Managing Anxiety in Clinical Supervision

Hung-Jen Kuo
Trenton J. Landon
Annemarie Connor
Roy K. Chen

The University of Texas Rio Grande Valley

Follow this and additional works at: https://scholarworks.utrgv.edu/rhc_fac

Part of the Rehabilitation and Therapy Commons

Recommended Citation
Managing Anxiety in Clinical Supervision

Hung-Jen Kuo
Michigan State University

Trenton J. Landon
Utah State University

Annemarie Connor
Michigan State University

Roy K. Chen
University of Texas Rio Grande Valley

Anxiety impacts both learning and performance. While the literature is replete with portrayals of the anxious student in clinical training, close examination of practical techniques to manage anxiety and its impacts on both supervisee and supervisor is lacking. This article examines the nature and sources of anxiety, instruments used to measure and track anxiety, and interventions for managing anxiety in clinical supervisory relationships. Skilled management of anxiety within the supervisory dyad fosters optimal learning and performance. Supervisors should seek out supervision trainings specific to interventions in managing anxiety and fostering professional counselor development.

Managing Anxiety in Clinical Supervision

The importance of clinical supervision (CS) to professional development and practice in the health sciences and human services fields is indisputable (Jones, 2006). Accreditation bodies and examination boards have increasingly recognized CS as the most critical component in the training and preparation of pre-service professionals (Jones, 2006; Thielsen & Leahy, 2001). Many professional programs, such as social work (Whiteley, 2010), family medicine (Saucier, Paré, Côté, & Baillargeon, 2012), rehabilitation counseling (Herbert, 2012), physical therapy (Sellars, 2004), clinical psychology (O’Donovan, Halford, & Walters, 2011), alcohol and drug dependency counseling (Roche, Todd, & O’Connor, 2007), and nursing (Jones, 2006) require direct onsite one-on-one and/or group supervision while students are completing their practicum, internships, and residencies. While CS represents an important pedagogy in practicum and internship, it is also imperative to the continued professional development of counselors in the field.

As an integrated experiential learning component of rehabilitation counseling curricula (Thielsen & Leahy, 2001), clinical supervision significantly contributes to the attitudes, counseling styles, self-efficacies, and clinical practices of future counselors (Magnuson, Norem & Wilcoxon, 2002). Bernard and Goodyear (2014) define clinical supervision as “an evaluative and hierarchical intervention in which a professional who is senior in terms of work experience supervises and mentors a junior colleague or colleagues” (p. 9). Although the interventions vary by supervisors, it is the supervisory relationship that is paramount. In fact, the supervisory relationship plays a more important role than the actual techniques or methods used to ensure effective supervision (Inman et al., 2014; Kilminster & Jolly, 2000). From an ethical perspective, clinical supervisors also serve as the ultimate gatekeepers for the profession supervisees aspire to join (Bernard & Goodyear, 2014). Therefore, clinical supervisors must provide a supportive environment in order to promote meaningful professional growth and skill development in their supervisees (Holloway, 1995). In other words, the quality and nature of interactions between supervisor and supervisee influences counselors’ professional performance beyond just the counselor-client relationship. Specifically, effective CS has been shown to increase satisfaction of counselors (Pitt, 2009) and clients (Capella & Andrew, 2004), and improve intervention outcomes (McCarthy, 2013).

For most preservice students, the transition from the didactic nature of classroom-based learning to the application of knowledge and skills with actual clients symbolizes a major milestone in their chosen career; this transition often produces feelings of excitement as well as anxiety. The purpose of this article is to detail prevalent causes and consequences of anxiety inherent to CS, and to provide potential interventions
Anxiety is a combination of normal psychophysiological reactions, such as feelings of apprehension, tension, and nervousness in response to stressful situations that seem threatening or uncertain (Bernard & Goodyear, 2014; Fitch & Marshall, 2002; Miller & Chesky, 2004). It is one of the most prevalent and recognized emotions experienced by both supervisors and supervisees in the CS process. The relationship between supervisor and supervisee is often complicated, and the inherent power-differential can lead to anxiety-provoking situations (Bernard & Goodyear, 2014). While such situations may sometimes facilitate students’ skill development and improve performance, they can also impede supervisees’ self-efficacy, which in turn, leads to self-defeating thoughts (Fitch & Marshall, 2002). In addition, supervisor anxiety can harm the supervisory relationship when inadequate supervisory practices are employed (Ellis et al., 2014).

