Building the Pyramid that Leads to Clients' Progress: Supervision, Therapists'
Work and Client Alliance

by

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CHAPTER I

INTRODUCTION

Live Supervision

Live supervision has been used for clinical and training purposes for over forty years (Champe & Kleist, 2003). Supervision is part of many clinical professionals' training experiences, including marriage and family therapists (MFTs), social workers, psychologists, mental health professionals, and alcohol and drug addiction counselors. One requirement of accredited (Commission on Accreditation for Marriage and Family Therapy Educations) MFT Programs is to provide supervision, some of which can be video or "live" supervision (Silverthorn, Bartle-Haring, Meyer, & Toviessi, 2009). Supervision is the main tool that MFT supervisors use to help therapists learn how to implement systemic psychotherapy. It is also the means through which professional therapists upgrade their knowledge and skills (Duffy-Roberts, 1999). Live supervision provides trainees with immediate feedback and support. It creates meaning for those involved. Live supervision has been shown to make a difference for MFT therapists' progress level over the course of therapy sessions with clients (Silverthorn et al., 2009). The interventions used in this study that we hope will make a difference in therapist's competence is praise for effort.

Types of Praise/Praise for Effort

Different forms of praise could be utilized in supervision. According to Dweck (1999), *praise for effort* motivates people to continue upgrading their skills. People who have been *praised for effort* show more persistence on tasks. Hence, *praise for effort* could be another supervision tool, which could lead to clients' positive outcomes and therapist's self-perception of competence level.

Therapist Competence Level

Becvar and Becvar (2009) pointed out some of the components revealing MFT students' competence level. Becvar and Becvar's components were: proficiency in theoretical foundations of family therapy; human development and family studies; sexual functioning and psychopathology; therapeutic models and approaches; MFT values and ethics; supervised practica experiences; and practical work with clients with a systems perspective. Other researchers have looked at some of the skills that MFT practicing professionals valued as being important in the field (Cornille, McWey, Nelson, & West, 2003). MFTs underlined the importance of using diversity of therapeutic skills such as intellectual curiosity, accepting feedback from colleagues and supervisors, accepting other's perspective, changing treatment plans with new information, and being flexible. Other significant themes showing the competence level of MFT students were the ability to integrate personal and professional selves, increase motivation for learning, use resiliency skills, balance different strategies and awareness, and maintain boundaries (Coward, 1996).

Therapeutic Alliance

Positive client outcomes have been shown to be strengthened via the therapeutic relationship (Lipchik, 2002) and supervisory working alliance (Cheon, Blumer, Shih, Murphy, & Sato, 2009). Therapists strengthen the relationship by making positive comments, encouraging statements, greeting the clients with a smile, and using empathy. The developmental shifts in the quality of the relationship help the therapist navigate its emergent properties, therapeutic goals, and timing of interventions, which helps clients, accomplish their treatment goals (Arnd-Caddigan, 2012). Hence, supervision is useful in

terms of facilitating the creation of a strong therapist-client relationship, which could help clients achieve their goals over fewer sessions.

Study Importance

Although many helping professions have used the method of supervision for over forty years, there is little empirical evidence that it works (Silverthorn et al., 2009; Watkins, 2011). After doing a supervision effects review, Holloway and Neufeldt (1995) indicated that research showing how the supervision process influences the clients was nonexistent. Watkins (2011) looked at the studies from 1981 to 2006 and additional post-review studies from 2006 to 2011. He revealed that the collective data of these studies did not show more empirical information about how supervision contributes to patients' well-being. While there has been research on the benefits of live supervision for therapist's training, research that examines whether supervision can directly alter therapist behaviors and whether therapists' and clients' perceptions of their alliance can be influenced by live supervision are still lacking (Cheon et al., 2009).

Live supervision helps trainees learn new techniques, understand the process of therapy and their own self, address self-of-the-therapist and family of origin issues, while also managing the clients' context and working on clients' 'progress in therapy' (McCollum & Wetchler, 1995). Some researchers claim that alliance-focused supervision could enhance client perception of working alliance (Bambling, King, Raue, Schweitzer, & Lambert, 2006). These authors assumed that increased client-rated working alliance would provide the mechanisms by which supervision would enhance clients' symptom outcomes. There is a gap in the literature that needs to be filled in relation to how

supervision leads to higher level of perceived therapist competency and therapeutic alliance.

