctuations over the course of therapy. Alliance ruptures such as disruptions in the collaborative bond between therapist and client are common, particularly during the middle phases of therapy when more challenging material is often addressed (Safran & Muran, 2000). These ruptures can take different forms, including withdrawal ruptures, where the client disengages emotionally from the process, or confrontation ruptures, where tension arises between therapist and client (Safran et al., 2011).

The therapeutic alliance is a dynamic construct that can change throughout therapy, responding to shifts in the therapeutic relationship, the client's emotional state, and the nature of the issues being addressed. Unlike traditional views of rapport, which emphasize a general sense of liking or comfort, the therapeutic alliance involves an active collaboration and a shared commitment to therapeutic work (Horvath & Luborsky, 1993). It has been proposed that the therapeutic alliance

evolves in cycles, with periods of breakdown and subsequent repair occurring throughout the course of therapy (Bordin, 1979). Bordin's model is significant because it emphasizes the flexibility of the alliance across various therapeutic frameworks, suggesting that its development is central to all forms of psychotherapy.

Building on Bordin's (1979) perspective of the therapeutic alliance, it has been suggested that alliance ruptures arise from: (1) disagreements over therapy tasks; (2) conflicts regarding treatment goals; or (3) tensions in the client-therapist relationship (Safran et al., 2011). Also, the therapeutic alliance has been found to fluctuate continuously over time, with patterns across sessions often showing abrupt declines in alliance strength followed by efforts to rebuild and restore the relationship (Safran et al., 1990; Safran et al., 2011; Steven et al., 2007).

If, as suggested by Zetzel (1956) and further elaborated by Safran & Muran (2000), the alliance is inherently prone to fluctuations, then it is expected that shifts in the alliance would naturally occur within therapy sessions and not only between sessions. The fluctuation of the therapeutic alliance over time is well-documented in psychotherapy research, with several studies highlighting the importance of early alliance building, mid-therapy ruptures, and repair processes.

While research suggests that therapeutic alliance fluctuates over the course of therapy, there is no universally accepted agreement as to when these fluctuations are most likely to occur. However, several studies and meta-analyses provide insight into this question. The therapeutic alliance is typically established in the first few sessions (that is, sessions one-to-three). The alliance's initial strength has been found to be crucial for long-term outcomes, but it can be fragile during the early stages due to the newness of the relationship and the negotiation of expectations (Flückiger et al., 2012; Horvath & Luborsky, 1993), and to misunderstandings or mismatched expectations (Horvath & Bedi, 2002). Many researchers agree that the middle phase of therapy (usually around sessions five-to-ten) is a period where significant fluctuations or ruptures in the alliance tend to occur (Horvath &

Luborsky 1993; Safran et al., 2011; Safran & Miran, 2000). Research indicates that alliance ruptures are more likely to occur during this time because this is when clients feel more vulnerable as they begin engaging in more emotionally charged or difficult discussions. This period is marked by both ruptures and the potential for significant alliance strengthening when deeper issues are explored, leading to moments of rupture and repair (Safran & Muran, 2000). The ability to repair ruptures and strengthen the alliance during this phase is often predictive of overall therapeutic success (Safran et al., 2011). By later sessions, the alliance may stabilize if ruptures have been successfully repaired. Trust is solidified and therapeutic progress is made, though deeper issues may still occasionally challenge the relationship (Martin et al., 2000). Therapists and clients who navigate mid-therapy challenges often report a stronger and more trusting alliance moving forward (Gelso et al., 1998; Safran et al., 2011).

It is important to note that ruptures do not necessarily undermine the therapeutic process. In fact, research has shown that when successfully repaired, alliance ruptures can lead to a stronger therapeutic alliance and better outcomes (Safran et al., 2011). The key to rupture repair lies in the therapist's ability to recognize the rupture, address it openly, and work collaboratively with the client to rebuild the alliance. Therapists who are skilled in navigating these challenges, validating the client's experience, and making necessary adjustments to the therapeutic approach tend to achieve more successful repairs and thus foster a more resilient working alliance (Safran & Muran, 2000).

The therapeutic alliance is a cornerstone of effective psychotherapy, influencing therapeutic outcomes across a range of modalities and client issues. Bordin's (1979) conceptualization of the alliance as a collaborative relationship involving goals, tasks, and bonds provides a flexible framework for understanding its development and importance. Research has consistently demonstrated that a strong therapeutic alliance contributes to positive outcomes, and that ruptures in that alliance, if effectively repaired, can even enhance the therapeutic process. Therapists must be attentive to the dynamic nature of the alliance, focusing on the factors that foster its development and the skills

needed to address and repair ruptures when they occur. Ultimately, the strength and resilience of the working alliance are central to the success of psychotherapy.

**Fluctuations in the Supervisory Alliance.** Like the therapeutic alliance, the supervisory alliance is not static and can experience ruptures or strains. Ruptures in the supervisory alliance can occur due to a variety of reasons, including disagreements about supervision goals, miscommunication, or supervisee perceptions of negative or critical feedback from the supervisor (Nelson & Friedlander, 2001). When ruptures occur, they can negatively impact the supervision process by creating tension, reducing the supervisee's willingness to disclose clinical challenges, and impairing the supervisee's professional development (Nelson & Friedlander, 2001).

However, as with the therapeutic alliance, research has shown that if appropriately addressed and repaired, ruptures in the supervisory alliance can lead to a stronger and more resilient alliance. Rupture repair involves recognizing the rupture, addressing it openly, and engaging in collaborative problem-solving to restore the alliance (Safran & Muran, 2000). In the supervision context, successful rupture repair requires the supervisor to create a safe space for discussing the rupture, acknowledge any contribution to the rupture, and work collaboratively with the supervisee to rebuild trust and realign supervision goals (Nelson & Friedlander, 2001).

The supervisee's ability to express concerns and the supervisor's responsiveness to these concerns are crucial to repairing ruptures. When supervisors are open to feedback and willing to discuss and repair ruptures, supervisees are more likely to feel supported and understood, leading to a stronger alliance moving forward (Ladany et al., 1999). In contrast, unresolved ruptures can lead to disengagement from supervision, decreased supervisee confidence, and potentially harmful outcomes for both the supervisee and their clients (Nelson & Friedlander, 2001).

### ***Similarities and Differences between Supervisory and Therapeutic Alliance***

There are similarities and differences between the supervisory and therapeutic alliances. The similarities lie in the value of the bond to the alliances, and how that bond facilitates the processes within the respective alliances (Bordin, 1980). Also, each type of alliance includes an element of power. The evaluative and hierarchical nature of supervision creates a power dynamic between the supervisor and supervisee (Gazzola & Thériault, 2007; Watkins, 2017), which is further enhanced by the fact of the supervisor's comparative expertise. The power differential inherent in the therapeutic alliance is due to the help-seeking nature and vulnerability of the client.

The differences between therapeutic and supervisory alliances lie in their respective structures. Specifically, the goals and tasks differ, and supervision is by nature an andragogical process rather than a therapeutic process.

### ***Summary of Research on Alliance***

Research has established alliance as a pantheoretical construct that applies to both supervision and therapy as a significant component of the change process. There is strong consensus that the supervisory alliance has a significant impact on supervisee learning, and that a healthy supervisory alliance has a positive impact on the supervisee's ability to integrate training and to learn new skills. Furthermore, both supervisory and therapeutic alliances are now regarded as dynamic, shifting over time, and a significant relationship has been found to exist between the supervisee's perception of the supervisory alliance and the client's perception of the therapeutic alliance.

In the context of the present research, studies of alliance clearly suggest that supervisory alliance and therapeutic alliance act as conduits for the transfer of parallel process. Both alliances provide the framework from which collaboration and growth can occur.

## **Factors Associated with Outcomes**

Researchers have looked at several different variables when measuring the factors that influence supervisee outcomes and client outcomes, such as supervisor competence, supervisee training and learning, supervisory alliance, therapeutic alliance, and satisfaction (Beinart & Clohessy, 2017; Horvath & Symonds, 1991; Krause & Allen, 1988; Son & Ellis, 2013). For the purposes of the present research project, this portion of the literature review focuses on those studies that pertain to or that might provide the foundation for further research into client outcomes.

Client outcomes, which are generally measured in symptomatic relief, have been characterized by some as the “acid test” of effective supervision (Ellis and Ladany, 1997, p. 485). However, given the importance of examining outcomes that complement and contribute to the safe and effective practice of supervision, the question has been raised as to whether using client outcomes as the acid test is the highest duty of supervision to ensure safe practice (Reiser & Milne, 2014). Predominantly, outcome studies have not addressed client outcomes in clinical supervision research (Ellis et al., 2014; Watkins, 2011). Some researchers infer that there is insufficient evidence to indicate the impact of supervision on client outcomes.

### ***Satisfaction in the Context of Outcome***

In the context of outcome, satisfaction refers to both the supervisee’s satisfaction with supervision and the client’s satisfaction with therapy (Ladany et al., 1999). Holloway & Wampold (1983) provided the most used definition of satisfaction as being, “trainees’ reaction to the supervisor’s perceived personal qualities and performance, the [supervisee’s] judgement of their own behaviour in supervision, and the level of comfort when expressing their own ideas in supervision,” (Ladany et al., 1999, p. 77).

Throughout clinical supervision literature there is a consistent call to examine the impact of supervision as an outcome measure (Ellis & Ladany, 1997; Falender, 2014; Falender & Shafranske,

2004), and outcome has since received significant focus in supervision research (Beinart & Clohessy, 2017; Ellis & Ladany, 1997; Friedlander & Ward, 1984; Holloway & Wampold, 1984; Olk & Friedlander, 1992).

**Supervisee Satisfaction.** Factors that impact the supervisory alliance can potentially impact the therapeutic alliance and, ultimately, client outcomes. While satisfaction was not directly measured in the present study, it has been considered to various degrees in most, if not all, research on supervisory alliance and outcomes to date.

The supervisee's satisfaction with the quality of supervision provides valuable feedback about the supervisee's perception of the supervisor and the supervision process (Grossl et al., 2014) and has therefore been utilized as an outcome measure in many studies. For example, in a study that collected data from 378 supervisees who were in training and receiving clinical supervision, the similarities and differences between American and South Korean cultures were explored in the context of clinical supervision. The finding was that role difficulties negatively impacted the supervisory working alliance, resulting in a negative effect on satisfaction with supervision among supervisees from both cultures (Son & Ellis, 2013). These findings were similar to earlier studies that found a relationship between role difficulties, supervisory alliance, supervisor style, and satisfaction with supervision (Ladany et al., 1999; Nelson & Friedlander, 2001).

Satisfaction with supervision is understood to reflect the overall supervisory experience and to be an indicator that the supervisory relationship is aligned with supervisee expectations (Beinart & Clohessy, 2017). Furthermore, relationships have been identified between supervisee satisfaction and: (a) patterns of verbal interaction between supervisee and supervisor (Holloway & Wampold, 1984); (b) congruence between the supervisee's and supervisor's perception of the supervisee's competence (Krause & Allen, 1988); (c) supervisee perceptions of supervisor trustworthiness, attractiveness, and expertise (Heppner & Handley, 1981); (d) supervisee perception of supervisory style (Friedlander &

Ward, 1984); (e) supervisee experience of role difficulties (Olk & Friedlander, 1992); (f) supervisee non-disclosures (Hutman & Ellis, 2020; Ladany et al., 1996); and (g) supervisor feedback (Lehrman-Waterman & Ladany, 2001). Overall, this indicates that supervisee satisfaction with supervision is reflected in the supervisory alliance and is associated with more favourable perceptions of the supervisory alliance (Horvath & Symonds, 1991). Furthermore, the above cited studies indicate that many variables can impact satisfaction.

A positive perception of supervision satisfaction is viewed as integral for supervisees to be fully engaged in their developmental goals and supervision (Heppner & Handley, 1981), while low satisfaction with supervision is considered a representation of the quality of the supervisory alliance (O'Donovan & Kavanagh, 2014). In addition, low satisfaction with the supervisory experience is identified as affecting supervisee confidence (Bambling, 2000), supervisee non-disclosure (Hutman & Ellis, 2020; Ladany et al., 1996), and supervisee self-efficacy (Cashwell & Dooley, 2001). However, some researchers indicate that relying solely on satisfaction as an indicator of effective supervision may not in itself be representative of the supervision experience (Beinart & Clohessy, 2017).

The question has been raised as to whether supervisee satisfaction is being overused as an outcome measure given that a supervisee's level of satisfaction may not reflect the quality or rigor of training received (Bernard & Goodyear, 2009). Other researchers assert that while this may be true, when considered with other outcome and process variables the supervisee's perspective matters (Grossl et al., 2014). For example, the supervisee's perspective has been found to affect their emotions, thoughts, and behaviours, all of which have the potential to significantly influence the way the supervisee engages in or disengages from the supervision process (Beinart & Clohessy, 2017; Grossl et al., 2014; Ladany et al., 1999).

Effective supervision that supports and contributes to supervisee development, and ultimately to client care, may be experienced as challenging or uncomfortable for the supervisee (Beinart &

Clohessy, 2017). As such, while supervision satisfaction is an important outcome measure, it may not be an accurate representation of supervisee behavioural change, skill development, or supervisory experience. Also, while challenging the supervisee may lead to a lower satisfaction rating of supervision and the supervisor, it is not necessarily representative of the quality or effectiveness of supervision (Ladany et al., 1999).

A supervisee may experience some dissatisfaction with the supervision process itself, and with the relationship within the context of effective supervision (Beinart & Clohessy, 2017). Clinical supervision theorists suggest that this is because the supervisory alliance is dynamic, fluctuating over the course of the supervisory relationship (Bordin, 1979), which could cause a fluctuation in the rating of satisfaction with supervision across the course of the relationship (Ladany et al., 1999).

Supervisees who discuss client feedback data during supervision have been found to report greater satisfaction with supervision than supervisees who did not discuss client feedback with their supervisors. This finding comes from the collection of data from 44 supervisees, 18 supervisors, and 138 clients, to assess whether using client feedback data during supervision would influence the supervisory process and outcomes. Supervisees reported that having client feedback data helped them to organize supervision and provided insight as to how they were doing with clients and clinical training (Grossl et al., 2014). These results differ from previous research which found no difference in supervisee satisfaction. In that study, the researchers proposed that the lack of difference may be because while the supervisees were aware that the supervisors were collecting client feedback data, they did not have access to it themselves (Reese et al., 2009).

**Client Satisfaction.** Another outcome variable for clients is their satisfaction with services received. A number of factors can contribute to overall client satisfaction such as: consensus on methods and goals of therapy; alliance between supervisee and client; and the client's overall perspective on the quality of care (Larsen et al., 1979; Miller & Duncan, 2004). Client satisfaction has

been assessed using various measures across supervision and psychotherapy studies, such as the service attachment questionnaire and the psychiatric care satisfaction questionnaire (Ankuta & Abeles, 1993; White & Winstanley, 2009), whereas supervisee satisfaction is consistently measured with the supervisory satisfaction questionnaire (Ladany et al., 1996).

Exploration of both client and supervisee satisfaction session-by-session over the course of psychotherapy has found that both clients and supervisees go through a low period of satisfaction prior to an increase. Monitoring and utilizing this information could contribute to greater client satisfaction and overall treatment outcomes. If satisfaction measures are low, the supervisee could reevaluate treatment planning and could also engage the client to understand what is not working for them (Tracey, 1989).

There is a positive correlation between client satisfaction and symptom improvement, with no significant differences in levels of satisfaction being associated with different treatment approaches. This finding is based on an exploration of client satisfaction and its relationship to symptom improvement as rated by both the supervisee and the client (Deane, 1993). A separate investigation looked at psychotherapy clients whose therapists were graduate student supervisees. This study explored whether clients who exhibited clinically significant symptom changes would report higher levels of satisfaction and benefit than those who improved moderately or not at all. Clients who experienced significant symptom improvement also reported a higher level of satisfaction and benefit, leading to the conclusion that symptom relief appears to have a relationship with client satisfaction and therapy outcomes (Ankuta & Abele, 1993).

While the research pertaining to client satisfaction and its role in influencing outcomes is less comprehensive than that addressing supervisee satisfaction, the findings that have been made seem to indicate that there may be grounds to investigate this variable more extensively.

### ***The Potential Impact of Supervision Outcomes on Client Outcomes***

Although the present research focused on client outcomes, an important element to consider is whether and how supervision outcomes can potentially influence client outcomes. The research reviewed below suggests that measuring supervisee satisfaction with supervision provides meaningful insight not only into the supervisee's experience, but also potentially into the impact of supervision outcomes on client outcomes.

Over more than 25 years, numerous studies have explored the extent to which there were parallels between relational aspects of supervisory and therapeutic relationships. The results have highlighted the need to investigate whether supervision is fundamentally beneficial to clients (Callahan et al., 2019; Ellis & Ladany, 1997; Friedlander et al., 1989; and Watkins, 2011). However, because its unconscious nature precludes parallel process from being measured by an empirical test, these studies relied on the subjective experiences of the participants to explore similarities between the supervisory and therapeutic relationships as possible indicators for the occurrence of parallel process.

In one single case study of a single triad the processes of psychotherapy and supervision were found to be reciprocal and interlocking (Friedlander et al., 1989). However, in that study, several issues with client participation confounded both reporting and results. Over a three-month period, client attendance was inconsistent in that the client attended eight sessions but cancelled twice and failed to show for five appointments. The client also failed to return outcome measures from two out of the eight sessions they did attend, even after being contacted by the researcher. These problems ultimately led to premature termination of therapy and may have minimized the usefulness of the data provided by the client. An additional and significant limitation of this research was that a single case study of a single triad does not provide for generalized application of the results at the best of times, and less so when one member of the triad (in this case the client) fails to participate fully. Still,

the parallels that were found between the other two members of the triad, that is, the supervisor and the supervisee, do encourage further study.

Specifically, the researchers used the Stiles & Snow (1984) Session Evaluation Questionnaire (SEQ) to measure fluctuations in participant evaluations over time to explore parallel patterns in the supervisee experience in both therapy and supervision. They also used the Barak & LaCrosse (1975) Counsellor Rating Form, which looks at the social influence characteristics of the supervisee to measure relationship from the clients' perspective, and the Friedland & Ward (1984) Supervisory Styles Inventory (SSI) to measure supervisor style.

The experience of parallel process in supervision contributes to positive outcomes for supervisees by promoting the supervisee's growth, understanding, and insight (Zetzer et al., 2020). It seems that addressing any challenges that may occur as result of parallel process contributes to the advancement of supervisee development and skill acquisition, and ultimately to favourable supervision outcomes. This approach provides the supervisee with insight into their own inner emotional world and increases their awareness of transference and countertransference and how to utilize them as effective intervention tools.

In contrast to the above-noted studies, the present study collected quantitative data to preclude the need to rely on subjective observation. It also drew from a larger sample of participants who reported directly on their own experience, eliminating the need to rely on extrapolation. Building on the findings of Friedlander et al., (1989), the present study looked at whether there are similarities in relational aspects and whether interpersonal dynamics are transferred from one dyad to another in a parallel fashion. Exploration of whether parallels exist between supervision outcomes and client outcomes was beyond the scope of the present research; however, this would be an important consideration for future study.

## **Client Outcomes**

In psychotherapy, the reduction of symptom distress is widely recognized as a key indicator of therapeutic success. Symptom distress encompasses the psychological and emotional discomfort experienced by the client, which can manifest in a variety of conditions such as anxiety, depression, post-traumatic stress, and other mental health disorders (Barlow, 2004). Assessing the reduction of symptom distress over the course of therapy offers clinicians and researchers a concrete metric to evaluate the effectiveness of treatment interventions.