As an evaluative component of counselor education and ongoing training, CS sets the stage for supervisees and supervisors to either positively or negatively anticipate performance. Novice counselors may be particularly prone to anxiety due to lower perceptions of self-efficacy (Chapin & Ellis, 2002), but anxiety affects counselors at all levels of experience (Nelson, Barnes, Evans, & Triggiano, 2008). In a study of 100 graduate student supervisees using semi-structured interviews, Skovholt and Ronnestad (1992) found that participants’ early anxiety was so intense and significant that participants were able to remember and report it well into their careers. Olk and Friedlander (1992) note that supervisee anxiety can exacerbate role conflict (e.g., the inner conflict between hoping to perform well in front of the supervisor and the desire to learn from one’s own weaknesses), which, in turn, can generate further anxiety. Furthermore, Bernard and Goodyear (2014) describe anxiety in supervision as both common and multifaceted, with anxiety affecting learning, performance, and the quality of supervisee-supervisor interactions. Some authors feel it is not anxiety per se, but rather a lack of self-efficacy that contributes to poor supervision outcomes (Ellis et al., 2014). Although the intent of the current article is not to discuss self-efficacy, generally speaking, self-efficacy and anxiety are negatively correlated: an individual with higher self-efficacy is likely to have fewer anxiety symptoms, and vice versa (Bandura, 1988).

Anxiety on a Continuum

A myriad of theories attempts to explain the effects of anxiety, and its effects are debated in the psychology and counseling literature. Some scholars believe anxiety is beneficial, while others consider it harmful. For example, both the multidimensional anxiety theory (Miller & Chesky, 2004) and the catastrophe model (Englund & Hooper, 1980) posit that anxiety negatively impacts individual performance. Similarly, Liddle (1986) describes anxiety as a potential threat to the learning experience of supervisees. Certainly, anxiety can feel overwhelming if levels exceed personal thresholds of tolerance. In response to overwhelming anxiety, supervisees may develop defense mechanisms, which can, in turn, impede the learning process (Costa, 1994). Negative anxiety may impact supervisees’ ability to be helpful to clients, to demonstrate and apply what they have learned in school or supervisory sessions, and to effectively respond to clients’ questions and requests. Even supervisees who have acquired the necessary counseling knowledge and skills may be unable to successfully translate those capabilities to their interactions with clients if they feel an overwhelming sense of anxiety in the process.

Alternatively, Larson and Daniels (1998) conceptualized anxiety as performance enhancing, and Hull (1952) proposed the “drive theory,” which describes anxiety as a motivator, driving the individual to perform at a higher level. Fear of making mistakes may foster increased care and caution in performance. Rioch, Coulter, and Weinberger (1976) reported that counselors who experienced manageable amounts of anxiety were able to learn more. Additionally, anxiety can boost supervisees’ attention to the supervisory process and thus, increase willingness to ask questions and seek help of supervisors.

Bernard and Goodyear (2014) posit a middle ground definition, implying that anxiety in supervision has both positive and negative influences on the quality of learning. Similarly, Yerkes and Dodson (1908) hypothesized the inverted-U model to illustrate that, with the right level of anxiety, performance can actually be enhanced. As depicted in the model (see figure 1), moderate levels of stress (i.e., arousal) act to motivate, thereby facilitating optimal performance, whereas high levels of stress lead to diminishing performance and, ultimately, debilitation (Bernard & Goodyear, 2014).

Ultimately, effective supervision encourages supervisees to extend beyond their comfort zone and push through anxiety, without becoming overwhelmed. Skillful awareness
Types and Sources of Anxiety

Before one can effectively deal with anxiety situations occurring within the relationship of CS, the nature of it should be understood. The following section discusses the types of anxiety and those originated from supervisees as well as supervisors.

Three Types of Anxiety: Anticipatory, Approval, and Dominance

The literature identifies three types of anxiety: (i) anticipatory, (ii) approval, and (iii) dominance. Each type plays a role in the relationships dynamics that are inherent to supervision.

Barlow (2000) characterizes anticipatory anxiety as a state of helplessness triggered by an individual's perceived inability to predict, control and obtain desired results in the context of upcoming events. The intensity of emotional arousal in the individual is future-oriented and largely depended on his or her readiness and preparation in dealing with such events (Barlow, 2000). Put simply, an individual feels anxious because he or she anticipates or expects that something negative might happen. Similarly, anxiety can be provoked when an individual anticipates or expects something positive might happen but is disappointed.