Theoretical Framework

The guiding theory for this study was General Systems Theory (GST). Ludwig von Bertalanffy (1973) introduced the idea that the system functions due to the interactions of its parts and their arrangements. Bertalanffy also introduced the concept of organism as an open system that maintains a new equilibrium through constant interaction with its parts. GST informed this study because I anticipated the supervision intervention would provide substantial positive feedback into the therapist-client system. Therefore, interrupting homeostasis and creating morphogenesis such as the system will reach a new equilibrium. Specifically, we hoped the supervision intervention would improve therapist's perception of competence, therapist's perception of therapeutic alliance, and client's perception of therapeutic alliance.

Purpose of the Study

The purpose of the study was to examine whether MFT live supervision, which utilizes Dweck's (1999) *praise for effort*, will make a difference in (1) the therapist's and client's scoring of their therapeutic alliance and (2) therapist's perception of competence. This study is important in the broader context of psychotherapy. Researchers have shown that when supervised therapists conceptualize cases with greater depth and complexity (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005), this results in a) fewer client drop-outs (Stein & Lambert, 1995); b) clients' better progress in therapy; c) therapists' and supervisors' better understanding of different aspects of supervision. This leads to clients' positive outcomes in treatment. Research questions and hypotheses for this study were

generated consistent with Dweck's (1999) theory and MFT supervision models. To effectively present this study, it is divided into two articles – Article 1: Building the pyramid that leads to clients' progress: Supervision, therapists' work and client alliance; and Article 2: How praise for effort in supervision can lead to supervisees' perception of high competency.

CHAPTER II

ARTICLE 1: BUILDING THE PYRAMID THAT LEADS TO CLIENT'S PROGRESS: SUPERVISION, THERAPISTS' WORK, AND CLIENT ALLIANCE

Abstract

The purpose of this study was to discover if MFT live supervision, which utilizes Dweck's (1999) *praise for effort*, makes a difference in the therapist's and client's scoring of their therapeutic alliance. The hypotheses for this study were tested with a single-case experimental design. Three single cases were explored and discussed separately in this study. The researcher designed an A-B-A phase implementation to supervision effects of *praise for effort* on clients' and therapists' perceptions of creating a stronger therapeutic alliance measured by the *Helping Alliance Questionnaire* (HA-qII) Client and Therapist version (Luborsky et al., 1996). Therapists and clients perceived therapeutic alliance level increased over time as a result of the *praise for effort* intervention used in supervision. The effect size of 102% for the client and 91% for the therapist indicated that the supervision intervention was very effective for both the client and therapist. The results supported the need for future research about supervision interventions, their direct effect on therapists' competence and their indirect effect on clients' outcomes.

Keywords: praise for effort, therapeutic alliance, therapist's work, supervision

Background

Supervision is important for therapists' professional development, and to ensure clients' maximum clinical outcomes. Some researchers have found that live supervision was effective for both trainees and clients (Kivlighan, Angelone, & Swafford, 1991). Others have suggested that live supervision could be detrimental to trainees' development (Lee & Everett, 2004). It is dangerous for researchers to automatically assume that supervision is helpful for both supervisees and clients without substantial research (Todd & Storm, 1997). Few researchers have assessed the extent to which clients perceive progress during the course of therapy (Champe & Kleist, 2003; Helmeke & Sprenkle, 2000).

Praise for Effort

Definition and effects of praise for effort. Muller and Dweck (1998) defined praise for effort as praising students for their efforts instead of their inner abilities or skills. They found that students who were praised for their effort when faced with failure showed increased motivation and persistence in performance. Students' choice to see failure as a challenge made them work harder toward achieving their learning goals. In addition, Cimpian, Arce, Markman, and Dweck (2007) revealed that students, who were praised for their effort showed fewer helpless behaviors after failure, were more persistent, and not willing to abandon tasks. Students who had been praised for their efforts were more likely to continue to upgrade their skills and were found to be in the high-achieving group of students. Kadieva and Kuehl (2011) conducted a survey of MFT students' recollections of their supervisors' use of two types of praise (praise for effort and praise for ability). Students received praise for effort (e.g., praise for using specific

behaviors or words) were more likely to have plans for continued therapy training than were those who were simply praised for being talented or doing great work (praise for ability). Let us now turn our focus from the supervision to the variable upon which we hope to be able to influence with supervision: therapeutic alliance.