Research has consistently demonstrated that reductions in symptom distress are linked to improved client outcomes, including enhanced interpersonal relationships, greater emotional well-being, and increased capacity to function effectively in social and occupational roles (Lutz et al., 2015). Clients who experience significant reductions in symptom distress during therapy are more likely to report higher levels of satisfaction with their treatment and to sustain long-term improvements in their mental health after therapy concludes (De Jong et al., 2014). Furthermore, reductions in symptom distress are associated with long-term mental health improvements, as clients become better equipped to manage stressors and challenges in their daily lives once their symptoms have been alleviated (Flückiger et al., 2018).

The reduction of symptom distress during therapy not only serves as an immediate marker of therapeutic success; it also holds significant long-term benefits for the client's mental health. Studies indicate that clients who experience substantial reductions in symptoms during therapy are more likely to sustain these improvements even after treatment has ended (Flückiger et al., 2018). In addition, regular monitoring of symptom distress throughout the therapeutic process has been found to allow clinicians to identify early signs of stagnation, which enables timely intervention and increases the likelihood of long-term improvement (Lambert, 2017).

Symptom reduction enhances the client's capacity to manage future stressors, as therapy often provides clients with effective coping strategies and emotional regulation skills. For example, clients who undergo cognitive-behavioural therapy (CBT) for depression frequently continue utilizing cognitive restructuring techniques after therapy, which helps them prevent relapse and handle stressors that could otherwise trigger a recurrence of symptoms (Wright et al., 2017). Consequently, reducing symptom distress becomes a critical goal in both the short-term and long-term, fostering overall resilience in mental health.

The reduction of symptom distress is a central outcome in psychotherapy, serving as a key indicator of treatment success across various therapeutic modalities. Reductions in symptom distress are associated with improved client satisfaction, better interpersonal functioning, and enhanced emotional well-being. Several factors, including the strength of the therapeutic alliance, the specificity of interventions, and client variables, influence the degree to which symptom distress is alleviated. Ultimately, the reduction of symptom distress not only improves the client's quality of life during therapy but also has lasting effects on their mental health and ability to cope with future challenges (Barlow, 2004; Flückiger et al., 2018).

### ***Comparing Client Outcomes for Supervised and Unsupervised Therapists***

Several studies have explored whether there is any significant difference between outcomes for the clients of supervised therapists and those of unsupervised practitioners. To date, evidence is mixed when utilizing client outcome as the litmus test for supervision success (Goodyear & Rousmaniere, 2017).

In a study that compared the client outcomes for supervised therapists to those for unsupervised therapists, the supervised group was found to have higher ratings of therapeutic alliance and treatment satisfaction, greater reductions in their clients' depressive symptoms, and more treatment completions than the unsupervised group (Bambling et al., 2006). Conversely, other studies

have found the provision of supervision to have no impact on treatment satisfaction or quality of care (White & Winstanley, 2009). Still other researchers have attributed improved client outcomes to the therapist increasingly acting like their supervisor over time, specifically with respect to interdependence (Apher & Freedheim, 1991).

Since 2009, three outcome studies have reported a slight to moderate supervisor effect on client outcomes (Callahan et al., 2009; Rieck et al., 2015; and Wrape et al., 2015). In one study that used archival data to explore whether the presence of supervisors working in a training clinic has any impact on client outcomes, it was found that supervisor presence has a moderate effect Callahan et al., (2009). A separate study looked at data from supervisors, supervisees, and clients at a training clinic to explore the impact of personal and relational factors such as emotional intelligence, perception of supervisory alliance, and client outcomes on the supervision process. One finding of this study was that improved client outcomes were associated with low supervisor agreeableness (Rieck et al., 2015). An exploration of archival data associated with discharged clients looked at whether a supervision-client outcome relationship exists. The variable of faculty status of supervisor was not found to be associated with client outcomes, while newer graduate supervisors were associated with better client outcomes (Wrape et al., 2015).

Individual characteristics that are unique to clinical supervisors, such as supervisor competence or experience level, have been found to potentially affect client outcomes (Rousmaniere et al., (2016). Also, counselling research consistently supports the assertion that supervision contributes to the development and strengthening of the therapeutic working alliance (Horvath & Symonds, 1991; Ladany et al., 1999; Rieck et al., 2015) and is effective in developing supervisee competence (Steward et al., 2001). However, a correlation between supervision and client outcomes has been challenging to research and substantiate (Rieck et al., 2015).

Skepticism about the impact supervisors may have on client outcomes led to a hypothesis that mediating variables at the client, supervisee, and supervisor levels separates supervisors from client outcomes. Wampold and Holloway (1997) found that, “detection of a relation between supervision process and the patient’s rating of patient change (the most distal outcome) would be expected to be extremely small” (p. 23) and concluded that it would be a challenge to provide evidence that a relationship exists between supervision and client outcomes.

### ***Summary of Research on Outcome Measures***

Client outcomes are measured by both symptom relief and client satisfaction with the therapeutic experience. However, although outcome studies have not addressed client outcomes in clinical supervision research, there does appear to be a positive correlation between client satisfaction with services rendered and symptom improvement. Also, the research suggests that measuring satisfaction with supervision is a meaningful way to gain insight into the supervisee’s experience, while also potentially providing valuable information about the potential impact of supervisee satisfaction on client outcomes. Supervisee satisfaction has therefore been utilized as an outcome measure in numerous studies, resulting in a consensus that it can be impacted by many variables (Grossl et al., 2014; Reese et al., 2009, Son & Ellis, 2013).

There is ongoing debate in the literature regarding the extent to which clinical supervision directly impacts client outcomes. While supervision is widely recognized as essential to the training and development of mental health professionals, empirical evidence linking supervision quality to improved client outcomes remains inconclusive. For instance, Alfonsson et al. (2018) concluded that while effective supervision contributes positively to therapist competence, there is limited and inconsistent evidence demonstrating a direct effect on client outcomes. Similarly, Rieck et al. (2015) argued that despite supervision being a cornerstone of professional development, the mechanisms by

which it may influence client change are still not well understood and are often assumed rather than empirically validated.

Due to this uncertainty, some researchers have shifted focus toward evaluating supervision through more proximal indicators, such as supervisee satisfaction, perceived support, and professional growth (Watkins, 2011; Wheeler & Richards, 2007). These factors, while important for understanding the learning environment, may not adequately capture the downstream impact on therapeutic effectiveness. In contrast, client satisfaction measures, though frequently used as outcome indicators, are subject to significant limitations. As Williams et al. (1998) highlight, client satisfaction data often reflect subjective perceptions influenced by various factors, including personal expectations and the desire to please the therapist, rather than objective measures of therapeutic progress. Moreover, satisfaction ratings can be inflated due to social desirability bias, where clients may report higher satisfaction to align with perceived expectations or to avoid expressing negative feedback.

Given these challenges, the present study emphasizes client outcomes, specifically symptom improvement over satisfaction-based metrics, responding to recent calls in the literature to examine how supervision-related processes may translate into measurable therapeutic results (Milne & Reiser, 2017; Alfonsson et al., 2018). This approach also presents an opportunity for future research. Specifically, exploring potential parallels between supervisee satisfaction and client satisfaction may offer a novel lens for examining the presence of parallel process. If a mirroring of relational experiences emerges—where both supervisee and client report similarly positive or negative perceptions of their respective interpersonal dynamics—it may serve as an indirect indicator of parallel process occurring within the system. Such findings could contribute to a deeper understanding of how systemic relational patterns influence both supervision and therapy, and whether shared perceptions are symptomatic of a broader interpersonal replication.

### **Support for Further Study of Parallel Process**

The growing body of research on parallel process seems to indicate a potentially powerful phenomenon that merits further study to better understand. For example, there is limited empirical evidence directly linking the impact of clinical supervision on client outcomes, and more robust research is needed to clarify this relationship (Watkins, 2011). In addition, cultural influences on parallel process are underexplored. Also, while some literature has begun to examine multicultural supervision (e.g., Soheilian et al., 2014), it remains unclear how cultural dynamics (e.g., power, identity, marginalization) may shape the enactment or recognition of parallel process. With respect to cultural dynamics, parallel process has been described as "...both a vehicle for the transmission of bias and a conduit for identifying and reducing biased practices and promoting or enhancing culturally responsive psychotherapy" (Zetzer, 2015, p. 20). Future research should examine how race, ethnicity, gender, and professional culture influence parallel processes in both the therapeutic and supervisory relationship, and how that may impact client outcomes.

A review of 30 years of research highlighted a consistent finding that good supervision can provide numerous indirect benefits for therapist development (Watkins, 2011). Effective supervision has also been found to enhance the therapist's skills and confidence as well as the therapeutic alliance, all of which are key to client progress. Furthermore, a strong supervisory alliance has been consistently found to be central to effective supervision, being built on trust, collaboration, and tailored feedback. These features of a strong alliance foster the therapist's professional growth, and their ability to handle challenges such as burnout and countertransference. However, there is limited empirical evidence directly linking supervision to client outcomes, and more robust research is needed to clarify this relationship. Despite these gaps, Watkins (2011) emphasized supervision's critical role in supporting therapists and the therapeutic process, advocating for future studies to identify effective supervisory practices and their impact on client success.

To date, parallel process studies have been based primarily on retrospective, anecdotal accounts that rely on the memory of participants recalling past experiences. The results of these studies have been potentially weakened by the limitations inherent in relying on anecdotal data, suggesting that using real time measures may provide more reliable evidence as to whether the phenomenon of parallel process is indeed occurring. In other studies, independent raters analyzed recorded sessions and answered questionnaires based on their opinions. This may have introduced a bias related to the raters having been primed to look for positive results.

In contrast, the present study looked at quantitative data based on the self-reporting of both therapist and client experience, gathering input from a larger sample in real time rather than relying solely on retrospection. Exploring the dynamics within and across a larger group of supervisee-client dyads, the present study captured a greater breadth and depth of data than could have been captured if the research was solely dependent on responses from single participants.

### **Intention of the Present Study**

The intention of the present study was to contribute to existing theoretical research by empirically examining evidence of parallel process with the goal of informing supervision practice, research, and clinical work with clients. To do this, the researcher empirically investigated the phenomenon of parallel process and its implications on client outcomes by further exploring the parallels between clinical supervision and psychotherapy against the background of research cited in the literature review above.

As shown in several parts of that literature review, the primary consensus is that parallel process occurs within the context of relationship. One of the premises of parallel process is that it begins either in the supervisory relationship or the therapeutic relationship, and that the supervisee carries the parallel processes into one or both relationships (Ekstein & Wallerstein, 1972). Therefore, it

follows that without both the therapeutic and supervisory relationships, the phenomenon of parallel process would not occur and must be studied in the context of both relationships.

### **Clinical Relevance**

Supervision and counselling have been described as, “reciprocal and interlocking processes” that are part of, “a complex interpersonal triangle,” (Friedlander et al., 1989, p. 156), and both personal and professional harm can result to both supervisees and clients from a poor supervisory experience (Ellis et al., 2014; Nelson & Friedlander, 2001; Ramo-Sánchez et al., 2002). As such, there is a call for empirical research to explore the impact of supervision on supervisee outcomes and client outcomes (Falender, 2014).

While there is some indication that supervisory processes may impact the therapeutic alliance and client outcomes (Bambling et al., 2006), there is insufficient and contradictory evidence regarding the relationship between the supervisory alliance and client outcomes (Watkins, 2011; Ybrandt et al., 2016). For example, while some consider client outcomes to be the “acid test” of effective supervision (Ellis & Ladany, 1997, p. 485), this link is not fully proven as there has not been enough research to substantively support it (Watkins, 2011).

Researching the impact of supervision on client outcomes is difficult. This is partly due to the challenges of tracing triadic impact and measuring the effect of supervisory experiences, because they are processed through the supervisee and experienced by the client (Watkins, 2011). Researchers have highlighted the need for research to go beyond the benefits of supervision for supervisees, to look at the “indirect link” (Watkins, 2011, p. 238) on client outcomes.

Similarities in behaviour between the supervisor and the supervisee are associated with positive client outcomes (Tracey et al., 2012), but the impact of supervisory alliance on client outcomes has not been sufficiently studied (Rieck et al., 2015). Watkins (2011) noted that many studies that examine the impact of supervision on client outcomes collect data from the supervisee’s

or supervisor's perception, rather than collecting self-report data from the client using psychometrically sound measures. It is hoped that by focusing on the relational aspects of parallel process, the present study will contribute to resolving this uncertainty.

Overall, while some knowledge has been acquired into the phenomenon of parallel process between clinical supervision and psychotherapy, some important questions remain. In particular, in the interest of safeguarding the supervisory and therapeutic relationships, it is important to gain a clearer perception of how the relational variables of alliance, affiliation, and autonomy fit within the parallel process phenomenon, and how they may impact client outcomes.

With the goal of helping to inform and guide the training of novice supervisees, the present study considered the therapists' perspective of both the supervisory and therapeutic alliances to gain a more in-depth-understanding of the relational dynamics and how they may impact client outcomes. It was hoped that collecting data directly from both supervisees and clients would provide a uniquely deeper insight into the respective experience of both, which would inform current knowledge and provide a more substantive foundation for further study. By yielding a better understanding of the phenomenon of parallel process through exploration of supervisee-rated and client-rated alliance and their links to client outcomes, the present study was expected to ultimately contribute to a better understanding of the links between supervision and the mechanisms of change in the therapeutic process.

### **Objective of the Study**

The objective of this study was to explore relational variables at three different time points to see if there was evidence of associations between the supervisory process and the therapeutic process, and whether these associations were linked to client outcomes. Specifically, the phenomenon of parallel process was explored through the lenses of the relationship variables of alliance, affiliation, and autonomy, which are the components of the therapeutic and supervisory relationships, to

examine their association with client outcomes. It was hoped that this study would inform the field of clinical supervision and supervisee development, and that it would ultimately contribute to the enhancement of client outcomes.

### **Hypotheses**

The present study tested the following two hypotheses:

1. There will be an association between the relational variables of alliance, autonomy, and affiliation at independent time points in the supervisory and therapeutic relationships, reflecting the possible presence of parallel process.
2. The relationship between therapeutic relational variables and client outcomes will be moderated by supervisory relational variables.

### **Method**

The design of the current study, the participants, and the measures used are described in detail below. The participant recruitment process is also discussed, along with an explanation of how data was collected.

### **Study Design**

A longitudinal, quantitative design was used to explore the possible presence of parallel process in supervisee and client relational experiences. The relational associations between supervision and therapeutic processes were explored with a focus on how they are associated with client outcomes. This was a longitudinal study wherein data was collected from each dyad at two-to-three-week intervals over the course of a 13-week semester, for a total of three collection time points. This provided the most feasible data collection schedule given that the study was conducted at an academic institution that operates under a semester cycle. The choice of collecting data at three time points was based on the goal of accessing real-time data over the 13-week semester. The expectation was that data collected at the first time point would establish baseline perceptions for each dyad and,

if present, parallels would be evident as data collection continued over the subsequent two time points.

The choice to use multiple time points was further supported by the fact that the nature of parallel process does not allow for the prediction of occurrence, and it is therefore not necessarily present in the therapeutic and supervisory dyads at every (or any) time point. Also, in the hope that a less time-consuming commitment would result in higher overall participation rate than would a longer-term commitment, the data was collected over only three time points. Even with the effort to minimize the time commitment for participants, the longitudinal design of the present study provided a more fulsome body of data than would be possible with the cross-sectional design that marked most previous studies.

### **Participants**

Volunteer sample participants who comprised the dyads used in this study included masters- or PhD-level psychotherapy students ( $n = 18$ ) and clients they were seeing in the context of their training program ( $n = 21$ ). The student (supervisee/therapist) participants were also undergoing weekly supervision sessions with an assigned psychotherapy supervisor as part of their training requirements. Supervisee recruits had to have completed the first semester of theoretical practicum training to counsel clients at the centre, and client recruits had to be seeing a supervisee at the centre.

Participants were recruited separately with the intention of preserving anonymity. A client's participation in the study was not contingent on their therapist participating, and a therapist did not necessarily have to have a client participating in order to be included. However, while responses were gathered from some non-dyadic clients and supervisees, data collected from non-dyadic participants was not included in the data analysis for this thesis project.

In total 93 participants (53 clients and 40 supervisees) were recruited and signed consent forms. As shown in Table 1, below, the final sample for which dyadic data was gathered and analyzed

consisted of 21 client/supervisee dyads. The 21 dyad sets that were analyzed included 18 supervisees and their 21 clients. Three supervisees responded with respect to two clients each.

**Table 1**

*Outlier Removal*

<b>Final Participation</b>	<b>Clients</b>	<b>Supervisees</b>	<b>Total</b>
Opted out before completing	8	6	14
Provided incomplete data	15	2	17
Not part of a client/supervisee dyad	9	11	20
Final Sample: client/supervisee dyads	21	18	21 dyads

14 people who originally consented to participate (eight clients and six supervisees) opted out of the study before it was complete. In addition, 17 participants (15 clients and two supervisees) failed to complete all the questionnaires. 20 non-dyadic participants (nine clients and 11 supervisees) completed all questionnaires, and the resulting data will be retained for future analysis. The demographic and baseline characteristics of the final sample are shown in Table 2, below.

**Table 2**

*Demographic and Baseline Characteristics of the Final Dyadic Sample*

<b>Variable</b>	<b>Clients</b>	<b>Supervisees</b>
Mean age	33.76	30.57
Std Dev	10.61	6.43
Gender identity		
Male	9	12
Female	11	7
Non-binary	1	2

Table 2 (Continued)

Variable	Clients	Supervisees
Ethnicity		
White/Caucasian	11	15
Asian	2	3
Black/African Canadian	1	2
Two or more races	4	1
Other	3	N/A
Education		
High school graduate	2	
Undergraduate degree	17	
Masters or graduate degree	2	

A power analysis was conducted for the most complex analysis proposed in this study. Specifically, a moderated regression analysis with a medium effect size (Cohen's  $d$ ) of 0.35 and power of 0.80, indicated a suggested total sample size of 20 dyads. The final sample included 21 dyads, comprised of 21 clients and 18 therapists.

Among clients, 52.38% (11) identified as female, 42.86% (9) identified as male, and 4.76% (1) identified as non-binary; age  $M = 33.76$ ,  $SD = 10.61$ . In terms of ethnicity, 52.38% of clients (11) identified as White/Caucasian, 9.52% (2) identified as Asian or Asian American, 4.76% (1) identified as Black or African Canadian, 19.05% (4) identified as two or more races, and 14.29% (3) identified as other. 9.52% (2) were high school graduates, 80.95% (17) held a bachelor's degree, and 9.52% (2) held a master's degree.

Among therapists, 57.14% (7) identified as female, 33.33% (12) identified as male, and 9.52% (2) identified as non-binary; age  $M = 30.57$ ,  $SD = 10.61$ . 71.43% (15) identified as White/Caucasian, 14.29% (3) identified as Asian, 9.52% (2) identified as Black or African Canadian, and 4.76% (1) identified as two or more races.

## Measures

The following measures were used to collect information from participants:

- Demographic Questionnaire—all participants,
- Counselling Orientation Scale—supervisees only,
- Working Alliance Inventory-Short Form and Working Alliance Inventory Short Form Modified (WAI-SF) and (WAI-SFM)—supervisees only and all participants, respectively,
- Outcome Questionnaire (OQ-45)—clients only, and
- Structural Analysis of Social Behaviour-Intrex Questionnaire (SASB)—all participants

### *Demographic Questionnaire*

The Demographic Questionnaire was administered to all participants at time point one. The questionnaire included questions about age, gender, level of education, occupation, ethnicity, and relationship status.