Approval anxiety can result from the sometimes zealous desire of supervisees to be recognized and accepted by supervisors (Dodge, 1982). Owing to the evaluative nature of the supervisory relationship, counselor anxiety increases when supervisees feel that their need for approval and perceived level of competence will not be met (Dodge, 1982).

Furthermore, dominance anxiety is a response to authority and power. In the supervisory relationship, a hierarchical power base is both natural and sometimes necessary. Effective supervisors harness reward power and expert power in order to influence the learning process (Schultz, Osookie, Fried, Nelson, & Bardos, 2002). For example, a reputable and knowledgeable supervisor's idea would be taken more seriously than one from a disrespected or novice supervisor. However, when not used properly, the hierarchical nature can also be a potential source of anxiety. This is particularly apparent when supervisors resort to coercive supremacy to control their supervisees, rather than facilitating the learning process inherent to supervision (Schultz et al., 2002).

Sources of Supervisor Anxiety

Evaluation. Evaluation is a key component of effective supervision that, when utilized correctly, allows for critical analysis of service provision to the client and skill development in the practitioner. Understandably, evaluation of performance is an area where supervisees are likely to experience anxiety (Glosoff & Matrone, 2010). Approval anxiety is inherent to the evaluative functions of supervision, chiefly when the individual is involved in a practicum or internship, and grading or future admission into the counseling profession is at stake. Furthermore, rehabilitation counseling supervisors often rely on self-report and case review methods of evaluation, as opposed to live-observation of counselor-client interaction (Herbert & Trusty, 2006). Supervisory interventions that are solely reliant on supervisee self-reflection may be interpreted as particularly challenging or threatening (Barnes, 2004) by supervisees experiencing high levels of anxiety, as they are less able to observe situations objectively (Dombeck & Brody, 1995).

Unclear Expectations. Hand in hand with the evaluation process is the need for clear expectations. Rehabilitation counseling supervisors often fail to use a supervisory contract (McCarthy, 2013; Schultz et al., 2002), which can potentially result in anticipatory anxiety among supervisees. Supervisee anxiety levels are likely to increase when the evaluative criteria they will be appraised against is ambiguous or absent. McCarthy (2013) suggests that the existence of a supervision contract is one factor associated with a more positive supervisory working alliance. Additionally, the use of a supervisory contract has been suggested as a necessary component of ethical clinical supervision (Glosoff & Matrone, 2010). As the supervisory working alliance is the amalgamation of the goals, tasks and bonds between the supervisor and supervisee, it is not surprising to see situations where unclear goals and tasks lead to poor relationships between supervisor and supervisee (McCarthy, 2013).

Conflicted Roles. Anxiety may also result from conflict that is generated from dual roles. Holloway (1995) notes that the roles of student/trainee and counselor are behaviorally distinctive. Supervisees are subordinate when they are students/trainees, whereas they are superordinate in counseling sessions. This role conflict of switching from evaluated trainee to competent practitioner may result in both dominance and approval anxiety. Freidlander and colleagues (1986) suggest that role conflicts influence supervisees’ anxiety levels, professional behaviors and ability to objectively self-evaluate. Therefore, role conflict among supervisees should not be overlooked.

Sources of Supervisor Anxiety

Personal Characteristics. Many authors have suggested that it is incumbent upon the supervisor to bring up topics such as multiculturalism and gender differences (Glosoff & Matrone, 2010; Herbert & Trusty, 2006). A supervisor who is struggling with any of these aspects may feel uncomfortable in broaching such topics with their supervisee and, in effect, experience approval and/or anticipatory anxiety. Failure to address differences in race/ethnicity, gender, religion, or sexual orientation can lead to a belief on the part of the supervisee that these subjects are taboo and not to be addressed within supervision. By extension, the supervisory relationship often provides the model for the counselor-client
Another supervisor characteristic potentially limiting the provision of rehabilitation counselor supervision is low levels of supervisor self-efficacy in delivering clinical supervision. Phillips, Schultz, and Thielsen (2012) address the correlation between self-efficacy and outcome expectations related to clinical supervision in rehabilitation settings. They suggest that supervisors who see themselves as capable of performing clinical supervision exhibit high self-efficacy and outcome expectations and, therefore, effect more positive outcomes. To date, research suggests clinical supervision is often provided for 30 minutes or less and on an as-needed basis, indicating that clinical supervision is not highly valued by many rehabilitation organizations (Herbert & Trusty, 2006; Phillips et al., 2012; Schultz et al., 2002). This lack of training and preparation specific to clinical supervision may decrease supervisor self-efficacy in providing supervision and also limit expected outcomes of supervision (Phillips et al., 2012), thereby leading to an increase in anxiety associated with the provision of clinical supervision.