Therapeutic Alliance

Definition. The therapeutic alliance has been described as consisting of three main components: “tasks, bonds, and goals” (Horvath, Gaston, & Luborsky, 1993, p. 252). Ackerman and Hilsenroth (2003) defined the therapeutic alliance as the “connection between two people that provides the opportunity for relief from suffering” (p. 28). They further described the alliance as “a pantheoretical construct impacting psychotherapy process in multiple levels” (p. 28). When a therapist worked with more than one person, the therapeutic alliance was expanded to include more people. The MFT therapist formed an alliance with each member of the family, with subsystems in the family, and with the family as a whole (Pinsof, 1995; Sprenkle, Blow, & Dickey, 1999). Sprenkle, Davis, and Lebow (2009) talked about therapeutic alliance as one of the essential common factors that enhanced the therapeutic process.

Effects of alliance. Arnd-Caddigan (2012) demonstrated that a strong therapeutic alliance was more important for the client in terms of treatment success than positive regard early in the treatment process. Lipchik (2002) also found that 80% of the clients said that they made significant improvement in therapy due to the strong therapeutic alliance with their therapists. It was discovered that what strengthened the therapeutic relationship was making positive comments, providing encouraging statements, and greeting the clients with a smile (Duffy-Roberts, 1999).

A strong therapeutic alliance was associated with increased treatment adherence and treatment effectiveness, enhanced efficiency in care, and improved outcomes among a variety of patient populations (Chinman, Allende, Bailey, Davidson, & Davidson 1999; Connors, Carroll, Di Clemente, Longabaugh, & Donovan 1997; Marziali & Alexander, 1991). Over three decades of psychotherapy research has consistently identified therapeutic alliance to be one of the most important factors in determining rates of attrition and outcome of treatment (Bachelor & Horvath, 1999; Horvath et al., 1993; Shahar et al., 2003, 2004; Solomon, Drain, & Delaney, 1995).

Supervision's Influence on the Therapeutic Alliance

Supervision was found to influence the working alliance between therapist and client and enhance clients' therapeutic progress (Patton & Kivlighan, 1997). Some researchers claimed that alliance-focused supervision could enhance client perception of the working alliance (Bambling, King, Raue, Schweitzer, & Lambert, 2006). Bambling et al. discovered that clients' supervised therapy allowed clients to create stronger alliance with their therapists and achieve significant reduction in depression symptoms. They also found that supervision could be used to strategically enhance client perception of the working alliance.

Freitas (2002) reviewed the literature and revealed that supervision influenced therapeutic alliance and clients' outcomes. However, he found serious methodological problems in the interpretability of the reported results (outcome measures with poor or even unknown psychometric properties). He made methodological suggestions for future research: 1) using sound psychometric measures to reduce Type I and Type II errors, 2) supervising individuals who have similar training backgrounds and level 3) assigning

clients to trainees randomly, 4) obtaining measures of clients' outcomes from multiple informants, 5) using therapists who are no longer in training. Callahan, Almstrom, Swift, Borja and Heath (2009) addressed the recommendations made by Freitas (2002). They observed that supervisors had a significant influence on the therapeutic alliance and clients' outcomes. Despite the rigor of their design, it generated a moderate effect. The supervision effect accounted for only 16% of the variance in clients' outcomes.

Previous research focused on the importance of establishing stronger therapeutic alliance; there is still a gap in the literature on using supervision in establishing stronger therapeutic alliance. In addition, there is a need for the use of a specific research design that can address methodological issues in the supervision literature.

The purpose of the present study is to reduce this gap in the professional literature and investigate if MFT live supervision, which utilized Dweck's (1999) *praise for effort*, would make a difference in the therapist's and client's scoring of their therapeutic alliance. The investigator is interested in the client's and supervised therapist's perceptions of the therapeutic alliance. This study was guided by two hypotheses. The first hypothesis was that clients working with a novice family therapist, who received supervision utilizing *praise for effort*, would report a stronger therapeutic alliance with their therapist. It is also hypothesized that a novice family therapist who received supervision with *praise for effort* would report having a stronger therapeutic alliance with her/his client.