### *Counselling Orientation Scale*

The Counseling-Orientation Scale (COS) (Loesch & McDavis, 1978) was administered to supervisees at the first time point to further understand their preferences with regard to theoretical orientation. The 35 COS items represent five characteristics, including: counselling techniques; personality constructs; nature of man; counselling goals; and the nature of anxiety for seven counselling orientations: existential ( $M = 14.29$ ,  $SD = 1.49$ ,  $\alpha = .53$ ), client-centered ( $M = 16.00$ ,  $SD = 1.48$ ,  $\alpha = .55$ ), behavioural ( $M = 12.24$ ,  $SD = 1.61$ ,  $\alpha = .50$ ), psychodynamic ( $M = 14.48$ ,  $SD = 1.54$ ,  $\alpha = .47$ ), trait-factor ( $M = 13.14$ ,  $SD = 1.28$ ,  $\alpha = .44$ ), Gestalt ( $M = 15.24$ ,  $SD = 1.37$ ,  $\alpha = .43$ ), rational emotive ( $M = 12.05$ ,  $SD = 1.36$ ,  $\alpha = .33$ ), and the entire scale ( $\alpha = .78$ ). The supervisees rated their responses using a four-point Likert scale that ranged from strongly agree to strongly disagree. The supervisees answered questions such as: “People are well adjusted when they take responsibility for their own lives and are in touch with themselves and the world” (Loesch & McDavis, 1978, para. 2),

“People’s personalities are the composite results of all that has happened previously in their own lives” (Loesch & McDavis, 1978, para. 19), and “A person is in a constant state of movement toward self-actualization” (Loesch & McDavis, 1978, para. 30).

***Working Alliance Inventory-Short Form (WAI-SF) and Short Form Modified (WAI-SFM)***

The Working Alliance Inventory Short Form (WAI-SF) (Bahrlick, 1990) was administered to supervisees at all three time points to assess their perception of their supervisory working alliances, and the Working Alliance Inventory-Short Form Modified (WAI-SFM) (Bahrlick, 1990) was administered to both clients and supervisees at all time points to measure the perceptions of both groups with respect to the therapeutic working alliance. Both the WAI-SF and the WAI-SFM are shorter versions of Horvath and Greenberg’s measure based on Bordin’s conceptualization of alliance. Adapted from the Working Alliance Inventory-Short Version (Tracey & Kokotovic, 1989), this self-report measure has been used in several studies pertaining to the supervisory working alliance and/or the therapeutic working alliance to measure perception of the three factors of alliance, conceptualized by Bordin (1979) as being bond, tasks, and goals (Falender & Shafranske, 2017 ; Flückiger et al., 2018; Gnilka et al., 2012; Ladany et al., 2013; McKnight & Reich, 2022).

The WAI uses a 12-item seven-point Likert scale rated from 1 (never) to 7 (always). A high score on each of the subscales reflects the perception of a quality alliance. In terms of reliability, previous internal consistency estimates have exceeded  $\alpha = .91$  for all subscales and have good predictive validity (Ladany et al., 1997; Ladany & Friedlander, 1995; Tracey & Kokotovic, 1989).

As a supervisee measure, the WAI-SF was administered to assess supervisee perception of their supervisory working alliance (Time 1:  $\alpha = .89$ ; Time 2:  $\alpha = .96$ ; Time 3:  $\alpha = .96$ ). Supervisees rated statements such as: "We are working towards mutually agreed upon goals" (Tracey & Kokotovic, 1989, para 6), and "I appreciate my supervisor as a person" (Tracey & Kokotovic, 1989, para. 7). To gather supervisee perceptions of the therapeutic working alliance (Time 1:  $\alpha = .94$ ; Time 2:  $\alpha = .89$ ;

Time 3:  $\alpha = .90$ ), the WAI-SFM, presented statements such as: “We are working on mutually agreed upon goals” (Tracey & Kokotovic, 1989, para 6) and, “My client and I have built a mutual trust” (Tracey & Kokotovic, 1989, para. 9).

Then, as suggested in Bahricks (1990) work, in the WAI-SFM administered to clients the word *supervisor* was replaced with the word *therapist* (Time 1:  $\alpha = .92$ ; Time 2:  $\alpha = .95$ ; Time 3:  $\alpha = .95$ ), wherein clients rated statements such as: “We are working on mutually agreed upon goals” (Tracey & Kokotovic, 1989, para 6) and “My therapist and I trust one other” (Tracey & Kokotovic, 1989, para 9).

#### ***Outcome Questionnaire-45 (OQ-45)***

The Outcome Questionnaire-45 (OQ-45) (Lambert et al., 1996) was administered to clients at time points one, two, and three. This 45-item self-report measures distress and assesses changes over the course of therapy with respect to: (a) symptom distress; (b) interpersonal relations; (c) social role performance; and (d) total distress. In the present study, the clients used a five-point Likert scale to rate statements based on their experience during the previous week, such as: “Disturbing thoughts come to my mind that I cannot get rid of” (Lambert et al., 1996, para. 25), “I have trouble getting along with acquaintances and close friends” (Lambert et al., 1996, para. 30), and “I have too many disagreements at work/school” (Lambert et al., 1996, para. 39).

The *symptom distress subscale* score includes items that reflect the symptoms of the most commonly diagnosed mental health disorders such as stress related illnesses, adjustment disorders, anxiety disorders, and affective disorders. High symptom scores have a high correlation with measures of anxiety and depression. A high score indicates that the client is bothered by these symptoms, while a low score indicates either the denial or absence of the symptoms.

The *social role subscale* measures the extent to which the client has difficulties in the social roles of student, homemaker, or worker. Various aspects are assessed such as: distress; overwork;

conflicts at work; or inefficiency in these roles. High scores indicate difficulties in the social roles, whereas low scores indicate adequate social role adjustment.

The *interpersonal subscale* assesses the client's conflict with others, family problems, marriage problems, and loneliness. High scores in this subscale are indicative of difficulties in these areas, whereas low scores suggest both satisfaction with the quality of intimate relationships and an absence of interpersonal problems.

The OQ-45 is used to track client outcomes in psychotherapy studies (Taber et al., 2011; Wrape et al., 2014) and has also been found to perform well with regard to specificity and sensitivity to changes during psychotherapy (Lambert et al., 1996). Test-retest reliability is 0.87 for the total score, and internal consistency is 0.93. The OQ-45 and each of its subscales have demonstrated high concurrent validity with other psychological functioning measures, at .71 and higher (Umphress et al., 1997).

### ***Structural Analysis of Social Behaviour-Intrex Questionnaire (SASB)***

One model that has been employed in various research studies to explore and quantify patterns in social behaviours and relationships is the Structural Analysis of Social Behaviour (SASB), which allows for a nuanced analysis of relationship dynamics (Benjamin, 1974; 1996). Individuals or groups can be assessed along these dimensions through: (a) self-reports using the SASB Intrex questionnaires; (b) ratings provided by others using the same instruments, or; (c) evaluations conducted by trained observers. This multi-directional approach allows for direct comparison between observer ratings and self-assessments when desired (Benjamin et al., 2006).

By comparing self-reports with observer ratings, researchers and therapists can track change over time and evaluate the effectiveness of interventions in altering dysfunctional interpersonal patterns (Benjamin, 2001). The SASB has also been utilized in psychotherapy research to examine the interpersonal dynamics that unfold within the supervisory and therapeutic relationships (Alpher &

Freedheim, 1991). Expanding on this work, the SASB was positioned as a robust assessment tool across therapeutic contexts, wherein the researchers argued for its capacity to evaluate both interpersonal and intrapsychic processes (Benjamin et al., 2006).

The present study employed the SASB to examine relational patterns in supervision and therapy because it offers a nuanced, empirically validated method for capturing interactional styles across contexts. Primarily due to its capacity to measure both self-directed and other-directed behaviour, the SASB is particularly useful for examining the bidirectional dynamics characteristic of parallel process. By applying SASB measures to both supervisory and therapeutic relationships, this study aimed to identify potential interpersonal mirroring indicative of parallel process. Furthermore, by integrating SASB findings with client outcome data, the present research sought to explore whether such relational patterns are associated with therapeutic outcomes, addressing an important gap in the empirical literature on supervision and client outcomes.

However, although the original SASB is an excellent measure of relational elements, its depth and breadth were beyond the scope of the present study. Therefore, a modified, abbreviated form of the SASB referred to as the SASB Intrex was used to capture self-report ratings of the target relationship variables.

The Intrex medium form of the original SASB model is notably an ideal measure for exploring dyadic relationships (Alpher & Freedheim, 1991), which aims to capture the complex dynamics of interpersonal relationships by providing self-report measures of the relational dimensions of affiliation and autonomy (Benjamin, 1974). This includes measuring perceptions of interpersonal and intrapsychic interactions in the underlying dimensions of affiliation (love-hostility), and autonomy (enmeshment-differentiation) (Benjamin et al., 2006).

In this study, the SASB was administered to all participants at time point three to measure the following:

- participants rating themselves at their best and worst,
- supervisees rating their supervisors at their best and worst in the context of their supervisory relationship,
- supervisees rating of themselves at their best and worst in the context of their supervisory relationship,
- all participants rating of themselves at their best and worst in the context of the therapeutic relationship, and
- all participants' ratings of the other (i.e., the therapist or the client, respectively) in the context of the therapeutic relationship.

In all cases, the questionnaires included such *at worst* statements as: “They put me down, blame me, punish me” (Benjamin, 1974, para. 3), and “Without giving it a second thought, they uncaringly ignore, neglect, and abandon me” (Benjamin, 1974, para. 4). *At best* ratings included such statements as: “In a very loving way, I help, guide, show them how to do things” (Benjamin, 1974, para. 29), and “Without much concern, I give them the freedom to do things on their own” (Benjamin, 1974, para. 30). Each statement was scored using continuous variables from 0 (never-not at all) to 100 (always-perfectly).

SASB scores on affiliation and autonomy between dyads were computed based on circumplex measurement as recommended by the developers of the SASB scale (Benjamin, 1974). Reliability estimate in the medium form was assessed by split half reliability, and its correlation averages approximately 0.82. Additionally, test-retest reliability for the medium form was 0.841 (Benjamin, 1996). Estimates of internal consistency cannot be calculated for this measure in the current study due to its circumplex nature, wherein constructs of affiliation and autonomy are not based on clear

clustering around a single construct. Rather each dimension has a range affiliation love-hostility and autonomy enmeshment-differentiation (Benjamin et al., 2006).

## **Procedure**

### ***Participant Recruitment***

The researcher obtained ethics approval from the Saint Paul University Research Ethics Board before recruitment commenced (see the [Certificate of Approval at Appendix A](#) to the .pdf version of this document). Supervisee and client participants were recruited through poster advertisements at the university training centre. The researcher approached supervisees through email and in-person discussion at the counselling centre and in practicum classes. Recruitment forms were sent by email to supervisees at the masters- and PhD-levels. The researcher also confidentially approached clients in the counselling centre waiting room and met with supervisees during their practicum classes to explain the study and answer any questions.

Supervisee recruits were informed that participation was voluntary and would have no bearing on either their course or their clinical evaluations. Client recruits were informed that their participation in the study would have no impact on their ability to access counselling services. All participants were informed that the information collected would be confidential and that they could withdraw from the study at any time.

### ***Data Collection Procedure***

There were two groups of participants, one client group and one supervisee group. Participants who were receiving therapeutic services were assigned to the *client* group, and participants who were providing therapeutic services were assigned to the *supervisee* group. Some participants completed consent forms manually at the university counselling centre, while others submitted consent forms through SurveyMonkey®. A description of the project and how it would be conducted was provided to each participant group (see [Appendix B to the .pdf version of this](#)

[document](#)) and then all other forms and questionnaires were distributed and completed electronically using the SurveyMonkey® platform, as described in Table 3, below.

Although data was collected at three time points, the client and therapist dyads were at different stages of the therapeutic relationship. At time point one, completed client sessions ranged from one to five, with a  $M = 2.19$  and  $SD = 1.4$ . At time point three, completed client sessions ranged from three to eleven, with a  $M = 7.1$  and  $SD = 2.19$ . Due to these differences in the length of the therapeutic relationships, hypotheses related to the fluctuations of alliance, affiliation, and autonomy were not tested.

For each questionnaire, a SurveyMonkey® link was sent out to the applicable respondents with a request to complete the included survey. Except for the SASBs, these questionnaires were sent at three time points that were approximately 14-19 days apart to coincide with the supervisee training program schedule, which includes weekly supervision as part of academic requirements. Data on dyadic alliance (client–therapist C-T, therapist–client T-C, and therapist–supervisor T-S) and on client outcomes was collected at all three time points. As shown in Table 3, below, the SASB questionnaires were sent out at the third time point.

**Table 3**

*Collection Procedure*

<b>Participants</b>	<b>Time Point 1</b>	<b>Time Point 2</b>	<b>Time Point 3</b>
<b>Clients</b>	Demographic Questionnaire		
	WAI-SFM	WAI-SFM	WAI-SFM
	OQ-45	OQ-45	OQ-45
			SASB
<b>Supervisees</b>	Demographic questionnaire		
	COS		
	WAI-SFM	WAI-SFM	WAI-SFM
	WAI-ST	WAI-ST	WAI-ST
			SASB

## Analysis

SurveyMonkey<sup>®</sup> results were exported to Statistical Package for the Social Sciences (SPSS- Version 29.0.2.0) to create the data base. SASB software was applied to run initial analyses of the SASB responses, and statistical R<sup>®</sup> software was used to analyze the quantitative data from all questionnaires. Process measures captured data pertaining to therapeutic alliance and supervisory alliance, and outcome measures considered client outcomes. The data was analyzed to examine the possible presence of parallels between processes, and to explore their association with client outcomes.

### Investigation of Hypotheses

#### *Hypothesis 1*

Hypothesis 1 (H1) was that there will be an association between the relational variables of alliance, autonomy, and affiliation at independent time points in the supervisory and therapeutic relationships, reflecting the possible presence of parallel process.

First, to examine whether the relational variable of alliance collected over three time points varied over the duration of the study period, three one-way repeated measures ANOVAs were conducted as preliminary analyses to examine their stability over time. Thereafter, Pearson correlational analyses were conducted to examine the association between relational variables (alliance, affiliation, and autonomy) at each of the three time points as stated in the following sub-hypotheses: (H1a) client ratings of therapeutic alliance will be positively correlated with therapist ratings of supervisory alliance; (H1b) client ratings of therapeutic alliance will be positively correlated with therapist ratings of therapeutic alliance; (H1c) therapist ratings of therapeutic alliance will be positively correlated with therapist ratings of supervisory alliance; (H1d) client ratings of therapeutic affiliation at best will be positively correlated with therapist ratings of therapeutic affiliation at best, and (H1e) at worst; (H1f) client ratings of therapeutic autonomy at best will be positively correlated

with therapist ratings of therapeutic autonomy at best, and (H1g) at worst; (H1h) client ratings of therapeutic affiliation at best will be positively correlated with therapist ratings of supervisory affiliation at best, and (H1i) at worst; and (H1j) client ratings of therapeutic autonomy at best will be positively correlated with therapist ratings of supervisory autonomy at best, and (H1k) at worst.

### ***Hypothesis 2***

Hypothesis 2 (H2) was that the relationship between therapeutic relational variables and client outcomes will be moderated by supervisory relational variables.

A series of 42 moderated regressions were conducted to examine whether the relationship between therapeutic relational variables and client outcomes would be moderated by supervisory relational variables. To investigate this, therapeutic alliance was entered as a predictor variable of client outcome variables and the associated supervisory alliance was introduced as a moderating variable. Participants were compared for all levels of the quality of the therapeutic alliance based on high and low levels of the supervisory alliance. Specifically, participants were classified into two groups: (1) low supervisory alliance (1 SD below mean), and (2) high supervisory alliance (1 SD above mean). These comparisons would provide insights into whether the quality of supervisory alliance moderates the association between therapeutic alliance and client outcomes. Broadly, it is hypothesized that high supervisory alliance would enhance the relationship between high therapeutic alliance and better client outcomes, providing evidence for the impact of positive parallel process.

Specifically, the following sub-hypotheses were tested: (H2a) therapist ratings of supervisory alliance will moderate the relationship between client ratings of therapeutic alliance and client outcomes (symptom distress, social role, and interpersonal relations) at each of the three time points; (H2b) therapist ratings of supervisory alliance will moderate the relationship between therapist ratings of therapeutic alliance and client outcomes (symptom distress, social role, and interpersonal relations) at each of the three time points; (H2c) therapist ratings of affiliation with supervisor will moderate the

relationship between client ratings of affiliation with therapist at best and client outcomes (symptom distress, social role and interpersonal relations), and (H2d) at worst; (H2e) therapist ratings of autonomy with supervisor will moderate the relationship between client ratings of autonomy with therapist at best and client outcomes (symptom distress, social role and interpersonal relations), and (H2f) at worst; (H2g) therapist ratings of affiliation with supervisor will moderate the relationship between therapist ratings of affiliation with client at best and client outcomes (symptom distress, social role and interpersonal relations); and (H2h) at worst; (H2i) therapist ratings of autonomy with supervisor will moderate the relationship between therapist ratings of autonomy with client at best and client outcomes (symptom distress, social role and interpersonal relations); and (H2j) at worst.

All hypotheses and corresponding analyses are summarized in Table 4, below.

**Table 4***Summary of Hypotheses and Corresponding Analyses*

<b>Hypothesis</b>	<b>Sub-hypothesis</b>	<b>Type of Analysis</b>
<b>H1</b> There will be an association between the relational variables of alliance, autonomy, and affiliation at independent time points in the supervisory and therapeutic relationships, reflecting the possible presence of parallel process.	H1a: Client ratings of therapeutic alliance will be positively correlated with therapist ratings of supervisory alliance.	Correlational analysis
	H1b: Client ratings of therapeutic alliance will be positively correlated with therapist ratings of therapeutic alliance.	
	H1c: Therapist ratings of therapeutic alliance will be positively correlated with therapist ratings of supervisory alliance.	
	H1d: Client ratings of therapeutic affiliation at best will be positively correlated with therapist ratings of therapeutic affiliation at best.	
	H1e: Client ratings of therapeutic affiliation at worst will be positively correlated with therapist ratings of therapeutic affiliation at worst.	
	H1f: Client ratings of therapeutic autonomy at best will be positively correlated with therapist ratings of therapeutic autonomy at best.	
	H1g: Client ratings of therapeutic autonomy at worst will be positively correlated with therapist ratings of therapeutic autonomy at worst.	
	H1h: Client ratings of therapeutic affiliation at best will be positively correlated with therapist ratings of supervisory affiliation at best.	
	H1i: Client ratings of therapeutic affiliation at worst will be positively correlated with therapist ratings of supervisory affiliation at worst.	
	H1j: Client ratings of therapeutic autonomy at best will be positively correlated with therapist ratings of supervisory autonomy at best.	
	H1k: Client ratings of therapeutic autonomy at worst will be positively correlated with therapist ratings of supervisory autonomy at worst.	