Lack of Training. Of particular concern in the field of rehabilitation counseling is the fact that the majority of supervisors have limited training in supervisory practices (Herbert, 2004) and are often promoted to their current position within a few years in the profession (Herbert, 2012; Schultz, 2008). Lack of specific knowledge and training often results in a supervisor who is ill prepared to conduct counselor evaluations or foster professional development. As a result, this lack of familiarity regarding the knowledge, skills and components of effective clinical supervision may lead to further anxiety about their role and function as a clinical supervisor.

Role of Evaluator. Most clinical supervisors are trained to be supportive counselors with a focus on counselor-client relationships. Similar to counselor-client interaction, the supervisor-supervisee relationship should also be supportive in nature. However, given their evaluator and gatekeeper roles, clinical supervisors are tasked with critiquing their supervisees’ performance and abilities (Glossoff & Matrone, 2010). Role conflict between being a supportive supervisor and an evaluator may challenge the supervisors’ self-image and, therefore, create feelings of approval anxiety.

In addition to evaluating supervisees, supervisors evaluate the quality of services being provided to clients (Glossoff & Matrone, 2010). As human service providers, counselors and supervisors are trained to ensure that the ethical values of beneficence and non-maleficence are maintained for all clients. This imperative can be particularly alarming for supervisors of novice counselors. In an increasingly litigious society, supervisors may be overly anxious about supervisees harming or jeopardizing their clients’ wellbeing. Anticipatory fear of liability can potentially cause supervisors to be overly protective, thereby limiting their supervisees’ learning experiences and, in turn, their self-efficacy (Costa, 1994). Ultimately, supervisors are responsible not only for their supervisees’ wellbeing, but also the welfare of clients. Accordingly, supervisors must find an appropriate balance between counselor growth and development and appropriate service provision (Glossoff & Matrone, 2010).

Organizational Culture. Defined by Cameron and Quinn (2006) as the “unwritten rules of how things work” in an organization (p. 16), organizational culture impacts all facets of the organization (Sherman et al., 2014). Leadership influences the culture of learning within an organization (Crimando, 2004; Sherman et al., 2014), and often focuses primarily on administrative processes within the organization, or on learning that is reactionary rather than proactive in seeking resolution to issues (Sherman et al., 2014). With high turnover rates in many state rehabilitation agencies (Barrett, Riggar, Flowers, Crimando, & Bailey, 1997; Kierpiec, Phillips & Kosciulek, 2010), due in part to occupational strain (Layne, Hohenshil, & Singh, 2004), rehabilitation counseling supervisors are in a unique position to influence both the individual counselor and the overall organization through the implementation of CS, yet they remain unaware of its purpose, practice, and potential benefits (Herbert & Trusty, 2006; Schultz et al., 2002). With limited training on the scope of CS and little organizational emphasis on it (Herbert & Trusty, 2006), it is likely that supervisors who desire to improve implementation will experience anticipatory and dominance anxiety resulting from lack of knowledge and poor organizational support.

Identification of Anxiety

While the effects of anxiety on learning can be both helpful and harmful, its presence in the supervisory relationship is inevitable (Bernard & Goodyear, 2014). Therefore, the question is not how to avoid anxiety, but how to identify, manage and utilize it. The following section discusses how to detect anxiety-provoking situations using clinical judgment and instruments. Table 1 lists some useful instruments for identifying anxiety-provoking situations in clinical supervision. Features and strengths of each instrument are also included in Table 1.

Clinical Judgment

Clinical judgment is defined as “a clinician’s observations and inferences about uncertain client characteristics or events that are systematic, deliberate, and explicit” (Austin, 2012). While this definition pertains to the relationship between counselor and client, it also applies to the relationship between supervisor and supervisee. Hence, in the context of clinical supervision, supervisory clinical judgment involves recognizing, understanding and managing individual supervisee characteristics as well as the nuances of anxiety. Before supervisors can effectively manage anxiety in clinical supervision, they must first recognize not only when anxiety
is present but also when it is problematic. Supervisors’ awareness of their own emotional arousal, as well as that of their supervisees’, becomes a critical first step. In order to enhance supervisors’ clinical judgment concerning anxiety, the sources and signs of anxiety should be discussed.

Horney (1950) posits that there are three ways in which people respond to anxiety and stressful situations: “move away”, “move toward” and “move against.” This is a useful model for supervisors since it helps identify potentially problematic anxiety. The “move away” reaction refers to situations in which people try to avoid potentially anxiety-producing situations by escaping or hiding. For example, during clinical supervision, supervisees who “move away” might frequently call in sick, arrive late for meetings, and/or make excuses for being late. There are other signs that supervisors should pay attention to when they meet with their supervisees, such as supervisees maintaining closed postures during the session, not maintaining active listening, or leaning back in the chair to move away from the supervisor.

The “move against” reaction refers to resistance behaviors associated with anxiety, such as constantly disagreeing with supervisors’ suggestions. This situation is particularly alarming, since it may accompany power issues. Some other common signs of “move against” responses include aggressive behaviors, arguing and criticizing. The “move toward” reaction is the opposite of the former. People with a “move toward” orientation might, out of a desire to appear helpful or wanting to demonstrate competence, comply with any request. Without thinking, “move toward” supervisees might agree with anything supervisors say and suggest. The “move toward” situation could be especially hard for the supervisor to notice. This anxiety reaction might limit supervisees’ opportunities to be independent. Supervisees who tend to “move toward” might not logically process or rationalize the suggestions and requests made by their supervisors. Consequently, when they have to perform counseling after supervision ceases, they may feel overwhelmed and lost.

The State-Trait Anxiety Scale

The State-Trait Anxiety Scale (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) is a widely used self-report instrument measuring two types of anxieties, situational state anxiety and general trait anxiety. These constructs were first defined by Catell and Scheier in 1961, and further developed and tested by Spielberger in subsequent decades. In order to remain culturally relevant and valid, items have been updated from the older X form to the newer Y form; for example, “I feel anxious” was found to be confusing to some respondents who interpreted it as “eager,” and “I feel high-strung” was misinterpreted as a drug reference. Accordingly, confusing items were replaced to avoid confusion, particularly among relatively young and less educated respondents, and those with lower socioeconomic status.

The 40-item, self-report inventory takes approximately 10 to 20 minutes to complete. State anxiety represents emotional arousal that may fluctuate in appearance and intensity according to appropriate stimuli. Some of the state anxiety questions include “I feel tense” and “I feel jittery.” On the other hand, trait anxiety is relatively stable and consistent to the individual, representing individual tendencies toward anxiety. Examples of trait anxiety items include “I feel like a failure” and “I lack self-confidence.” Trait scores may be of interest in understanding an individual’s anxiety baseline, and state scores may be of interest in assessing changes after intervention, over time, or in comparison to trait scores. Both the trait and state subscales, each composed of 20 questions, can be administered independently. In sum, the STAI is a reliable, valid, fast, and flexible measure of anxiety used extensively in clinical and research settings. Among all the measures presented in this article, the STAI is perhaps the most amenable to clinical practice, including clinical supervision.

Table 1: Useful Instruments for identifying anxiety provoking situation in supervision

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Feature</th>
<th>Number of Items</th>
<th>Scale</th>
<th>Used by</th>
</tr>
</thead>
<tbody>
<tr>
<td>State-Trait Anxiety Inventory</td>
<td>Anxiety is conceptualized in two constructs: state and trait (Spielberger et al., 1983). It is particularly useful to determine whether the anxiety is caused by the current situation (state) or individual characteristics (trait). State and trait scores can be used separately. Not designed for supervision, but can be useful.</td>
<td>40</td>
<td>1–4</td>
<td>Supervisor/Supervisee</td>
</tr>
<tr>
<td>Anticipatory Supervisee Anxiety Scale</td>
<td>All anxiety is anticipatory (Barlow, 2000). Can be used before the supervision session. Can be used to measure a specific supervision session.</td>
<td>28</td>
<td>1–9</td>
<td>Supervisee</td>
</tr>
<tr>
<td>Role Conflict and Role Ambiguity Inventory</td>
<td>Supervisors and supervisees have to play different roles during the supervisory relationship (Holloway, 1984). The lack of clarity regarding the training expectation causes role ambiguity which in turns provokes anxiety situation (Oks &amp; Friedlander, 1992). Two subscales in role conflict and role ambiguity can be particularly useful when determine the source of anxiety.</td>
<td>29</td>
<td>1–5</td>
<td>Supervisee</td>
</tr>
<tr>
<td>Supervisory Working Alliance Inventory</td>
<td>Base on Bordie’s (1983) idea of working alliance which incorporates three key components: a) agreements on goals, b) agreement on tasks, and c) bonds. Two separate instruments with one measures supervisor and the other measures supervise. Both measure “report” and “client focus” with the exception that supervisor form has an additional subscale in “identification.”</td>
<td>23</td>
<td>1–7</td>
<td>Supervisor/Supervisee</td>
</tr>
</tbody>
</table>