Table 4 (Continued)

Hypothesis	Sub-hypothesis	Type of Analysis
<b>H2</b> The relationship between therapeutic relational variables and client outcomes will be moderated by supervisory relational variables.	H2a: Therapist ratings of supervisory alliance will moderate the relationship between client ratings of therapeutic alliance and client outcomes (symptom distress, social role and interpersonal relations) at each of the three time points.	Moderation analyses
	H2b: Therapist ratings of supervisory alliance will moderate the relationship between therapist ratings of therapeutic alliance and client outcomes (symptom distress, social role and interpersonal relations) at each of the three time points.	
	H2c: Therapist ratings of affiliation with supervisor will moderate the relationship between client ratings of affiliation with therapist at best and client outcomes (symptom distress, social role and interpersonal relations).	
	H2d: Therapist ratings of affiliation with supervisor will moderate the relationship between client ratings of affiliation with therapist at worst and client outcomes (symptom distress, social role and interpersonal relations).	
	H2e: Therapist ratings of autonomy with supervisor will moderate the relationship between client ratings of autonomy with therapist at best and client outcomes (symptom distress, social role and interpersonal relations).	
	H2f: Therapist ratings of autonomy with supervisor will moderate the relationship between client ratings of autonomy with therapist at worst and client outcomes (symptom distress, social role and interpersonal relations).	
	H2g: Therapist ratings of affiliation with supervisor will moderate the relationship between therapist ratings of affiliation with client at best and client outcomes (symptom distress, social role and interpersonal relations).	
	H2h: Therapist ratings of affiliation with supervisor will moderate the relationship between therapist ratings of affiliation with client at worst and client outcomes (symptom distress, social role and interpersonal relations).	
	H2i: Therapist ratings of autonomy with supervisor will moderate the relationship between therapist ratings of autonomy with client at best and client outcomes (symptom distress, social role and interpersonal relations).	
	H2j: Therapist ratings of autonomy with supervisor will moderate the relationship between therapist ratings of autonomy with client at worst and client outcomes (symptom distress, social role and interpersonal relations).	

### **Descriptive Statistics and Internal Consistency**

After reverse scoring the relevant items, individual item scores from each scale (WAIs, OQ-45s, and SASBs) were summed to create their respective composite score for the three time points. Higher scores on the alliance questionnaires indicate a more favourably rated alliance between dyads.

For data screening, a Shapiro-Wilk's test for normality was performed on the three variables of interest (alliance [WAI]; autonomy and affiliation [SASB]; and client outcomes [OQ-45]) and found evidence for a normal distribution with no outliers. Therefore, no data points were removed from this sample. Descriptive statistics were examined for WAI, OQ-45, and SASB scales. In addition, estimates of internal consistency (Cronbach's alpha) were computed for each scale. Cronbach's alpha levels were above the recommended .70 threshold for all scales (See Table 5, below).

**Table 5**

*Descriptive Statistics and Measures of Internal Consistency for Ratings of Alliance, Client Outcomes (OQ-45: Symptom Distress, Social Role, and Interpersonal Relations), Affiliation and Autonomy*

Measure	Time 1		Time 2		Time 3	
	<i>M (SD)</i>	Cronbach's Alpha ( $\alpha$ )	<i>M (SD)</i>	Cronbach's Alpha ( $\alpha$ )	<i>M (SD)</i>	Cronbach's Alpha ( $\alpha$ )
WAI (C-T)	70.76 (10.22)	0.92	71.14 (10.95)	0.95	69.05 (11.21)	0.95
WAI (T-C)	64.29 (8.29)	0.94	64.46 (7.76)	0.89	65.40 (6.39)	0.90
WAI (T-S)	63.76 (8.80)	0.89	65.05 (11.35)	0.96	67.76 (9.62)	0.96
OQ-45 Symptom Distress	44.4 (15.50)	0.94	42.70 (12.60)	0.91	45.00 (16.20)	0.96
OQ-45 Social Role	13.00 (4.88)	0.85	12.20 (5.15)	0.86	14.00 (5.86)	0.90
OQ-45 Interpersonal Relations	18.20 (7.86)	0.74	17.60 (6.92)	0.77	18.60 (7.62)	0.84
OQ-45 Total Distress	75.20 (27.50)	0.96	73.30 (23.30)	0.95	79.50 (29.60)	0.97
Affiliation at Best (C-T)	-	-	-	-	145 (54)	-
Affiliation at Best (T-C)	-	-	-	-	95.60 (39.60)	-
Affiliation at Worst (C-T)	-	-	-	-	130 (70.90)	-
Affiliation at Worst (T-C)	-	-	-	-	58.60 (43.50)	-
Autonomy at Best (C-T)	-	-	-	-	23.90 (29.60)	-
Autonomy at Best (T-C)	-	-	-	-	65.40 (39.30)	-
Autonomy at Worst (C-T)	-	-	-	-	36.30 (27.30)	-
Autonomy at Worst (T-C)	-	-	-	-	45.20 (51.70)	-
Affiliation at Best (T-S)	-	-	-	-	148.23 (58.57)	-
Affiliation at Worst (T-S)	-	-	-	-	118.97 (59.37)	-
Autonomy at Best (T-S)	-	-	-	-	24.38 (35.06)	-
Autonomy at Worst (T-S)	-	-	-	-	15.69 (31.48)	-

Before the hypotheses were tested, several client and therapist variables were tested for potential confounding effects on client outcomes. This entailed using correlational analyses and one-way measures ANOVAs with client outcomes as the dependent variable at each of the three time points. Since participant age, number of supervisory sessions completed, the number of client sessions completed, and therapeutic orientation are continuous variables, correlational analyses were used to examine their relationship with client outcomes. Further, one-way measures ANOVAs were used to examine the relationship between client outcomes and the categorical variables of ethnicity, education, and gender identity. Only the number of supervision sessions was found to be significantly correlated with client outcome variables, and thus was included as a control variable in analyses regarding client outcomes.

The COS was used in the study to measure the theoretical orientation of the supervisees as a potential confounding/control variable. However, preliminary analyses, specifically correlational analyses examining the effect of counselling orientation on study variables, yielded non-significant results over the entire duration of the study. It was also observed that the scale had relatively low reliability (i.e., internal consistency) in the current study, with sub-scale Cronbach's alpha estimates ranging between .33 to .55. Due to the low internal consistency estimates and non-significant estimates of the relationship between counselling orientation and study variables (i.e., client outcomes), the COS results were not included in the analyses pertaining to testing the hypotheses.

## Results

The results with respect to each hypothesis are described below.

### Results for Hypothesis 1

To examine the first hypothesis, that there would be an association between the relational variables of alliance, autonomy, and affiliation at independent time points in the supervisory and therapeutic relationships, supporting the possible presence parallel process, a series of correlational analyses were conducted between ratings of therapeutic and supervisory alliance at each of the three time points. Correlational analyses were also conducted for client and therapist ratings of affiliation and autonomy at best and at worst using data collected at time point three (see Tables 6a and 6b, beginning on page 83, below).

Prior to testing hypothesis 1, three one-way repeated measures ANOVAs were conducted to assess whether each of the alliance ratings (i.e., client-rated therapeutic alliance, therapist-rated therapeutic alliance, and therapist-rated supervisory alliance) varied over the duration of the study period. Results from the one-way repeated measures ANOVA with client-rated therapeutic alliance as the dependent variable and time as the within-subjects variable indicated that this alliance rating was stable across the three time points of the study ( $F(2, 40) = 1.845, p = .171$ ). Similarly, results from the one-way repeated measures ANOVA with therapist-rated therapeutic alliance as the dependent variable and time as the within-subjects variable indicated that this alliance rating was also stable across the three time points of the study ( $F(2, 24) = .508, p = .608$ ). However, results from the one-way repeated measures ANOVA with therapist-rated supervisory alliance as the dependent variable and time as the within-subjects variable indicated that this alliance rating was not stable across the three time points of the study ( $F(2, 28) = 5.248, p = .020$ ). Post-hoc analyses with a Bonferroni correction adjustment suggest that therapist-rated supervisory alliance improved from time point one to time point three ( $p = .025$ ) and from time point two to time point three ( $p = .007$ ).

For sub-hypothesis H1a, client-rated therapeutic alliance had a significant negative correlation with therapist-rated supervisory alliance at time point two ( $r(19) = -.488, p = .025$ ), suggesting that an increase in client-rated therapeutic alliance was associated with a decrease in therapist-rated supervisory alliance. However, these findings were not consistent across time points one and three, which yielded non-significant findings (time point one:  $r(19) = -.313, p = .167$ ; time point three:  $r(19) = -.275, p = .227$ ). Sub-hypothesis H1a is not supported.

Correlational analysis for sub-hypothesis H1b yielded non-significant results when tested for the association between client-rated therapeutic alliance and therapist-rated therapeutic alliance at all three time points (time point one:  $r(19) = .112, p = .630$ ; time point two:  $r(11) = -.34, p = .255$ ; and time point three:  $r(13) = .328, p = .233$ ). Hypothesis H1b is not supported.

Offering partial support to sub-hypothesis H1c, there was a significant positive correlation between therapist ratings of therapeutic alliance and their ratings of supervisory alliance at time point two ( $r(11) = .609, p = .027$ ), indicating a positive relationship between the two alliance ratings. However, these results were not consistent, with non-significant findings at time point one, ( $r(19) = .425, p = .055$ ) and time point three, ( $r(19) = .407, p = .132$ ). Sub-hypothesis H1c, that therapist ratings of therapeutic alliance would be positively correlated with therapist ratings of supervisory alliance, is partially supported.

There were no consistent or significant findings with regard to the relational variables of autonomy and affiliation examined in sub-hypotheses H1d through H1k. These sub-hypotheses were not supported. All results from hypothesis 1 are summarized in Tables 6a and 6b, below.

**Table 6a**

*Summary of Results from Correlational Analyses Testing Relationship Variable of Alliance*

<b>Variable</b>	<b>M</b>	<b>SD</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
<b>Time 1</b>										
1. WAI (C-T)	70.76	10.22								
2. WAI (T-S)	63.76	8.80	<b>-.31</b>							
3. WAI (T-C)	64.29	8.29	<b>.11</b>	<b>.42</b>						
<b>Time 2</b>										
4. WAI (C-T)	71.14	10.95	<b>.89**</b>	-.37	-.07					
5. WAI (T-S)	65.05	11.35	-.41	<b>.79**</b>	.16	<b>-.49*</b>				
6. WAI (T-C)	64..46	7.76	-.30	<b>.68*</b>	<b>.75**</b>	<b>-.34</b>	<b>.61*</b>			
<b>Time 3</b>										
7. WAI (C-T)	69.05	11.21	<b>.91**</b>	-.17	.19	<b>.84**</b>	-.34	.05		
8. WAI (T-S)	67.76	9.62	-.40	<b>.77**</b>	.10	-.44*	<b>.96**</b>	<b>.68*</b>	<b>-.28</b>	
9. WAI (T-C)	65.40	6.39	.06	<b>.53*</b>	<b>.76**</b>	-.10	.32	<b>.91**</b>	<b>.33</b>	<b>.41</b>

*Note 1:* M and SD are used to represent mean and standard deviation, respectively.

*Note 2:* Correlations relevant to hypothesis 2a have been bolded \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

**Table 6b**

*Summary of Results from Correlational Analyses Testing Relationship Variables of Affiliation, and Autonomy*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11
1. Affiliation at Best (C-T)	145.18	54											
2. Affiliation at Worst (C-T)	130.08	70.93	.77**										
3. Autonomy at Best (C-T)	23.89	29.58	.43	.30									
4. Autonomy at Worst (C-T)	36.33	27.33	.13	.02	.71**								
5. Affiliation at Best (T-C)	95.61	39.61	<b>.07</b>	.00	.20	.17							
6. Affiliation at Worst (T-C)	58.62	43.52	.07	<b>-.04</b>	.54*	.41	.64***						
7. Autonomy at Best (T-C)	65.37	39.30	.52*	.33	<b>.33</b>	.11	.14	.25					
8. Autonomy at Worst (T-C)	45.23	51.66	.46*	.34	.36	<b>.33</b>	.13	.54*	.65*				
9. Affiliation at Best (T-S)	148.23	58.57	<b>.10</b>	.02	.06	.05	.62**	.46*	.32	.18			
10. Affiliation at Worst (T-S)	118.97	59.37	.11	<b>-.04</b>	.23	.27	.63**	.45*	.33	.19	.86**		
11. Autonomy at Best (T-S)	24.38	35.06	.27	.22	<b>.16</b>	.09	-.32	.12	.52*	.63**	.15	.11	
12. Autonomy at Worst (T-S)	15.69	31.48	.10	-.01	.30	<b>.19</b>	-.38	.14	.42	.33	.08	.12	.62**

Note 1: *M* and *SD* are used to represent mean and standard deviation, respectively.

Note 2: Correlations relevant to hypothesis 2a have been bolded \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

## Results for Hypothesis 2

The second hypothesis was that the relationship between therapeutic relational variables and client outcomes would be moderated by supervisory relational variables.

### *Results for Sub-hypothesis H2a*

Sub-hypothesis H2a was that therapist ratings of supervisory alliance would moderate the relationship between client ratings of therapeutic alliance and client outcomes. The results from the moderation analyses pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2a, are summarized in Table 7 (see page 92).

**Symptom Distress.** At time point one, results from the moderation analysis did not find a significant effect of the interaction between client ratings of therapeutic alliance and therapist ratings of supervisory alliance on symptom distress,  $\beta = .049$ ,  $p = .268$ . Similarly, at time point two there was no significant effect of the interaction term on symptom distress,  $\beta = .031$ ,  $p = .188$ .

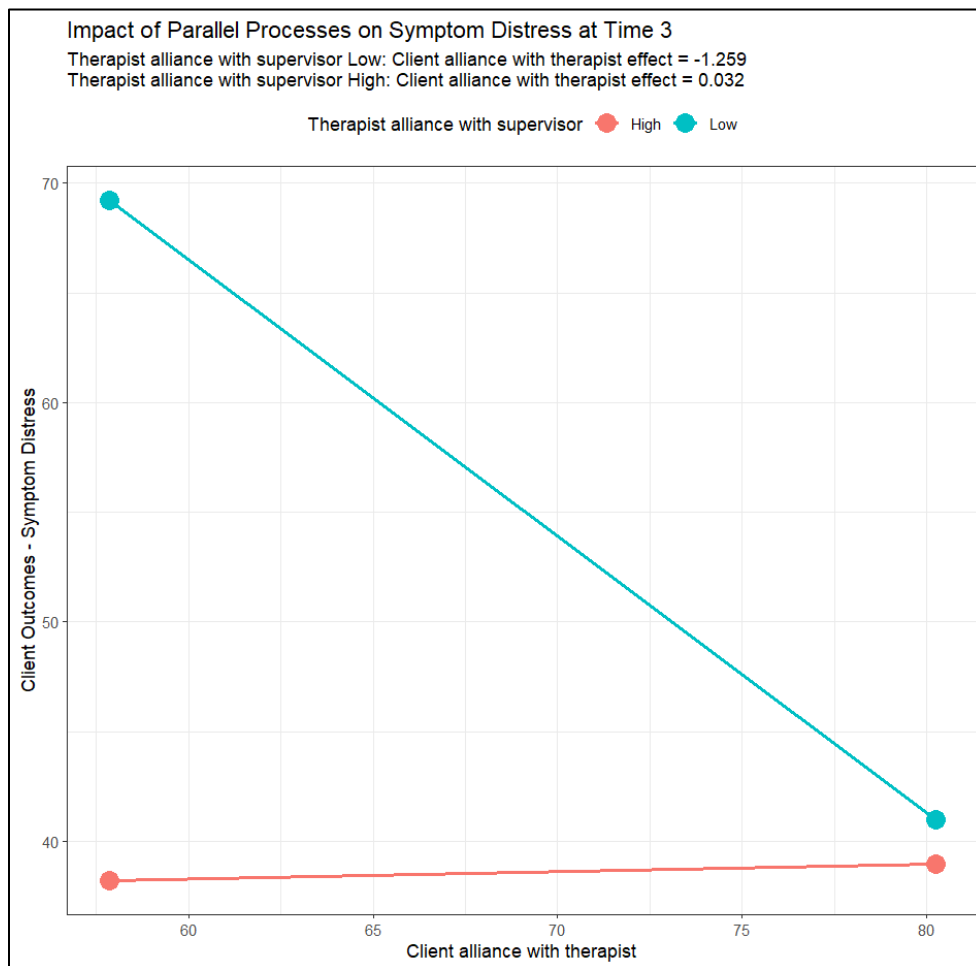
However, at time point three there was a significant effect of the interaction between client ratings of therapeutic alliance and therapist ratings of supervisory alliance,  $\beta = .067$ ,  $p = .018$ . To examine simple slopes, as described earlier, therapist-rated supervisory alliance was converted into categorical variables to indicate low (1 SD below the mean) and high (1 SD above the mean) alliance.

Simple slopes suggest that when therapists reported high supervisory alliance, high client-rated therapeutic alliance was related to lower symptom distress ( $M = 45.70$ ,  $S.E. = 3.66$ ,  $95\% CI = [38.00, 53.50]$ ) compared to dyads whose therapists reported low supervisory alliance ( $M = 52.70$ ,  $S.E. = 3.94$ ,  $95\% CI = [44.40, 61.00]$ ). In interpreting the simple slopes, it is observed that symptom distress remains relatively low when supervisory alliance was high for both high and low levels of client rated therapeutic alliance (see Figure 1 [page 87], and Table 7 [page 92]). Specifically, high supervisory alliance appears not only to have buffered the impact of low therapeutic alliance on

symptom distress; it also appears to have enhanced the impact of high therapeutic alliance on reducing symptom distress. It is observed that high client-rated therapeutic alliance is associated with lower symptom distress and this relationship is enhanced when supervisory alliance is high. Further, compared to dyads with low therapeutic alliance, when supervisory alliance is high, clients reported experiencing lower levels of symptom distress even when they had low therapeutic alliance. This supports the argument that high supervisory alliance may have (1) buffered the impact of low therapeutic alliance on high symptom distress, and (2) enhanced the impact of high therapeutic alliance on low symptom distress. This speaks to the importance of a strong supervisory alliance for both the supervisory process and client outcomes.

**Figure 1**

*The Moderating Role of Supervisory Alliance on the Relationship between Client-rated Therapeutic Alliance and Symptom Distress*



**Social Role.** At time point one, results from the moderation analysis did not demonstrate a significant effect of the interaction between clients' view of the therapeutic alliance and therapists' view of the supervisory alliance on social role outcomes,  $\beta = .018, p = .192$ . Similarly, at time point two there was no significant effect of the interaction term on social role,  $\beta = .017, p = .083$ .

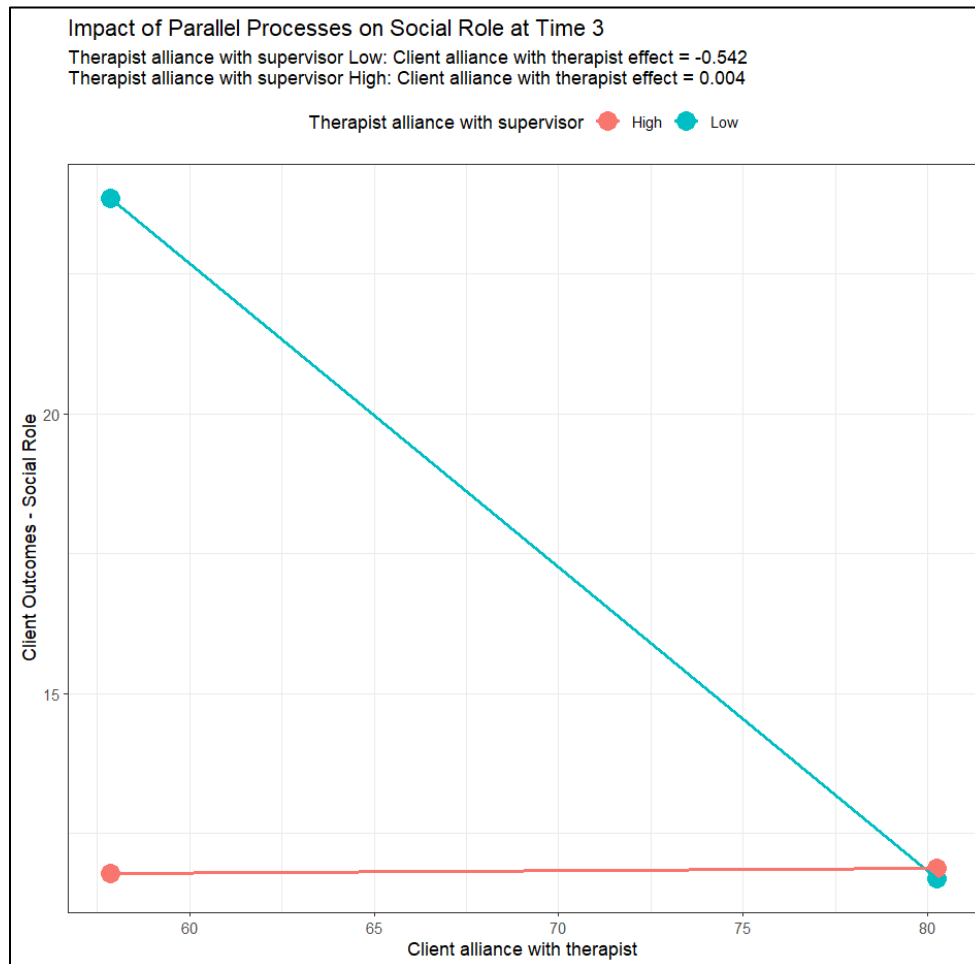
However, at time point three, there was a significant effect of the interaction between clients' therapeutic alliance and therapists' supervisory alliance,  $\beta = .023, p = .018$ . To examine simple slopes, therapist-rated supervisory alliance was converted to categorical variables to indicate low (1 SD below

the mean) and high (1 SD above the mean) alliance. Similar to the results for symptom distress, when therapists reported high supervisory alliance, high client-rated therapeutic alliance was related to lower social role-related client outcomes ( $M = 13.5$ ,  $S.E. = 1.51$ ,  $95\% \text{ CI} = [10.30, 16.70]$ ), compared to dyads whose therapists reported low supervisory alliance ( $M = 16.90$ ,  $S.E. = 1.53$ ,  $95\% \text{ CI} = [13.70, 20.20]$ ).

In interpreting the simple slopes, it was observed that social role related client outcomes remained relatively low when supervisory alliance was high, for both levels of client-rated therapeutic alliance (see Figure 2, below, and Table 7 [page 92]). Like the effect observed with symptom distress, high supervisory alliance appeared to buffer the impact of low therapeutic alliance on poor social role related client outcomes (indicated by a lower score on the OQ-45 scale). It is observed that low client-rated therapeutic alliance is associated with poor client outcomes related to social role and this impact is buffered when supervisory alliance is high compared to dyads with low supervisory alliance. This supports the argument that high supervisory alliance may have buffered the impact of low therapeutic alliance on poor client outcomes related to social role. This highlights the importance of a strong supervisory alliance both for the supervisory process and for client outcomes.

**Figure 2**

*The Moderating Role of Supervisory Alliance on the Relationship between Client-rated Therapeutic Alliance and Social Role*



**Interpersonal Relations.** At time point one, results from the moderation analysis did not find a significant effect of the interaction between clients' therapeutic alliance and therapists' supervisory alliance on outcomes related to interpersonal relations related,  $\beta = .026, p = .199$ . Similarly, at time point two there was no significant effect of the interaction term on interpersonal relations related outcomes,  $\beta = .016, p = .232$ .

However, at time point three there was a significant effect of the interaction between clients' therapeutic alliance and therapists' supervisory alliance,  $\beta = .028, p = .048$ . This suggests that the

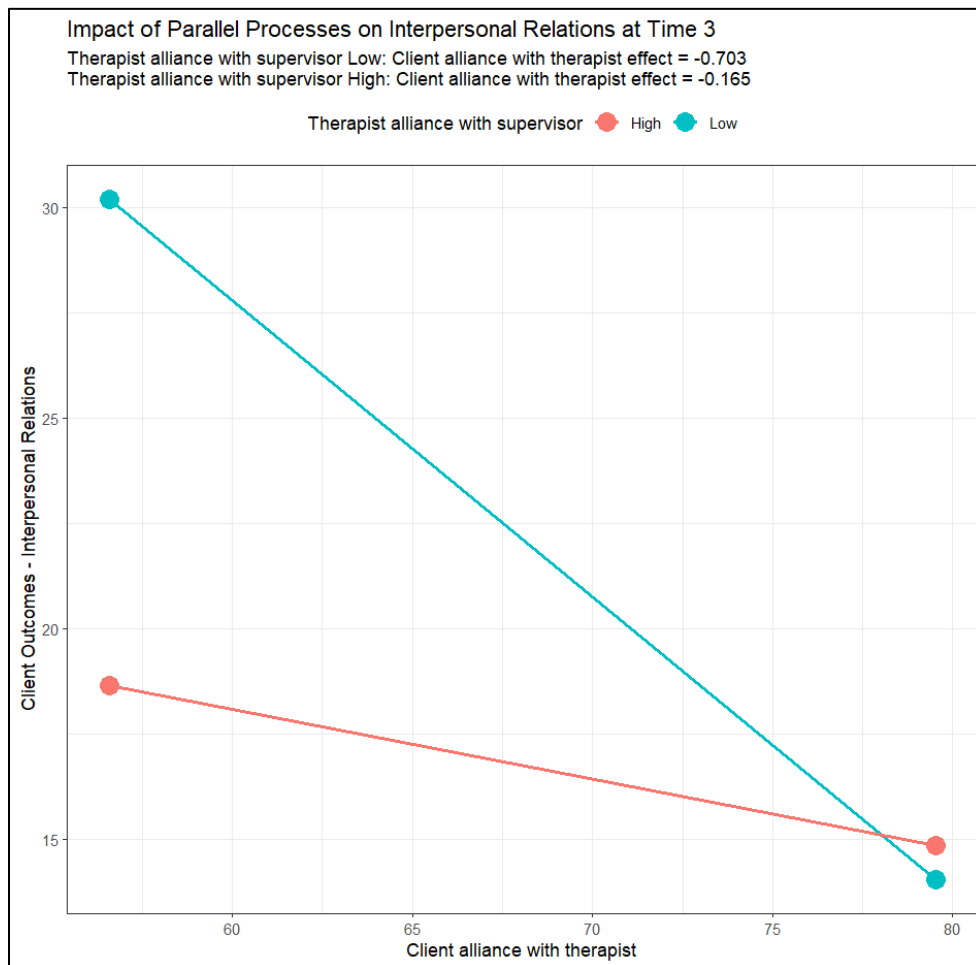
dynamic relationship between these two alliances plays a role in enhancing client outcomes. To examine simple slopes, therapist-rated supervisory alliance was converted to categorical variables to indicate low (1 SD below the mean) and high (1 SD above the mean) alliance. This categorization allowed for the exploration of how variations in the quality of supervisory alliance moderated the relationship between therapeutic alliance and client outcomes.

Consistent with earlier results, among dyads where therapists reported high supervisory alliance, higher client-rated therapeutic alliance was associated with better client outcomes related to interpersonal relationships ( $M = 19.3$ ,  $S.E. = 1.74$ ,  $95\% CI = [15.50, 23.10]$ ) compared to dyads whose therapists reported low supervisory alliance ( $M = 20.4$ ,  $S.E. = 1.94$ ,  $95\% CI = [16.20, 24.60]$ ).

In interpreting the simple slopes, it was observed that client outcomes related to interpersonal relations remained relatively low when supervisory alliance was high, for both levels of client rated therapeutic alliance (see Figure 3 and Table 7, below). Like the effects observed with symptom distress and social role related outcomes, high supervisory alliance also appeared to buffer the impact of low therapeutic alliance on poor client outcomes related to interpersonal relations (indicated by a lower score on the OQ-45 scale). It is observed that low client rated therapeutic alliance is associated with poor client outcomes related to interpersonal relations and this impact is buffered when supervisory alliance is high compared to dyads with low supervisory alliance. This supports the argument that high supervisory alliance may have buffered the impact of low therapeutic alliance of poor client outcomes related to interpersonal relations.

**Figure 3**

*The Moderating Role of Supervisory Alliance on the Relationship between Client-rated Therapeutic Alliance and Interpersonal Relations*



**Table 7**

*Regression Analysis of the Moderating Effect of Supervisory Alliance on the Relationship between Client Rated Therapeutic Alliance and Client Outcomes (OQ-45: Symptom Distress, Social Role, and Interpersonal Relations)*

<b>Variable</b>	<b>Est</b>	<b>SE</b>	<b>t</b>
<i>DV: OQ-45 Symptom Distress; Time 1</i>			
WAI (C-T)	-3.561	2.909	-1.224
WAI (T-S)	-3.739	3.149	-1.187
WAI (C-T) x WAI (T-S)	.049	.043	1.145
<i>DV: OQ-45 Symptom Distress; Time 2</i>			
WAI (C-T)	-2.202	1.619	-1.360
WAI (T-S)	-2.195	1.769	-1.240
WAI (C-T) x WAI (T-S)	.031	.022	1.374
<i>DV: OQ-45 Symptom Distress; Time 3</i>			
WAI (C-T)	-5.159	1.737	-2.971**
WAI (T-S)	-5.490	1.861	-2.950**
WAI (C-T) x WAI (T-S)	.067	.026	2.628*
<i>DV: OQ-45 Social Role; Time 1</i>			
WAI (C-T)	-1.285	.871	-1.475
WAI (T-S)	-1.319	.948	-1.391
WAI (C-T) x WAI (T-S)	.018	.013	1.363
<i>DV: OQ-45 Social Role; Time 2</i>			
WAI (C-T)	-1.223	.665	-1.841
WAI (T-S)	-1.201	.726	-1.653
WAI (C-T) x WAI (T-S)	.017	.009	1.852
<i>DV: OQ-45 Social Role; Time 3</i>			
WAI (C-T)	-1.854	.603	-3.074**
WAI (T-S)	-1.924	.640	-3.004**
WAI (C-T) x WAI (T-S)	.023	.009	2.643*

Table 7 (Continued)

Variable	Est	SE	t
<i>DV: OQ-45 Interpersonal Relations; Time 1</i>			
WAI (C-T)	-2.114	1.292	-1.635
WAI (T-S)	-2.091	1.395	-1.499
WAI (C-T) x WAI (T-S)	.025	.019	1.345
<i>DV: OQ-45 Interpersonal Relations; Time 2</i>			
WAI (C-T)	-1.291	.901	-1.433
WAI (T-S)	-1.151	.982	-1.173
WAI (C-T) x WAI (T-S)	.016	.012	1.245
<i>DV: OQ-45 Interpersonal Relations; Time 3</i>			
WAI (C-T)	-2.288	.888	-2.578*
WAI (T-S)	-2.166	.975	-2.222*
WAI (C-T) x WAI (T-S)	.027	.013	2.187*

Note: \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

### Results for Sub-hypothesis H2b

Sub-hypothesis H2b was that therapist ratings of alliance with supervisor would moderate the relationship between therapist ratings of alliance with client and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2b, are summarized in Table 8, below.

**Symptom Distress.** At time point one, results from the moderation analysis did not find a significant effect of the interaction between therapist ratings of therapeutic alliance and therapist ratings of supervisory alliance on symptom distress,  $\beta < .001$ ,  $p = .999$ . Similarly, at time points two and three there was no significant effect of the interaction term on symptom distress, Time 2:  $\beta < .001$ ,  $p = .989$ ; Time 3:  $\beta = .05$ ,  $p = .387$ .

**Social Role.** At time point one, results from the moderation analysis did not find a significant effect of the interaction between therapist ratings of therapeutic alliance and therapist ratings of supervisory alliance on social role,  $\beta = -.004, p = .809$ . Similarly, at time points two and three there was no significant effect of the interaction term on social role, Time 2:  $\beta = -.01, p = .612$ ; Time 3:  $\beta = .009, p = .711$ .

**Interpersonal Relations.** At time point one, results from the moderation analysis did not find a significant effect of the interaction between therapist ratings of therapeutic alliance and therapist ratings of supervisory alliance on interpersonal relations,  $\beta = .01, p = .728$ . Similarly, at time points two and three there was no significant effect of the interaction term on interpersonal relations, Time 2:  $\beta = -.01, p = .747$ ; Time 3:  $\beta = -.01, p = .780$ .

Sub-hypothesis H2b is not supported.

**Table 8**

*Regression Analysis of the Moderating Effect of Supervisory Alliance on the Relationship between Therapist Rated Therapeutic Alliance and Client Outcomes (OQ-45: Symptom Distress, Social Role, and Interpersonal Relations)*

Variable	Est	SE	t
<i>DV: OQ-45 Symptom Distress; Time 1</i>			
WAI (T-C)	-.24	3.14	-.08
WAI (T-S)	.03	3.30	.01
WAI (T-C) x WAI (T-S)	<.01	.05	<-.01
<i>DV: OQ-45 Symptom Distress; Time 2</i>			
WAI (T-C)	.08	3.44	-.02
WAI (T-S)	<.01	3.30	<.01
WAI (T-C) x WAI (T-S)	<.01	.05	-.01
<i>DV: OQ-45 Symptom Distress; Time 3</i>			
WAI (T-C)	-4.60	3.78	-1.22
WAI (T-S)	-3.68	3.93	-.94
WAI (T-C) x WAI (T-S)	.05	.06	.90

Table 8 (Continued)

Variable	Est	SE	t
<i>DV: OQ-45 Social Role; Time 1</i>			
WAI (T-C)	.15	1.04	.15
WAI (T-S)	.30	1.07	.28
WAI (T-C) x WAI (T-S)	<.01	.02	-.25
<i>DV: OQ-45 Social Role; Time 2</i>			
WAI (T-C)	.71	1.38	.51
WAI (T-S)	.66	1.33	.50
WAI (T-C) x WAI (T-S)	-.01	.02	-.53
<i>DV: OQ-45 Social Role; Time 3</i>			
WAI (T-C)	-1.05	1.68	-.63
WAI (T-S)	-.58	1.70	-.34
WAI (T-C) x WAI (T-S)	.01	.02	.38
<i>DV: OQ-45 Interpersonal Relations; Time 1</i>			
WAI (T-C)	-.92	1.57	-.59
WAI (T-S)	-.46	1.69	-.27
WAI (T-C) x WAI (T-S)	.01	.03	.35
<i>DV: OQ-45 Interpersonal Relations; Time 2</i>			
WAI (T-C)	.70	2.32	.30
WAI (T-S)	.73	.23	.33
WAI (T-C) x WAI (T-S)	-.01	.03	-.33
<i>DV: OQ-45 Interpersonal Relations; Time 3</i>			
WAI (T-C)	-.08	2.33	-.04
WAI (T-S)	1.01	2.46	.41
WAI (T-C) x WAI (T-S)	-.01	.04	-.29

Note: \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

### Results for Sub-hypothesis H2c

Sub-hypothesis H2c was that therapist ratings of affiliation (SASB) with supervisor would moderate the relationship between client ratings of affiliation (SASB) with therapist at best and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from

moderation regression analyses at all three time points pertaining to sub-hypothesis H2c, are summarized in Table 9, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between client and therapist ratings of affiliation at best on symptom distress ( $\beta = .001, p = .224$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between client and therapist ratings of affiliation at best on social role ( $\beta = .0004, p = .387$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between client and therapist ratings of affiliation at best on interpersonal relations ( $\beta = .0005, p = .458$ ).

Sub-hypothesis H2c was not supported.

#### ***Results for Sub-hypothesis H2d***

Sub-hypothesis H2d was that therapist ratings of affiliation (SASB) with supervisor would moderate the relationship between client ratings of affiliation (SASB) with therapist at worst and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2d, are summarized in Table 9, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between client and therapist ratings of affiliation at worst on symptom distress ( $\beta = .0003, p = .630$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between client and therapist ratings of affiliation at worst on social role ( $\beta = .0001, p = .676$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between client and therapist ratings of affiliation at worst on interpersonal relations ( $\beta = -.0001, p = .750$ ).

Sub-hypothesis H2d was not supported.

***Results for Sub-hypothesis H2e***

Sub-hypothesis H2e was that therapist ratings of autonomy (SASB) with supervisor would moderate the relationship between client ratings of autonomy (SASB) with therapist at best and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2e, are summarized in Table 9, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between client and therapist ratings of autonomy at best on symptom distress ( $\beta = -.003, p = .358$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between client and therapist ratings of autonomy at best on social role ( $\beta = -.001, p = .343$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between client and therapist ratings of autonomy at best on interpersonal relations ( $\beta = -.0006, p = .665$ ).

Sub-hypothesis H2e was not supported.

***Results for Sub-hypothesis H2f***

Sub-hypothesis H2f was that therapist ratings of autonomy (SASB) with supervisor would moderate the relationship between client ratings of autonomy (SASB) with therapist at worst and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from

moderation regression analyses at all three time points pertaining to sub-hypothesis H2f, are summarized in Table 9, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between client and therapist ratings of autonomy at worst on symptom distress ( $\beta = .0002, p = .962$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between client and therapist ratings of autonomy at worst on social role ( $\beta = -.001, p = .406$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between client and therapist ratings of autonomy at worst on interpersonal relations ( $\beta = -.001, p = .581$ ).

Sub-hypothesis H2f was not supported.