Anticipatory Supervisee Anxiety Scale

Liddle (1986) conceptualized supervisee anxiety using a bi-dimensional system, which stated that anxiety related to performance and evaluation are two major sources of supervisee resistance. While the argument seems logical and intuitive, the measurement of these constructs has not been an easy task. For example, Ellis and his colleague (1993) attempted and failed to create an instrument (i.e., Supervisee Anxiety Scale) based on Liddle’s idea of supervisee anxiety. As a result, researchers turned their attention to Barlow’s (2000) model of anxiety, which stated that all anxiety is anticipatory. Fittingly, they
created the Anticipatory Supervisee Anxiety Scale (ASAS) (Singh & Ellis, 2000).

The 28-item ASAS is designed to measure supervisees’ anticipatory anxiety. As a self-report instrument, supervisees can use the ASAS to evaluate their personal anxiety level before any supervision session. The ASAS is measured on a 9-point Likert-type scale. Two reverse scoring items are used to avoid patterned answers. Each of the 28 items contains a statement describing physical or emotional situations, and the user answers the questions according to their agreement with the statement. Questions, for example, include “have my heart pounding” and “feel annoyed with my limitations.” While the total score can be used to determine the level of supervisee anticipatory anxiety, individual responses to questions are useful for tracking specific sources of anxiety.

**Role Conflict and Role Ambiguity Inventory**

A supervisee might simultaneously be a counselor, a student, a client, a supervisee, and a colleague. Each role has its own expectations and responsibilities. As the number of roles increases, a trainee might experience role ambiguity and potential role conflict. Role conflict can, in turn, increase anxiety (Nelson et al., 2008). Besides role conflict, role ambiguity also influences the effectiveness of supervision. Role ambiguity arises when there is a lack of clarity regarding the expectations for one’s role, the methods for fulfilling these expectations, and the consequences of effective or ineffective performance (Olk & Friedlander, 1992). For instance, reflecting on weaknesses can be helpful for supervisees’ learning, yet supervisees could be hesitant to disclose such information, fearing their supervisors might evaluate them poorly. Such ambiguity creates uncertainty in terms of how to appropriately respond.

The Role Conflict and Role Ambiguity (RCRA) Inventory was designed to address these concerns (Olk & Friedlander, 1992). It consists of 29 statements using a 5-point Likert-type scale for supervisees to self-evaluate levels of role conflict and ambiguity. Supervisors can assist supervisees in reviewing and discussing answers to specific questions, so that ambiguity and potential conflict can be identified and addressed. For example, there are questions designed to explore power differential issues in the supervisory relationship such as “the supervisor wanted me to use an assessment technique that I considered inappropriate for a particular client,” and “the feedback I got from my supervisor did not help me to know what was expected of me in my day to day work with clients.” It is useful for supervisors and supervisees to discuss these concerns before, during, and after the process of clinical supervision.

**Supervisory Working Alliance Inventory**

The foundation of the supervisory working alliance is built on three critical elements: a) agreement on goals, b) agreement on tasks leading to goal achievement, and c) the bonds between the supervisor and the supervisee (Bordin, 1983). Ladany, Ellis, and Friedlander (1999) described the supervisory working alliance as “one of the most important common factors in the change process of supervision.” The importance of the working alliance also applies to supervisory anxiety. The relationship between the two is well supported by empirical evidence (Kaib, 2010). In order to deal with supervisory anxiety, the strength of the working alliance must be considered.

Based on the supervisory working alliance literature, Efstation, Patton, and Kardash (1990) developed the Supervisory Working Alliance Inventory, which contains both a supervisor and supervisee form. Three subscores are included in the supervisor form: a) rapport, b) client focus, and c) identification. The measure includes a total of 33 items, using a 7-point Likert-type scale. The score for each subscale is calculated by the mean score, so that the score can be compared across different scales. Example questions include “I make an effort to understand my supervisee” and “I welcome my supervisee’s explanations about his/her client’s behavior.” The supervisee form contains only two subscales: a) rapport and b) client focus. A total of 19 items is included, using the same 7-point Likert-type scale. Example questions include “I feel comfortable working with my supervisor” and “my supervisor helps me talk freely in our sessions.” The scoring mechanism is identical to that of the supervisor form.

**Recommendations**

Clinical supervision has been found to reduce the burnout and turnover associated with professions that provide emotional caregiving, such as nursing (Koivu, 2013) and counseling (Ladany, Ellis, & Friedlander, 1999). To maximize these protective effects, supervisors can take some simple steps toward building supportive supervision, including: obtaining CS training, using supervisee assessments and contracts, and cultivating a strong supervisory working alliance.

**Effective Supervision Requires Training**

Training expectations and curricula are clearly delineated through accreditation standards and certification examinations in order to ensure appropriate utilization of counseling interventions and, fundamentally, to maintain client safety. As supervision is a specialized intervention in its own right (Bernard & Goodyear, 2014), it seems intuitive that a profession would not “turn untrained supervisors loose on those untrained therapists” (Watkins, 1997, p. 603). Rehabilitation counseling supervisors are mandated by their professional code of ethics to seek out and obtain training on supervisory practices (Glossoff & Matrone, 2010). As such, training on supervision would be best implemented in a two-part process, one specific to counseling students and the other designed especially for practicing supervisors. Supervision courses in master’s level training programs should include supervision models and skill acquisition techniques in order to equip learners with adequate knowledge and better prepare them for future positions as supervisors (Herbert & Bieschke, 2000; Scott, Nolin, & Wilburn, 2006). For example, Stoltenberg and Delworth’s Integrated Developmental Model (Maki & Delworth, 1995) has been suggested as an efficient way to conceptualize professional growth of both the counseling
students and the supervisors. Based on the model, supervisors would benefit from periodic skill reviews and development evaluations, in a similar way to all new professionals. Such reporting would allow for feedback and facilitate learning. In essence, providing supervision for supervisors would help to ensure professional development and quality, with a focus on balancing administrative and clinical supervision needs.

While the suggestion for increased clinical supervision training is not new (Herbert & Bieschke, 2000; Scott, Nolin, & Wilburn, 2006), it is difficult to implement without strong organizational support and cultural change at administrative levels, particularly within the state/federal vocational rehabilitation system (Sherman et al., 2014). Regardless of institutional guidelines, supervisors can individually choose to seek out training designed to improve their skills. With better knowledge and increased confidence, both supervisors and supervisees can be better consumers and providers of supervisory practices.

Effective Supervision Requires Familiarity with Tools

As it can be difficult to anticipate when anxiety will occur, supervisors need to be able to identify anxiety and understand how to respond to supervisee’s concerns. Fortunately, there are emotional and behavioral signs that point to excessive emotional arousal, and numerous instruments were created for the purpose of capturing these signs.

While the literature is lacking in guiding supervisors on how to identify potential anxiety in the relationship, there are studies illustrating typical behaviors an individual might display in an anxiety-provoking situation. For example, signs such as “move toward”, “move away”, and “move against” reactions are behavioral indicators that supervisors can pay attention to. An array of instruments is introduced to aid supervisory clinical judgement and better identify potential anxiety-producing situations. Intentional supervision entails appropriate selection and use of measures to identify and track anxiety over time. Effective supervisors should not only be familiar with these instruments, but also have knowledge of how to choose from them. Table 1 provides a list of some useful instruments.