**Table 9**

*Regression Analysis of the Moderating Effect of Supervisory Affiliation on the Relationship between Client Rated Therapeutic Affiliation (at Best and Worst) and Client Outcomes (OQ-45: Symptom Distress, Social Role, and Interpersonal Relations) (OQ-45)*

Variable	Est	SE	t
<i>DV: OQ-45 Symptom Distress; IVs: Affiliation at Best</i>			
C-T	-.169	.118	-1.435
T-S	-.274	.141	-1.939
C-T x T-S	.001	.0009	1.262
<i>DV: OQ-45 Social Role; IVs: Affiliation at Best</i>			
C-T	-.074	.074	-.992
T-S	-.105	.084	-1.253
C-T x T-S	.0004	.0005	.890

Table 9 (Continued)

Variable	Est	SE	t
<i>DV: OQ-45 Interpersonal Relations; IVs: Affiliation at Best</i>			
C-T	-.119	.098	-1.209
T-S	-.108	.112	-.965
C-T x T-S	.0005	.0006	.764
<i>DV: OQ-45 Symptom Distress; IVs: Affiliation at Worst</i>			
C-T	-.078	.090	-.870
T-S	-.189	.083	-2.277*
C-T x T-S	.0003	.0006	.491
<i>DV: OQ-45 Social Role; IVs: Affiliation at Worst</i>			
C-T	-.039	.045	-.876
T-S	-.068	.044	-1.549
C-T x T-S	.0001	.0002	.426
<i>DV: OQ-45 Interpersonal Relations; IVs: Affiliation at Worst</i>			
C-T	-.066	.059	-1.125
T-S	-.060	.057	-1.064
C-T x T-S	.0001	.0004	.325
<i>DV: OQ-45 Symptom Distress; IVs: Autonomy at Best</i>			
C-T	-.099	.159	-.625
T-S	.063	.117	.535
C-T x T-S	-.003	.003	-.945
<i>DV: OQ-45 Social Role; IVs: Autonomy at Best</i>			
C-T	-.049	.049	-.999
T-S	.050	.036	1.382
C-T x T-S	-.001	.001	-.976
<i>DV: OQ-45 Interpersonal Relations; IVs: Autonomy at Best</i>			
C-T	-.084	.068	-1.245
T-S	.049	.048	1.027
C-T x T-S	-.0006	.001	-.444
<i>DV: OQ-45 Symptom Distress; IVs: Autonomy at Worst</i>			
C-T	-.199	.183	-1.092
T-S	.051	.167	.307
C-T x T-S	.0002	.005	.048

Table 9 (Continued)

Variable	Est	SE	t
<i>DV: OQ-45 Social Role; IVs: Autonomy at Worst</i>			
C-T	-.058	.055	-1.055
T-S	.056	.051	1.112
C-T x T-S	-.001	.001	-.853
<i>DV: OQ-45 Interpersonal Relations; IVs: Autonomy at Worst</i>			
C-T	-.064	.084	-.767
T-S	.055	.069	.786
C-T x T-S	-.001	.002	-.655

Note: \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

### Results for Sub-hypothesis H2g

Sub-hypothesis H2g was that therapist ratings of affiliation with supervisor would moderate the relationship between therapist ratings of affiliation with client at best and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2g, are summarized in Table 10, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between therapeutic and supervisory ratings of affiliation at best on symptom distress ( $\beta = .001, p = .555$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between therapeutic and supervisory ratings of affiliation at best on social role ( $\beta = .0002, p = .794$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between therapeutic and supervisory ratings of affiliation at best on interpersonal relations ( $\beta = .0003, p = .795$ ).

Sub-hypothesis H2g was not supported.

**Results for Sub-hypothesis H2h**

Sub-hypothesis H2h was that therapist ratings of affiliation with supervisor would moderate the relationship between therapist ratings of affiliation with client at worst and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2h, are summarized in Table 10, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between therapeutic and supervisory ratings of affiliation at worst on symptom distress ( $\beta = .0008, p = .533$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between therapeutic and supervisory ratings of affiliation at worst on social role ( $\beta = .0004, p = .446$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between therapeutic and supervisory ratings of affiliation at worst on interpersonal relations ( $\beta = .0005, p = .521$ ).

Sub-hypothesis H2h was not supported.

**Results for Sub-hypothesis H2i**

Sub-hypothesis H2i was that therapist ratings of autonomy with supervisor would moderate the relationship between therapeutic ratings of autonomy with client at best and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2i, are summarized in Table 10, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between therapeutic and supervisory ratings of autonomy at best on symptom distress ( $\beta = -.003, p = .333$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between therapeutic and supervisory ratings of autonomy at best on social role ( $\beta = -.001, p = .261$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between therapeutic and supervisory ratings of autonomy at best on interpersonal relations ( $\beta = -.001$ ,  $p = .521$ ).

Sub-hypothesis H2i was not supported.

***Results for Sub-hypothesis H2j***

Sub-hypothesis H2j was that therapist ratings of autonomy with supervisor would moderate the relationship between client ratings of autonomy with therapist at worst and client outcomes. The results pertaining to this sub-hypothesis are described below. All results from moderation regression analyses at all three time points pertaining to sub-hypothesis H2j, are summarized in Table 10, below.

**Symptom Distress.** Results from the moderation analyses indicated no significant effects of the interaction between therapeutic and supervisory ratings of autonomy at worst on symptom distress ( $\beta = .001$ ,  $p = .767$ ).

**Social Role.** Similarly, there were no significant effects of the interaction between therapeutic and supervisory ratings of autonomy at worst on social role ( $\beta = -.0001$ ,  $p = .906$ ).

**Interpersonal Relations.** Consistently, there were no significant effects of the interaction between therapeutic and supervisory ratings of autonomy at worst on interpersonal relations ( $\beta = -.0002$ ,  $p = .878$ ).

Sub-hypothesis H2j was not supported.

**Table 10**

*Regression Analysis of the Moderating Effect of Supervisory Affiliation on the Relationship between Therapist Rated Therapeutic Affiliation (at Best and Worst) and Client Outcomes*

*(OQ-45: Symptom Distress, Social Role, and Interpersonal Relations)*

<b>Variable</b>	<b>Est</b>	<b>SE</b>	<b>t</b>
<i>DV: OQ-45 Symptom Distress; IVs: Affiliation at Best</i>			
C-T	-.24	.27	-.90
T-S	-.15	.14	-1.04
C-T x T-S	<.01	<.01	.60
<i>DV: OQ-45 Social Role; IVs: Affiliation at Best</i>			
C-T	-.08	.16	-.51
T-S	-.04	.07	-.53
C-T x T-S	<.01	<.01	.27
<i>DV: OQ-45 Interpersonal Relations; IVs: Affiliation at Best</i>			
C-T	-.09	.21	-.43
T-S	-.03	.10	-.33
C-T x T-S	<.01	<.01	.27
<i>DV: OQ-45 Symptom Distress; IVs: Affiliation at Worst</i>			
C-T	-.24	.20	-1.19
T-S	-.16	.08	-1.95
C-T x T-S	<.01	<.01	.64
<i>DV: OQ-45 Social Role; IVs: Affiliation at Worst</i>			
C-T	-.09	.09	-1.05
T-S	-.07	.04	-1.71
C-T x T-S	<.01	<.01	.78
<i>DV: OQ-45 Interpersonal Relations; IVs: Affiliation at Worst</i>			
C-T	-.13	.12	-1.08
T-S	-.04	.06	-.80
C-T x T-S	<.01	<.01	.66

Table 10 (Continued)

Variable	Est	SE	t
<i>DV: OQ-45 Symptom Distress; IVs: Autonomy at Best</i>			
C-T	<.01	.14	.02
T-S	.33	.32	1.03
C-T x T-S	<-.01	<.01	-1.00
<i>DV: OQ-45 Social Role; IVs: Autonomy at Best</i>			
C-T	.01	.05	.26
T-S	.15	.10	1.42
C-T x T-S	<-.01	<.01	-1.17
<i>DV: OQ-45 Interpersonal Relations; IVs: Autonomy at Best</i>			
C-T	-.03	.07	-.43
T-S	.14	.15	.98
C-T x T-S	<-.01	<.01	-.66
<i>DV: OQ-45 Symptom Distress; IVs: Autonomy at Worst</i>			
C-T	-.15	.10	-1.48
T-S	.04	.20	-.18
C-T x T-S	<.01	<.01	.30
<i>DV: OQ-45 Social Role; IVs: Autonomy at Worst</i>			
C-T	-.02	.04	-.46
T-S	.03	.08	.39
C-T x T-S	<-.01	<.01	-.12
<i>DV: OQ-45 Interpersonal Relations; IVs: Autonomy at Worst</i>			
C-T	-.07	.05	-1.32
T-S	.10	.10	.98
C-T x T-S	<-.01	<.01	-.16

Note: \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

## Discussion

The purpose of this research project was to explore the parallels between supervisory and therapeutic relationships, and to consider which processes, if any, may impact client outcomes. Specifically, the project was designed to explore the phenomenon of parallel process through the lens of the relationship variables of alliance, affiliation, and autonomy, examining whether and how those variables influence client outcomes. In this longitudinal study, alliance within dyads was assessed from the unique perspectives of both parts of the supervisee/client dyad, including ratings of the perceived alliance as rated by the supervisee and the client. In addition, supervisory alliance was measured using the therapists' ratings of their alliance with their supervisors at each of the three time points. Study findings may help to inform the field of psychotherapy and clinical supervision, with particular impact on supervisee development and the role supervision may play regarding client outcomes. It is hoped that the results will ultimately contribute to the enhancement of both professional services and client outcomes.

The supervisory alliance has previously been found to be dynamic in nature, fluctuating in quality over the duration of the relationship due to negative and positive experiences throughout the supervision process (Bordin, 1979; Bordin, 1983; Ladany et al., 1999). In the present study, there were indications that the supervisory alliance does impact and can be a factor in client outcomes. As seen in a previous study by Patton and Kivlighan (1997), the supervisee's view of the supervisory alliance was found to be significantly associated with the client's perception of the therapeutic alliance. Several previous studies have also indicated the existence of such a relationship and have suggested that psychotherapy and supervisory relational interactions share similarities in interpersonal processes (Alpher & Freedheim, 1991; Doehrman, 1976; Friedlander et al., 1989; Martin et al., 1987).

Previous research has identified the relational dynamics of the supervisory and therapeutic alliances to have "reciprocal, interlocking processes" (Friedlander et al., 1989, p. 149), and has found

that supervision should primarily enhance the supervisee's ability to build alliances with their clients and to follow treatment protocols (Holloway & Neufeldt, 1995). Furthermore, there is consensus in the literature that the shared objective and focus of both the supervisee (Bordin, 1994; Gelso & Carter, 1994) and the supervisor (Efstation et al., 1990) is to establish both the therapeutic alliance and the supervisory alliance. The findings of the present study support this view, demonstrating the impact of both a positively rated and a negatively rated alliance and how either can impact client outcomes. A summary of the findings and the researcher's interpretation of them are discussed in the "Summary and Interpretation of the Findings" section, below.

### **Summary and Interpretation of the Findings**

The key results of this study and the researcher's interpretations with respect to the two hypotheses are as follows.

#### ***Hypothesis 1***

Hypothesis 1 was that there will be an association between the relational variables of alliance, autonomy, and affiliation at independent time points in the supervisory and therapeutic relationships, reflecting the possible presence of parallel process. In examining this hypothesis, preliminary results indicated that therapeutic alliance ratings remained stable over the course of the study. However, supervisory alliance appeared to improve over the three time points.

The quality of the supervisory alliance as perceived by the supervisee has been frequently observed in previous studies to improve over the course of clinical supervision (Ladany et al., 1999; Watkins, 2014). This enhancement is attributed to the development of trust, mutual respect, and effective communication between supervisor and supervisee. Research indicates that a strong supervisory alliance is characterized by agreement on goals and tasks and the establishment of a positive emotional bond, which collectively contribute to supervisee satisfaction and professional growth (Ladany et al., 2005; Watkins, 2014). This dynamic relationship evolves as the supervisee gains

confidence in their supervisor's support, fostering a more collaborative and productive environment (Ladany et al., 2005; Watkins, 2014). This finding is consistent with past research that suggests that supervisory alliance often improves over time (Patton & Kivlighan, 1997), which may be a reflection of a supervisee's increased confidence in their supervisor and the development of a more supportive and collaborative relationship.

Several factors influence the improvement of the supervisory alliance over time. Regular feedback, open discussion about expectations, and the supervisor's attentiveness to the supervisee's developmental needs are crucial (Bernard & Goodyear, 2019; Stoltenberg & Delworth, 1987). Studies have shown that supervisors who engage in reflective practices and adapt their supervisory style to the evolving competencies of their supervisee foster a more robust alliance (Bernard & Goodyear, 2019; Borders, 2006). This adaptability helps address challenges and misunderstandings promptly, strengthening the relationship and enabling the supervisee to feel supported and understood throughout their clinical training.

Moreover, the incorporation of structured supervision models and tools has been found to enhance the supervisory alliance. For instance, the use of the supervisory working alliance allows for the assessment and monitoring of the alliance's quality, providing opportunities for supervisors to make informed adjustments to their approach (Bambling et al., 2006; Efstation et al., 1990). This approach facilitates ongoing dialogue about the supervisory process, leading to continuous improvement in the alliance as rated by the supervisee and enabling the supervisor to align their methods with the supervisee's needs. This promotes both professional development and positive therapeutic outcomes (Bambling et al., 2006; Efstation et al., 1990).

The results of the present study align with those of several studies that have examined the improvement of the supervisory alliance as rated by supervisees over the course of clinical supervision. For instance, a study that investigated the relationship between the supervisory working

alliance and supervisee satisfaction found that supervisee perceptions of the supervisory alliance improved over time, correlating with increased satisfaction with supervision (Patton & Kivlighan, 1997). Similarly, the current study observed that the supervisory alliance appeared to improve significantly across three time points, further supporting the notion that as the supervisory alliance develops, supervisees feel more supported and engaged. This progression appears to enhance the overall quality of supervision, emphasizing the dynamic nature of the supervisory alliance and its critical role in effective clinical supervision.

An exploration of the supervisory working alliance and its impact on supervisee disclosure found that a strong supervisory alliance as perceived by supervisees was associated with greater openness and willingness to discuss clinical challenges (Ladany, Ellis, and Friedlander, 1999). This openness is crucial for professional growth and effective client care, highlighting the importance of fostering a positive supervisory alliance. Additional research has previously examined the influence of clinical supervision on client outcomes and the supervisory alliance. For example, supervisees who experienced a high-quality supervisory alliance demonstrated better client outcomes, emphasizing the significance of the supervisory alliance in clinical practice (Bambling et al., 2006). These studies collectively underscore the importance of developing and maintaining a strong supervisory alliance and leveraging the parallel process phenomenon to enhance supervisee development and client care.

In the present study, there was support for parallel process between therapist-rated therapeutic alliance and therapist-rated supervisory alliance (H1c) at time point two. Unexpectedly, there was a negative relationship between client-rated therapeutic alliance and therapist-rated supervisory alliance at all three time points, as indicated by the correlation analyses; however, this negative correlation was only significant at time point two. Therefore, only sub-hypothesis H1c was partially supported. There was also no significant relationship between therapist-rated and client-rated therapeutic alliance at any of the three independent time points (H1b).

This finding aligns with earlier research on parallel process in psychotherapy and supervision. For instance, a seminal study demonstrated that the dynamics within the supervisory alliance often mirror those within the therapeutic alliance, suggesting that enhancements in the supervisory alliance can lead to corresponding improvements in the therapeutic alliance (Doehrman, 1976). Similarly, one review of the literature on parallel processes emphasized the significance of supervisors being attuned to these dynamics to bolster the effectiveness of both supervision and therapy (Friedlander et al., 1989). These findings support the notion that the quality of the supervisory alliance is intricately linked to that of the therapeutic alliance, reinforcing the results observed in the present study.

One possible explanation for the lack of significant associations between therapist-rated and client-rated alliance in the present study may lie in the longitudinal design and the inherent fluctuations in therapists' perceptions of their own performance over time. Prior research consistently indicates that therapists tend to rate the therapeutic alliance more negatively than clients do, suggesting that therapist self-evaluations may be shaped, in part, by their momentary self-efficacy or perceived effectiveness.

For instance, a study conducted within a university mental health center found that while therapists and clients showed temporal concordance on the goals, tasks and bond dimensions of the Working Alliance Inventory (WAI), therapists, on average, rated the goals and tasks component lower than clients. Interestingly, no significant differences were found in bond ratings. Crucially, therapists with lower client-specific self-efficacy were more likely to underrate both alliance components, underscoring the role of therapist confidence in shaping alliance perceptions (Lai et al., 2021). Similarly, Atzil-Slonim et al. (2015) reported that although therapists and clients demonstrated substantial temporal congruence in their session-by-session bond ratings, therapists consistently rated the bond lower than their clients. Moreover, dyads that showed stronger sessional concordance also exhibited directional discrepancies, with clients persistently rating the bond dimension higher. These

findings collectively suggest that therapist self-efficacy and internal appraisals may significantly influence alliance ratings over time, potentially obscuring measurable associations between therapist and client rated alliance in longitudinal designs.

There were no significant findings with respect to the correlation between SASB variables of affiliation and autonomy. These correlations were negligible; therefore, sub-hypotheses H1d through H1k were not supported; that is, no indication of parallel process was detected for these variables using the SASB-Intrex. This stands in contrast to the seminal work of Alpher and Freedheim (1991), which provided compelling evidence for parallel processes in the context of supervision and therapy. That case study utilized the SASB framework to demonstrate that patterns of interaction within the supervisory alliance often mirror those within the therapeutic alliance. Specifically, they identified correlations between supervisees' relational dynamics with their supervisors and similar dynamics with their clients, suggesting that supervisory processes can shape, or reflect, therapeutic processes. This parallel process concept has since become a key consideration in supervision literature, emphasizing the interconnected nature of these relational domains.

The lack of parallel process findings in the present study also challenges the universality of the conclusions of Alpher and Freedheim (1991) and raises questions about the conditions under which parallel process manifests. Possible explanations for this discrepancy might include differences in study design, collection points, population characteristics, or study duration. Additionally, variations in supervisory approaches, therapeutic interventions, or even cultural factors could influence whether parallel process is observable. This divergence highlights the importance of contextual factors in shaping relational dynamics.

In addition, the present findings might reflect a methodological distinction in how the SASB-Intrex captures relational dynamics. The Alpher and Freedheim (1991) case study utilized the SASB framework to perform in-depth qualitative analyses, allowing for nuanced interpretation of relational

interactions. In contrast, the present study employed a more quantitative and standardized approach, which may have limited the sensitivity or nuance required to detect subtle parallels between supervision and therapy. This contrast underscores the need for further research, with the goal of refining methods for studying parallel process and exploring the variability of that phenomena across different contexts. In short, the findings of the present study contribute to a growing body of literature that questions the conditions in and the extent to which parallel process occurs, and emphasizes the need for a more nuanced understanding of its role in supervision and therapy.

### ***Hypothesis 2***

Hypothesis 2 (H2) was that the relationship between therapeutic relational variables and client outcomes will be moderated by supervisory relational variables.

At time point three there was evidence of a moderation in the relationship between client-rated therapeutic alliance and client outcomes (symptom distress, social role, and interpersonal relations) as a function of therapist-rated supervisory alliance. It appears that within dyads, high supervisory alliance may buffer the effect of low client-rated therapeutic alliance on all three client outcomes compared to dyads with low supervisory alliance. This finding supports the assertion by Bordin (1983) that the strength of the supervisory alliance determines outcomes. However, there were no statistically significant differences in the effect of this enhancement on client outcomes.

Additionally, upon further examination of whether parallel process between alliances within a dyad differentially impacted client outcomes, it appeared that when there were low levels of alliance ratings in both dyads (i.e., supervisee with supervisor and client with therapist) client outcomes were consistently poor, especially at time point three. In contrast, high supervisory alliance had a buffering effect, such that when dyads reported high supervisory alliance, clients reported better outcomes despite indicating low therapeutic alliance. Further, when supervisory alliance was high, higher therapeutic alliance was also related to lower symptom distress compared to when supervisory

alliance was low. This suggests an enhancing effect of high supervisory alliance on this relationship. However, the differences between these groups in client outcomes were not statistically significant. This may be attributed to a relatively small sample size.

There was significant interaction at time point three, and an increasing difference in client outcomes between dyads with parallel presentation of negatively-rated alliance and positively-rated alliance across all three time points. This suggests that the difference could increase over time, eventually causing a statistically significant difference at later time points as the alliances within dyads shift.

The supervisory alliance plays a crucial role in influencing the therapeutic alliance between therapists and clients, often supporting positive therapeutic outcomes. When the supervisor and supervisee have a strong, collaborative relationship, it creates a foundation of trust, openness, and guidance that the supervisee can draw upon in their clinical practice. Research indicates that a supportive supervisory alliance contributes to the supervisee's sense of competency and confidence, which can improve the quality of the therapeutic alliance the supervisee builds with their client (DePue et al., 2016; Ladany et al., 2005; Watkins, 2014).