Effective Supervision is Built on a Strong Working Alliance

The establishment of a strong working alliance has been found to increase supervisee satisfaction (Ladany, 2004). Such an alliance also impacts client outcomes, not just supervisor-supervisee relationships (Bezyak, Ososkie, Trice, & Yeager, 2010). Organizational and supervisory time and attention given to developing the bonds, goals, and tasks of a strong working alliance can substantially benefit counselors, supervisors, and clients. Wampold’s (2001) meta-analysis of working alliance notes a moderate effect (r = .28) on counseling outcomes. Even more powerful is the combination of counselor skill and working alliance, which accounts for 79% improvement in outcomes over those who did not receive counseling at all (Wampold, 2001). In addition, Horvath and Symonds (1991) describe working alliance as the key therapeutic ingredient in counseling, and O’Sullivan (2012, p. 218) states that the working alliance is the “primary function for therapeutic change for almost any helping relationship,” including supervisory relationships. Given the strong evidence for the efficacy and broad applicability of working alliance, it is clear that the working alliance can and should be used as an evidence-based practice in addressing the counseling needs of both clients and supervisees. Supervisors should integrate working alliance and Bernard’s Discrimination Model (1979) by remembering that they are not just teachers and consultants, but also counselors.

In addition, supervisors should draw healthy boundaries with supervisees by keeping counseling functions relevant to supervisees’ professional development, not individual therapeutic needs. While the effect of the working alliance can affect the role of supervisor as a counselor, it can also influence the role of supervisor as teacher. In fact, Ursano and colleagues (2007) posit that working alliance mitigates teaching barriers, including competition, fear, shame and anxiety. Kaib (2010) discovered a significant relationship between the working alliance and levels of anxiety in supervision, indicating that secure supervisor-supervisee attachment offers a protective effect on supervisees who experience non-productive anxiety. Her work shows both the positive and negative aspects of anxiety in supervision. Specifically, the study illustrates the power of the working alliance in mitigating excessive anxiety, and the unique temporal aspects of anxiety in supervision. Supervisee anxiety tends to be highest in the initial stages of the supervisory relationship; yet, Kaib (2010) postulates that this high initial anxiety is what primes attachment between supervisee and supervisor and helps to establish the alliance. In sum, working alliance affects anxiety across all three supervisory roles and, in turn, anxiety helps to drive a strong alliance.

Effective Supervision Requires Use of Supervisory Contracts

The supervisory working alliance consists of the agreed goals and tasks to be completed during the supervision process, as well as the strength of the relationship or bond between the supervisee and the supervisor (Bordin, 1983). The goals and tasks of supervision can be clearly outlined in the supervisory contract. Knowing the goals and tasks, and the evaluative measures used to analyze the realization of goals or completion of the associated tasks, will help to strengthen the bond between supervisee and supervisor. While the use of a supervisory contract has been strongly recommended (Bernard & Goodyear, 2014) for its utility in building a strong working alliance (McCarthy, 2013), and even identified as a component of the ethical delivery of supervision (Glosoff & Matrone, 2010), at present, rehabilitation counselor supervisors do not commonly utilize supervisory contracts. Furthermore, much of rehabilitation counselor supervision is provided on an as-needed, reactive basis, in which provision of a contract is unlikely to be considered (Herbert & Trusty, 2006; Schultz et al., 2002).

Without the stabilizing effect of codified expectations and goals that are readily available for reference in some type of
succinct and durable format, a rehabilitation counselor may be left wondering what exactly the supervisor is looking for in terms of growth and development. Moreover, the lack of a contract may signify that little forethought was given to the direction or implementation of the supervisory intervention, including evaluative components. This lack of clarity decreases the strength of the relationship between supervisee and supervisor, and increases anxiety related to evaluation.

Summary

While anxiety within the supervisory relationship is normal, its magnitude affects performance and relationships at the supervisory and practice levels (Bernard & Goodyear, 2014). The primary responsibility for the identification and reduction of anxiety related to the CS process rests with the supervisor. Supervisors can effectively manage both supervisees' and their own anxiety levels by first understanding the role of anxiety and cultivating an awareness of its influences, and then applying focused and intentional use of the various tools suggested in this article. Such efforts will help foster the development of a strong working alliance, which in turn impacts the counselor-client working alliance. It is hoped that the information presented in this article will provide supervisors with a fundamental understanding of anxiety's positive and negative effects on learning and performance, accessible tools to monitor and manage the supervisory relationship, and the primacy of managing anxiety in order to foster professional development.

Lastly, further research on supervision is warranted. For years, experts in the field have recognized the need for more supervisory training (Herbert & Bieschke, 2000), but little effort has been made in discussing the detail and content of the training. The dynamic, such as anxiety factors, of the years, experts in the field have recognized the need for more supervisory training (Herbert & Bieschke, 2000), but little training. The dynamic, such as anxiety factors, of the supervisory relationship, and the primacy of managing anxiety in order to foster professional development.

References