In one study that examined the relationships between the supervisory working alliance, supervisee attachment styles, and the therapeutic alliance with clients, the researchers aimed to understand how these factors interrelate and influence each other within the context of supervisee education and supervision. The study found that the supervisee's perception of a strong supervisory working alliance is positively related to their perception of their therapeutic alliance with clients. This suggests that a positive and collaborative alliance between the supervisor and supervisee can enhance the quality of the therapeutic alliance (DePue et al., 2016). This alignment between supervisor and supervisee allows the supervisee to feel secure in exploring challenging cases, receiving constructive feedback, and developing adaptive strategies that enhance their engagement with clients (Ladany et

al., 1999; Watkins, 2014). Supporting this, the findings of the present study indicate that when both dyads (supervisor-supervisee and supervisee-client) had high alliance ratings, client outcomes were significantly better, particularly over time. This underscores the pivotal role of strong alliances at multiple relational levels.

A robust supervisory alliance has also been found to mitigate therapist stress and burnout, which are common factors that have been found to negatively impact the therapeutic alliance and, consequently, client outcomes. Supervisors who provide empathy, encouragement, and a safe space for therapists to discuss professional and personal challenges contribute to their supervisees' emotional resilience (Bambling et al., 2006). This is particularly valuable when a therapist faces complex or high-risk cases. By helping the therapist to manage stress and maintain emotional stability, a strong supervisory alliance reduces the likelihood of countertransference, therapist disengagement, or therapeutic ruptures, any or all of which can hinder client progress (Ladany et al., 2013). The findings of the present study further illuminate this dynamic by showing that when the supervisory and therapeutic alliances were both rated poorly, client outcomes were consistently poor. This was particularly evident at the third time point, emphasizing the detrimental impact of weak relational alliances on therapy progress.

The quality of supervisory alliance is an important factor in supervision as it can impact the therapeutic alliance and client outcomes. Studies suggest that when therapists feel supported and validated in supervision, they are more likely to convey empathy, attunement, and authenticity with clients, all of which are key components of a strong therapeutic alliance (Horvath & Symonds, 1991). This alliance has been consistently linked to positive therapeutic outcomes across various modalities and populations, highlighting the crucial role of the alignment between supervisory and therapeutic alliances; when both are strong, clients experience better outcomes. This emphasizes the importance of cultivating high-quality relational bonds at all levels of the supervisory and therapeutic processes,

and reinforces the general consensus that the supervisory alliance is a pivotal aspect of therapeutic work. Thoughtful, supportive supervision practices can effectively optimize outcomes for both therapists and clients.

Sub-hypotheses H2b to H2j were not supported. Although alliance ratings did result in significant findings, the SASB ratings did not. The estimates were almost .0001, essentially indicating that this particular SASB variable is not effective at measuring the relationship variables of affiliation and autonomy. Therefore, there could be an issue with the SASB scale rather than with the relationship itself.

The alliance ratings in this study provided significant findings. This was likely due to the fact that the study directly captured critical relational dimensions of the supervisory and therapeutic alliances. The alliance (i.e., WAI) ratings are designed to assess the quality of the alliance based on perceptions of bond, task, and shared goals, which are foundational to both the supervisory and therapeutic processes (Bordin,1979). In contrast, the SASB ratings, while providing a valuable means of analyzing interpersonal dynamics, may not effectively measure specific relationship variables in the context of clinical supervision and therapy. The SASB framework focuses on broader patterns of interaction and structural aspects of behaviour, which might not align closely with the nuanced and subjective experiences captured by alliance ratings. The almost negligible estimates (.0001) suggest that the SASB variables, as applied in this study, are not sensitive enough to detect the affiliative and autonomous dynamics that are critical to understanding the relational components of the supervisory and therapeutic alliances.

This discrepancy highlights potential limitations in the applicability of the SASB framework for evaluating the specific dimensions of relational qualities in supervision and therapy. While the SASB is well-suited to identifying overarching behavioural patterns and relational roles, it may lack the precision needed to capture the interpersonal subtleties that underpin high-quality alliances or

problematic alliances. By contrast, alliance ratings are designed to measure constructs like the negotiation of goals, execution of therapeutic tasks and establishment of trust, making them more directly relevant to the study of dyadic relationships (Bordin, 1979). These findings underscore the importance of using measurement tools that are tailored to the specific constructs being examined, as mismatches between theoretical frameworks and measurement tools can lead to underestimation of critical relational dynamics. The results of the present study suggest that while the SASB can be valuable for other contexts, it may not be the most effective instrument for assessing the relational variables central to alliance quality in supervision and therapy.

### **Differential Impact of Negative and Positive Alliances**

The data collected in the present study indicates that the parallels in negative alliance ratings have a more substantial impact on client outcomes than parallels in positive alliance ratings. This finding is critical as it highlights that the potential harm of negative dynamics is greater than the benefits of positive dynamics. In other words, the potential damage to client outcomes related to a poor alliance ratings can be significantly greater than the potential improvement to client outcomes associated with a strong alliance.

This phenomenon may be explained by the notion that negative interactions or perceptions can create a reinforcing cycle of mistrust and disengagement. For example, when a supervisee perceives a poor alliance with their supervisor, it can lead to decreased motivation, reduced adherence to supervisory guidance, and ultimately poorer therapeutic practices. This effect is compounded when the client simultaneously perceives a poor alliance with their therapist, potentially leading to reduced engagement in therapy, lower adherence to therapeutic interventions, and overall negative client outcomes.

The consistently negative client outcomes observed when both the supervisee-supervisor and client-therapist alliances were rated poorly highlight the interconnected nature of these alliances. The

therapeutic process relies heavily on trust, communication, and mutual understanding, not only between therapist and client but also between supervisee and supervisor. When either alliance suffers, it can create a ripple effect that diminishes the overall effectiveness of the therapy provided.

Interestingly, while the negative impact of poor alliance ratings on client outcomes was evident at all time points, it was only at time point three that the moderation effect reached statistical significance. This finding suggests that the detrimental effects of poor alliances may become more pronounced or detectable over time, perhaps as initial compensatory mechanisms or resilience factors are exhausted.

The most significant finding of this study was that the relationship between the supervisory alliance and the therapeutic alliance was significantly associated with client outcomes. Specifically, results showed that supervisory alliance may play a moderating role in the relationship between client-rated therapeutic alliance and client outcomes, wherein poor therapeutic alliance was associated with poor client outcomes, particularly in the presence of a poor supervisory alliance. In contrast, when the supervisory alliance was high client outcomes were relatively better both when the therapeutic alliance was high and when it was low. Interestingly, this suggests that strong supervisory alliance may serve to buffer the negative effects of poor therapeutic alliance on worsening client outcomes, and that strong supervisory alliance may in fact enhance the relationship between high therapeutic alliance and better client outcomes.

### **Strengths of the Present Study**

An important strength of the present study was that it addressed some of the criticisms presented in the literature review with respect to parallel process research. For example, where several previous researchers looked at single case studies (Alpher & Freedheim, 1991; Friedlander et al., 1989; Jacobsen, 2007), the present exploration collected data from 21 supervisee/client dyads (39 dyadic participants in total), with 35 questionnaires being completed by each dyad. Also, the present

study included a formalized data analysis process, and the dyadic data offered insight into the shared relational experiences of both supervisees and clients.

Previous studies have confirmed the occurrence of parallel process by drawing inferences from various aspects of relational processes such as: interpersonal communication dynamics, similarities in interdependence, and dominance (Alpher & Freedheim, 1991; Friedlander et al., 1989; Jacobsen, 2007; Raichelson et al., 1997; Tracey et al., 2012; Zetter et al., 2020). The present study captured the alliance ratings for both the supervisee and the client, and found alliance to be a significant aspect, representing key dimensions of the relationship.

The present study differs in that it collected real time data on an on-going basis directly from both therapists and clients about their shared interactions, which contributed to more accurate reporting. Also, whereas, for example, one study relied on the perspective of one member of each of only nine triads (Zetter et al., 2020), the present study provided a greater accuracy and depth of understanding by exploring the therapist and client perspectives equally and drawing data from a larger number of participants. In addition, the present study collected data to capture the therapists' alliances with both their supervisor and their client(s), while also collecting data directly from clients that rated both the therapeutic alliance and client outcomes.

The relationship between clinical supervision and client outcomes has been the subject of various studies, yielding mixed results. Some research indicates that supervision can enhance the quality of care provided by supervisees, potentially leading to improved client outcomes. For instance, one systematic review aimed to synthesize empirical literature regarding the effects of clinical supervision in cognitive-behavioural therapy on both supervisees and their patients. However, that review highlighted that the effects of clinical supervision on treatment outcomes and other patient variables are debated and largely unknown, indicating a need for more rigorous research in this area (Alfonsson et al., 2018). In contrast, other research suggests that supervision can enhance the quality

of care provided by supervisees, potentially leading to improved client outcomes. For instance, one study found that supervisors had a moderate effect on client outcomes, accounting for 16% of the variance (Callahan et al., 2009). However, other studies have found supervision to have minimal or no direct impact on client outcomes. For example, an analysis of data from 23 supervisors, 175 supervisees, and 6,521 clients over five years found that supervisors accounted for only 0.04% of the variance in client outcomes (Rousmaniere et al., 2016). The present study is one of few that link supervision to positive client outcomes.

The present study was also the first of its kind in that the data was not collected retrospectively or by raters. Previous studies relied on therapists' or raters' assessment, as with the study by Tracey et al., (2012), in which a rater assessed client outcomes based on viewing only the middle 20 minutes of a therapy session. In contrast, the present study collected real time, self-reported data using reliable measures, wherein supervisees directly rated their own experience in the context of both the therapeutic and supervisory alliances, and clients directly reported on their own symptoms and on their own perception of their alliance with their therapist. In addition to providing direct data collection, this approach prevented observer-confirmation bias because data collection did not rely on the memory of participants being asked to recall events that had occurred months or years earlier, which has been a criticism of previous parallel process research (Mothersole, 1999; Watkins, 2015).

Another strength of the present study was the use of the alliance WAI (Bahrnick, 1990) to measure both supervisory and therapeutic alliances. The WAI is a reliable measure that provides direct insight regarding these alliances, rather than using other measures to make inferences about them. Furthermore, having the supervisee rate both the supervisory alliance and the therapeutic alliance is valuable because the supervisee acts as the conduit between both dyads (Bromberg, 1982; Friedlander et al., 1989). This approach allowed for a greater understanding of the quality of the

therapeutic and supervisory alliances while also providing further insight into the relational processes and dynamics, without relying on extrapolation from interpersonal process measures.

### **Limitations of the Present Study**

The present study was somewhat limited by several factors. For example, because the researcher is not bilingual, access to French speaking clients and supervisees was limited to those who were comfortable using English-only forms. Some individuals in the French academic stream did consent to participate using the English-only forms, but the language barrier still precluded part of the client and supervisee populations in the clinic from participating, which decreased the number of available participants. In addition, this study had a lower sample size than hoped. However, in the challenging landscape of dyadic research it was still a relatively large sample. In fact, it was one of the largest samples to date in parallel process research.

Another limitation was that post-COVID-19 pandemic patterns in clinic attendance created challenges with respect to participant recruitment. Access to potential participants was limited by the fact that many supervisees and clients were still working together through virtual meeting platforms. In addition to limiting access to participants, the nature of the virtual sessions may also have had a potentially significant impact on the overall results of the study in the sense that the parameters being measured (alliance, autonomy, affiliation and client outcomes) may have been impacted to varying degrees by the comparative remoteness that virtual communication imposes.

Recruiting client participants by way of electronically distributing the service agreement forms was unsuccessful. Numerous clients who had initially provided their signatures consenting to participate and to being contacted by the researcher were no longer interested in participating when the researcher contacted them directly. The most favourable recruitment outcomes resulted from approaching potential participants directly. When the researcher was able to meet potential participants in person in the counselling centre, explain the research, and answer questions, recruits

were more likely to actively and completely participate in the study. Furthermore, the continued visibility of the researcher over the course of the study acted as a visual reminder and allowed the researcher to check in with participants, answer any questions that arose, and thank them for their continued support.

The study design itself may have been a factor in relatively low completion rates. Participants were asked to complete many questionnaires across the three time points, with the largest number of questionnaires (ten to supervisees and six to clients) being sent at time point three. Overall, supervisees were asked to complete 18 questionnaires, and clients were asked to complete 15. Several individuals who responded to the questionnaires that were sent at the first time point stopped responding at the second or third time points. A full dyadic data set for analysis required that all questionnaires be completed in full by both members of the dyad; therefore, when a dyadic participant stopped responding, both the responses they had provided to date and any data their dyadic counterpart provided were excluded from the final analysis. In addition, for the purposes of this study a significant body of data generated from non-dyadic participants was excluded from analysis.

Another limitation was that the SASB measure is not open source and there are barriers to access this scale. The licensing cost to use this measure creates a loss of autonomy for the researcher, and the data needs to be set up in a specific way that is not intuitive. In addition, the data is circumplex and quite complex. Another potential limitation to be considered is the manner in which some of the SASB questions are worded. For example, the SASB questionnaire where the therapist rates their relationship with their client when their client is at their worst includes statements such as: "They happily, gently, very lovingly approach me, and warmly invite me to be as close as I would like," and "With much sulking and fuming, they scurry to do what I want." Two participants reported that they found the nature of the questions somewhat perplexing.

Results could potentially be different if the SASB was administered at all three time points rather than being issued only at time point three. However, the volume of questions was taken into consideration when deciding to administer the SASBs only once. The set of client SASBs included 160 questions, and the combined supervisee SASBs included 288 questions. It was therefore decided that too many participants might withdraw if asked to invest the time required to complete these sets of surveys three times. The decision to administer the SASBs only at the last time point was further supported by the possibility that it might allow some time for the supervisory and therapeutic alliances to develop before those questionnaires were presented.

There were no significant findings with respect to theoretical orientation. Prior research indicates that while it is a meaningful aspect of supervisee identity and clinical decision-making, its impact on client outcomes and the development of therapeutic or supervisory alliances may be indirect. Its influence is often mediated by factors such as the supervisee's confidence in their theoretical approach, their flexibility in its application, and the quality of their interpersonal skills (Holm et al., 2018; Prescod et al., 2020; Bartle-Haring et al., 2022). It is likely that in the current sample of 18 therapists, all trained from the same graduate program, there simply was not enough diversity in counselling orientations to observe significant differences in client outcomes as a result of the therapist's counselling orientation. It is recommended that future research aim to also test whether a sample of therapists with potentially more diverse counselling orientations would moderate the relationship between parallel processes and client outcomes.

In addition, it is likely that the directional support for parallel process between client-rated and therapist-rated therapeutic alliance and between therapist-rated therapeutic and supervisory alliances would be further strengthened and manifested if a similar study was conducted over a longer duration, with a larger number of dyads.

## Implications for Practice

While parallel process can occur with any supervisee, it has been established that the rate of occurrence may be impacted by the development level of the supervisee (Stoltenberg & Delworth, 1987). In the context of a clinical training program this may be important to note as it is a potential factor that could be monitored proactively, which could contribute to safeguarding both the supervisory and therapeutic alliances.

Currently, there is limited empirical evidence demonstrating that clinical supervision of supervisees has a positive impact on development of the therapeutic alliance and client outcomes (Hill & Knox, 2013; Ybrandt et al., 2016). The research findings of the present study contribute to that previously limited evidence by indicating that parallels in high ratings of supervisory alliance and high ratings of therapeutic alliance as rated by the client are associated with symptom improvement and positive client outcomes. Similarly, this study found that a poorly rated supervisory alliance combined with a poorly rated therapeutic alliance as rated by the client is associated with negative client outcomes, including higher levels of symptom distress, challenges in social roles, and challenges in interpersonal relations.

Parallel process as it relates to supervisory alliance impacts not only the supervisee but also the quality of care provided to clients. When the supervisory alliance is strong, supervisees are more likely to feel supported and confident in their clinical work, which translates to better client care (Ladany et al., 2001). Conversely, a poor supervisory alliance can result in supervisees feeling hesitant to disclose the challenges or uncertainties they are experiencing in their clinical work, potentially leading to poorer client outcomes (Ladany et al., 1999).

Various factors can contribute to low ratings for supervisory alliance, such as the stress associated with being in training, being observed in clinical work, and ongoing clinical evaluation (Ybrandt et al., 2016). Some studies have reported that supervisees show negative emotions towards

their supervisor and the evaluative process as a result of these factors (Corbett, & Nutt, 1996; Ladany, Hill, Webb & Wheeler, 1998; Yourman & Farber, 1996).

In a qualitative study, Hutman et al. (2023) explored supervisees' experiences across a spectrum of supervision quality. Supervisees who reported harmful experiences described their supervisors as neglectful and emotionally detached, while those who experienced inadequate supervision cited issues such as inappropriate feedback, unavailability of the supervisor, and a lack of responsiveness. In contrast, exceptional supervision was characterized by feelings of psychological safety, opportunities for significant clinical insight, and the effective modeling of therapeutic techniques or theoretical approaches.

The supervisory alliance has been established as a critical relational element of the triadic dynamic (Ladany, 2004), and Freitas (2002) highlighted the need to determine how to convert positive supervision experiences such as a positive supervisory alliance into positive client outcomes. Applying the findings of the present study to practice in training facilities could leverage parallel process to provide a proactive awareness of positively versus negatively rated supervisory alliance. This would enable harnessing of the supervisory alliance to potentially improve client outcomes overall.

Developing and maintaining a strong supervisory working alliance is foundational to effective clinical supervision and supervisee development. Research consistently demonstrates that specific supervisor characteristics and relational behaviours significantly contribute to the quality of the supervisory working alliance (Hutman & Ellis, 2020; Inman, 2006; Lizzio et al., 2005; Soheilian et al., 2014; Taylor & Ellis, 2023). For practitioners in supervisory roles, this evidence highlights the importance of fostering relational conditions that enhance supervisee growth, confidence, and competence.

A supportive supervisory alliance is fostered when supervisors create a climate that encourages supervisees to openly engage in discussions about the supervisory relationship, the

inherent power dynamics, and their personal reactions to the supervisor and the supervision process, as well as the intersecting identities of the supervisor, supervisee, and client (Inman, 2006; Soheilian et al., 2014). Hutman and Ellis (2020) further emphasize that such an environment is essential for promoting supervisee disclosure, professional development, and culturally responsive supervision.

A facilitative supervisory approach grounded in reflective practice was found to foster a positive supervisory alliance (Lizzio et al., 2005). This approach involves encouraging supervisees to consider different perspectives, supporting their learning goals, promoting shared control of the learning process, and helping them learn from experience through a process-focused lens. These elements were found to collectively enhance supervisee engagement and trust, reinforcing the quality of the supervisory alliance.

The findings of Borders et al. (2017) underscore the critical role of feedback in shaping the supervisory alliance, and point to important implications for supervisor training. While doctoral supervisors acknowledged feeling uncertain or insecure when delivering corrective feedback, the study found that when such feedback was delivered directly and effectively it enhanced the supervisory alliance. Conversely, poorly managed feedback was associated with a deterioration in the alliance. Supervisors also recognized the importance of tailoring feedback to individual supervisees' personalities and learning styles, emphasizing that a one-size-fits-all approach is insufficient. As a result, Borders et al. (2017) recommend a three-pronged strategy to support supervisors in this area: (1) providing explicit instruction in feedback skills; (2) encouraging personalized delivery based on supervisee needs, and; (3) helping supervisors overcome the hesitations associated with giving critical feedback. These findings highlight the need for supervision training programs to prioritize feedback competency as a core supervisory skill, as it directly influences the effectiveness and relational quality of supervision.

Interestingly, it has also been found that supervisees who perceive their supervisors as multiculturally competent are more likely to develop a stronger supervisory working alliance, which in turn contributes to greater supervisee satisfaction and enhanced counseling self-efficacy (Crockett & Hays, 2015). A study by Moore (2023) that explored the experience of minority supervisees supported the need to train supervisors on how to support supervisees who are navigating various intersectionalities.

Shaffer and Friedlander (2017) have identified five key relational strategies that supervisors can employ to effectively navigate critical events or dilemmas within supervision. These strategies include: (1) exploring supervisees' emotional responses; (2) attending to potential parallel process; (3) addressing countertransference dynamics; (4) focusing on the therapeutic process; and, (5) reinforcing the supervisory alliance. Together, these relational strategies serve as essential tools for fostering insight, strengthening the supervisory alliance, and promoting supervisee development (Taylor & Ellis, 2023).

When supervisors engage in relational behaviours, they create opportunities for supervisees to address clinical concerns that might remain unspoken without explicit encouragement (Taylor & Ellis, 2023). These behaviours have been linked to increased supervision satisfaction, stronger supervisory working alliances, and greater perceived interpersonal sensitivity on the part of the supervisor (Shaffer & Friedlander, 2017).

Humility has been increasingly recognized as a significant factor in the context of clinical supervision and supervision research (Watkins et al., 2019). In particular, relational humility, defined as the perception of humility within interpersonal relationships, has emerged as a key relational quality (Watkins et al., 2019). A recent study by Taylor and Ellis (2023) found that supervisors being perceived as relationally humble positively influenced both the quality of the supervisory working alliance and the extent of supervisee disclosure. These findings underscore the importance of

relational characteristics such as humility in fostering trust, openness, and psychological safety within the supervisory relationship (Taylor & Ellis, 2023).

The conceptualization of exceptional supervision offered by Ellis et al., (2015) provides a valuable framework for informing supervisory practice and training. They define exceptional supervision as a multidimensional approach that extends beyond meeting minimum standards, emphasizing the consistent use of best practices in clinical supervision. This includes cultivating a collaborative and professional supervisory relationship grounded in humility, respect, genuineness, mutual care, transparency, and flexibility. Additionally, exceptional supervisors demonstrate a deep understanding of and respect for the cultural identities of supervisees and their clients, using this awareness to foster empowerment, insight, and professional growth. These elements highlight the importance of integrating both relational and culturally responsive competencies into supervision training to enhance supervisee development and ultimately support client outcomes (Ellis et al., 2015).

A highly rated supervisory alliance has wide-ranging positive effects on both the supervisee and the clients they serve. A strong supervisory alliance fosters a supportive environment for professional growth, enhances supervisee self-efficacy and satisfaction, and contributes to reduced stress and reduced emotional exhaustion. Furthermore, the quality of the supervisory alliance directly influences the quality of client care, with supervisees in strong supervisory alliances being more likely to provide effective and ethical therapeutic services. Given the critical role that the supervisory alliance plays in clinical supervision, supervisors should prioritize building and maintaining a strong, collaborative, and supportive relationship with their supervisees.

Conversely, a low-rated supervisory alliance has significant negative impact on the supervisee's professional development, satisfaction, emotional well-being, and ability to provide quality client care. When the supervisory alliance is weak, supervisees are less likely to engage fully in the supervision process, leading to reduced opportunities for feedback, slower professional growth,

and greater dissatisfaction with supervision. Additionally, a poor supervisory alliance can exacerbate supervisee stress, contribute to burnout, and undermine supervisee confidence. Perhaps most concerning, a weak supervisory alliance can negatively affect client outcomes by reducing the quality of supervision and guidance that supervisees receive. Given these far-reaching consequences, it is crucial for supervisors to prioritize building and maintaining a strong supervisory alliance to support supervisees in their professional development and ensure the provision of high-quality client care.

The findings of the present study underscore the need for robust training programs that emphasize the development of strong supervisory and therapeutic alliances. Supervisors should be trained to foster positive, supportive alliances with their supervisees, as this can have downstream effects on the therapist-client alliance which in turn can directly impact client outcomes. This would seem to provide strong support for the supervision of clinical supervisors, referred to as meta-supervision, to enhance supervisory effectiveness and improve therapeutic outcomes (Kisthinos & Carlson, 2019) and to ultimately strengthen the supervisory alliance (Apostol et al., 2025).

Meta-supervision, or the supervision of clinical supervisors, is increasingly regarded as an essential process for enhancing supervisory effectiveness and improving therapeutic outcomes. It provides a reflective space in which supervisors can critically evaluate their own supervisory strategies, fostering the development of stronger guidance for supervisees (Kisthinos & Carlson, 2019). Additionally, meta-supervision supports the cultivation of self-awareness and ethical sensitivity, encouraging supervisors to examine personal biases and adopt more culturally responsive practices (Apostol et al., 2025). It also serves as a valuable space for emotional processing, helping supervisors to manage the emotional demands of their role and reduce burnout (Kisthinos & Carlson, 2019). Furthermore, meta-supervision facilitates deeper understanding of relational dynamics, ultimately strengthening the supervisory alliance (Apostol et al., 2025).

Additionally, therapists should be informed about parallel process and its significance, and should be equipped with skills to build and maintain strong alliances with their clients from the outset of therapy. Regular assessment and monitoring of alliance ratings in both dyads could help identify potential issues early, and implementing interventions to address and rectify negative perceptions and interactions in a timely manner could prevent the deterioration of client outcomes over time. Supervisors and therapists alike should be mindful of the dynamic nature of these alliances, and should be proactive in addressing any potential alliance issues or other parallel process considerations as they arise.

The present study connects with previous research from Zetzer et al., (2020) in highlighting the need to leverage the benefits of understanding parallel process and the awareness of when it is occurring. This applies both when there are indicators of parallels in negatively rated alliance and when there are indicators of parallels in positively related alliance, as both impact client outcomes. This connection further emphasizes the importance of bringing awareness to the relational dynamics of parallel process in a timely manner. This could be potentially important in addressing any challenges in either the supervisory alliance or the therapeutic alliance or both, and both are seen in this study to impact client outcomes.

Clients' perceptions of the therapeutic alliance tend to be more strongly associated with treatment outcomes than therapists' perceptions. This has been explained in part by the fact that the client is the one experiencing the change process, and their sense of collaboration, bond, and shared goals is directly tied to their engagement and progress (Flückiger et al., 2018; Horvath et al., 2011).

The significant interaction between client ratings of therapeutic alliance and therapist ratings of supervisory alliance observed at time point three, along with the increasing difference in client outcomes between dyads with negative versus positive alliance ratings, suggests that the negative impact of poor alliances may intensify over time. This pattern implies that the initial stages of therapy

might not fully capture the adverse effects of poor alliance, and that such effects may become more apparent and more impactful as therapy progresses. As the therapeutic alliance evolves over time, the compounding negative effects of poor alliances could lead to a progressively greater negative impact on client outcomes, in which case early intervention to improve alliance ratings in both dyads could be crucial. Efforts to strengthen the supervisee-supervisor alliance may, in turn, enhance the therapist-client alliance, leading to better client outcomes.

### **Recommendations for Further Research**

Further study could include examining how the different session formats (i.e., in-person, virtual, and hybrid clinical appointments) impact alliance and client outcomes and the presence of parallel process. Collecting data across more time points over a longer period could also be beneficial. This would provide information about the quality of the supervisory and therapeutic alliances over a longer time, and the data would more clearly indicate whether and when there were any fluctuations in the quality of the alliances. If the data was being monitored by collection time point, fluctuations could be flagged for qualitative follow-up. This could provide further insight into what is contributing to positively rated alliance or negatively rated alliance. Collecting data across a longer period could also provide further insight into the relational dynamics over time.

Having access to a larger group of potential participants across a longer data collection period would potentially provide the opportunity to select only participants that are beginning at the same time points in their dyadic relationships. As an example, having all participants begin the study at their first or second supervisory or therapy session (as applicable) and gathering data over the course of a full semester would add a valuable body of evidence to the research. Furthermore, screening for dyadic participants who are both in new supervisory and/or therapeutic roles might yield interesting results as to whether the newness of either or both alliances was a factor in the results. Also, the

above example might be even better explored if the study were to be expanded to include a separate group of participants in established alliances, allowing comparison between groups.

While the alliance measures were effective in the present study, the SASB measures were not as effective. In addition to the barriers mentioned above, this scale can be onerous for supervisees who are already taxed with the demands of their academic program, and for clients who are potentially navigating mental health challenges. In addition, factors such as therapist characteristics, client characteristics, type of therapy, and specific interventions used could be explored to see how they influence therapeutic and supervisory alliances. Research could also explore whether and how cultural and socioeconomic factors impact the formation and effectiveness of the alliances and how these factors influence relationships. This information could help in developing more tailored and effective therapeutic approaches for diverse populations.

Overall, the results of the present study suggest the presence of parallel process in the supervisory and therapeutic alliances, and highlight their critical role with respect to client outcomes. The negative impact of poor alliance was evident across all time points with a significant moderation effect at time point three, suggesting an intensification of these effects over time. The differential impact of negative versus positive alliance underscores the need for early intervention and ongoing support to foster strong, positive relationships within supervisory and therapeutic settings.

The study's most noteworthy finding was the significant association between the supervisory alliance and the therapeutic alliance in predicting client outcomes. Specifically, the results indicated that the supervisory alliance may moderate the relationship between the client-rated therapeutic alliance and client outcomes. When the therapeutic alliance was low, client outcomes were also poor, particularly in the context of a low supervisory alliance. Conversely, a strong supervisory alliance appeared to improve client outcomes, regardless of whether the therapeutic alliance was high or low. This finding suggests that a robust supervisory alliance can mitigate the negative impact of a poor

therapeutic alliance on client outcomes and may also amplify the positive effects of a strong therapeutic alliance on achieving better client outcomes.

In addition, reflective practice is an essential component of clinical supervision that is directly relevant to the findings of this study. Supervision provides a structured environment in which the supervisee can reflect on their experiences, explore their thoughts and feelings, and receive constructive feedback. This reflective process is critical for personal and professional growth, as it allows the supervisee to gain insight into their practice and make necessary adjustments. By reflecting on their supervisory experiences' supervisees can identify areas for improvement in their therapeutic work, which enhances their ability to connect with clients and address their needs effectively. Reflective practice, therefore, serves as a bridge between the supervisory and therapeutic alliances, linking the two in a continuous cycle of learning and improvement.

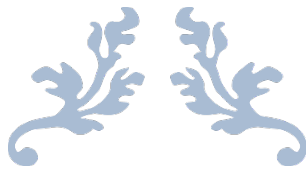
By prioritizing alliance-building at multiple levels and appreciating the potential impact of parallel process, we can enhance the overall effectiveness of therapy and improve client outcomes. In particular, it is hoped that addressing the issues within supervisory and therapeutic alliances through structured and continuous feedback mechanisms, counselling and psychotherapy practices can improve overall client outcomes and foster more effective relationships.

**Appendix A****Ethics Certificate**

The Ethics Certificate is included in the following two pages of the .pdf version of this document.



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# CERTIFICAT D'ÉTHIQUE ETHICS CERTIFICATE

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**1360.2/23 - Tina Fallis**

**Ph.D. Candidate**

**School of Counselling, Psychotherapy and Spirituality**

- Student number: 1699870 -

**Doctoral Thesis**

**“ Parallels Between Clinical Supervision and Psychotherapy”**



June 1, 2023

Université Saint Paul University

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## CERTIFICAT D'ÉTHIQUE | ETHICS CERTIFICATE

**SPU-REB Number** 1360.2/23

Last name	Name	Affiliation	Role
Fallis	Tina	Faculty of Human Science	PhD Candidate-PI
Bilodeau	Cynthia	Faculty of Human Science	Thesis Director

**Type of project** Doctoral Thesis

**Title** Parallels Between Clinical Supervision and Psychotherapy.

Approval date	Expiry Date	Decision (*)
dd-mm-yyyy	dd-mm-yyyy	
01-06-2023	31-05-2024	1 (Approved)

**(\*) Approved:**

The Research Ethics Board (REB) approved the project. Recruitment and data collection may begin as outlined in the application. Please use the **REB Protocol 1360.2/23**.

The ethics approval applies for one year. However, any [modification to the project](#) must first be approved by the REB before the changes can be implemented. The REB must be notified of all changes or unanticipated circumstances ([Unanticipated issues / adverse events report](#)) that have a serious impact on the conduct of the research, that relate to the risk to participants and their safety. An [annual renewal report](#) for ongoing projects must be submitted. The researcher must provide a [final report](#) for projects that have been approved by the Research Ethics Board (REB) in order to close all REB-approved files.

In accordance with the [Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2](#) and other applicable laws and regulations, the Saint Paul University Research Ethics Board (REB) has examined and approved the application for an ethics certificate for this project for the period indicated and subject to the conditions listed above.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completed four weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

  
  
 Louis Perron, Ph.D.  
 Chair  
 SPU Research Ethics Board (REB)

## **Appendix B**

### **Project Descriptions**

The project descriptions provided to supervisee and client participants are included on the following four pages of the .pdf version of this document.

## DESCRIPTION OF RESEARCH PROJECT—THERAPIST

### **Title of research project: Parallels Between Clinical Supervision and Psychotherapy**

Tina Fallis, a PhD candidate under the supervision of Dr. Cynthia Bilodeau from Saint-Paul University and Dr. Anne Thériault from the University of Ottawa, is inviting you to participate in a study that aims to explore parallel processes between clinical supervision and psychotherapy.

**Principal Investigator:** Tina Fallis **under the supervision of** Dr. Cynthia Bilodeau, and Dr. Anne Thériault

**Co-investigators:** Dr. Christian Bellehumeur and Dr. Stephanie Weibe

### **Description of the research project**

The purpose of the present study is to explore the parallels between supervisory and therapeutic relationships, and to explore which processes may impact therapeutic outcomes. Specifically, the study will consider the phenomenon of parallel process through the lens of relationship variables such as alliance, affiliation, interdependence, focus, and alignment of outcomes, examining whether and how those variables influence parallel process, and their role in predicting outcome.

### **Participation in the research project**

Participants are being recruited through poster advertisements in the University Counselling Centre and through emails. In addition, participants will be recruited through information sessions in practicum classes hosted by the researcher, Tina Fallis. The researcher will meet with all therapists during their practicum classes to explain the study and answer any questions.

The study aims to gather data from 30 dyads consisting of an equal number of therapists and clients (although it is expected that numbers may not be equal given that, for example, a single therapist may have multiple clients participating in the study). Therapists and/or clients who want to participate will not necessarily have to comprise part of a dyad to take part in this study; however, results from non-dyadic participants will be flagged as such. Participation of one party (client or therapist) in a given dyad will not be contingent on participation of the other. Researchers will not inform either party to a dyad of whether the other is included in the study, and participants will be advised that their inclusion in the study will be kept confidential.

Free and informed consent is being obtained from participants by way of an online consent form. Before consenting, you are invited to ask any questions or express any concerns that you may have. Your consent is needed before you can participate in the research project, prior to completing any of the research questionnaires. As soon as you are ready, you will be presented with a virtual consent form to complete.

You will have access to a private room at the Saint Paul University Counselling Centre in which to read the materials in a relaxed environment free from disruption.

### **Confidentiality**

We assure you that all your answers will be strictly confidential. Anonymity and confidentiality will be assured throughout the study. Your participation will have no bearing on your performance evaluations now or in the future. Only members of the research team (Tina Fallis, Dr. Cynthia Bilodeau, Dr. Anne Thériault) will know who participated in the research, and only they will have access to the results. Once completed, your questionnaires will be coded even before the analysis is done and it will not be possible to identify the participant(s) by name. Data will be kept on an encrypted USB key and only the research team will have access. Data will only be analyzed to inform **this research project**. Results of the study will be disseminated through the researcher's dissertation, articles, and conference presentations. The data will be retained for five (5) years. After five years, the raw data will be disposed of in a confidential manner.

## **Possible advantages and disadvantages of this research**

Your participation in this research will not be paid. However, to thank you for your contribution to this research project, you will be given the option to enter your name into a draw to win one of three \$100 gift certificates. The draw is open to all research participants who enter their name in the draw, regardless of whether they decide to withdraw from further participating in the research project. Upon completion of the study, three names will be randomly selected from amongst those who have entered, and the persons whose names are drawn will be informed by email. To win the prize, each person must correctly answer a skill testing question. If a person cannot be reached within 14 days from the date of the draw, the prize will be awarded to a second name that is randomly selected and so on until the prize has been awarded. The odds of winning a prize will depend on the number of eligible entries received. The prize must be accepted as awarded or forfeited and cannot be redeemed for cash. The email address that you provide when you enter the draw is collected solely for the purpose of contacting you if your name is selected in the draw. Your name and the contact information you have provided will be kept confidential and then destroyed once the prizes have been awarded. We reserve the right to cancel the draw or cancel the awarding of the prize if the integrity of the draw or the research or the confidentiality of participants is compromised. The draw is governed by the applicable laws of Canada.

If a summary of the results of the study becomes available, it will be emailed to you if that is your wish. Your participation in this study will allow a greater understanding of the learning process within the supervisory context. Participation in this study poses minimal risk. If participation in this study generates in you a psychological discomfort, which is unlikely, and you would like to further explore this discomfort, we recommend that you contact the university's student counselling services.

## **Your participation in this research**

Your participation in this research is completely voluntary and you are free to withdraw from the research, or refuse to answer certain questions, at any time or. Withdrawal or refusal to participate will have no bearing on your course or your clinical evaluations, or on your general relationship with the University. The results will be reported in a comprehensive manner and no names will appear in papers published from this study. If you choose to withdraw from the study, all data gathered until the time of withdrawal will be kept and will be included in the data analysis.

## **Your questions**

If you have any questions, concerns, or comments about this study, please contact Tina Fallis at the following address: [tfour075@outtawa.ca](mailto:tfour075@outtawa.ca). For information about your rights as a participant, you can contact Dr. Louis Perron, Director of the Ethics Committee for Research at Saint Paul University, to the following email address: [lperron@ustpaul.ca](mailto:lperron@ustpaul.ca).

Thank you for your attention and please accept our warmest regards,

Tina Fallis (Ph.D. cand.)  
Saint Paul University  
Tél.: (613) 298-4971

Cynthia Bilodeau, Ph.D.  
Associate Professor  
Saint Paul University  
Faculty of Human Sciences  
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You will have access to a private room at the Saint Paul University Counselling Centre in which to read the materials in a relaxed environment free from disruption.

### **Confidentiality**

We assure you that all your answers will be strictly confidential. Anonymity and confidentiality will be assured throughout the study. Your participation will have no bearing on your access to counselling services at the Saint Paul University Counselling Centre, now or in the future. Only members of the research team (Tina Fallis, Dr. Cynthia Bilodeau, Dr. Anne Thériault) will know who participated in the research, and only they will have access to the results. Once completed, your questionnaires will be coded even before the analysis is done and it will not be possible to identify the participant(s) by name. Data will be kept on an encrypted USB key and only the research team will have access. Data will only be analyzed to inform **this research project**. Results of the study will be disseminated through the researcher's dissertation, articles, and conference presentations. The data will be retained for five (5) years. After five years, the raw data will be disposed of in a confidential manner.

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