Method

Participants

After this research project was approved by the appropriate Internal Review Board (IRB) the participants for the study were recruited. Therapist inclusion criteria were therapists currently enrolled full time in a large Southwestern American master's program, who had between 50 and 300 hours of therapy training. Therapists were made aware of this study via email through the program's administrative assistant. Volunteers contacted the primary researcher via email. The researcher reviewed the therapist's informed consent and answered questions. The first five therapists who signed informed consent became participants. Two therapists were dropped when their clients terminated therapy prior to completing this study. See table 1.1 for demographics of the therapists. There were no incentives for therapists to participate.

Individual clients were ruled out from participation if in their first session assessment they endorsed: suicide, violence, or psychosis on the *Brief Symptom Inventory's* (BSI). No attempts were made to obtain people of any particular ethnic identity, sexual orientation, or religion. Since individuals were not compared, a balanced participant pool was moot. New individual clients were told about the study in their first session. If clients were interested the primary researcher met with them after their first session to review informed consent. See table 1.2 for demographics for the clients. The incentive offered to the clients was six free sessions during the research process. Prior to the study the average cost of a session was \$20.00.

Procedure

Validation of intervention or no-intervention. Supervision sessions (brief discussions between the supervisor and therapist about the case) were conducted directly before the session, in the middle of the session, and after the session. Every supervision

session on all cases were digitally recorded. The primary researcher's dissertation chair renamed each session and removed the date stamp from each recording. Supervision sessions were coded so that the third member of the research team could know which three sessions went together, but not when the triad happened chronologically (ex: Lamp Pre, Lamp Mid, Lamp Post). Another member of the research team coded each triad for presence or absence of the supervision intervention using the guide in Appendix F (following rules found in Appendices D and E). Triads were coded for having used or not having used the intervention "praise for effort". If the third team member had questions, she received clarification from the dissertation chair so that the procedure remained masked and the primary researcher could proceed with analyses. The third team member affirmed all session one, two, five, and six supervision session had no "praise for effort" and that all sessions three and four did exhibit "praise for effort".

Research Design

The researcher used a single-case experimental design to demonstrate experimental control within three single cases (Kennedy, 2005). Although larger-scale studies are important and necessary, the method used in this study is particularly well suited for systems-oriented research in clinical settings (Oka & Whiting, 2013). Single-case experiment is a good fit for the research hypothesis of this study, because it has been shown to provide, "a strong basis upon which to assert the benefits of therapy" (Dickey, 1996, p.266). The single cases in this study consisted of an individual client and his/her therapist. The individual case was used as its own control. All conditions were kept the same, except for the independent variable (in this study, the IV was the supervision

intervention), which was introduced and then withdrawn to test the effects on the therapist's and clients' perception of the therapeutic alliance.

Although individual cases in single-case experiments are not compared, it was important that multiple cases were recruited for the study. Multiple cases were recruited to ensure successful completion of the research project and all three completed cases were reported. This study was marked by three phases: A-B-A (Anastas, 1999; Ray & Schottelcorb, 2010). In this A-B-A design, A denoted the baseline prior to intervention, B marked an intervention phase, and the second A was the follow-up phase after the intervention (Trepper, 1990; Morgan & Morgan, 2003; Kennedy, 2005). The alliance in both hypotheses is expected to go up and stay up due to the supervision intervention. Phase A2 scores would either go down below phase B scores or would stay the same as in phase B, after the supervision intervention is withdrawn.

Measures

Helping alliance questionnaire (HAQ-II). Both clients and therapists completed the revised version of the questionnaire designed originally by Luborsky, Crits-Christoph, Alexander, Margolin, and Cohen (1983) and revised by Luborsky et al. (1996). The *Helping Alliance Questionnaire* (HAQ-II) has 19 items rated on a 6-point Likert-type scale used to assess the client's alliance with the therapist, ranging from 1 (strongly disagree) to 6 (strongly agree). Luborsky et al. reported that the scale's reliability was strong for both clients ($\alpha = .93$) and therapists ($\alpha = .95$). Improvement rates after the third session were significantly correlated with improvement rates after the sixth session ($r = .39, p < .01$), and with less complaint distress, ($r = -.26, p < .05$). Scores that fall below 86 show poor alliance and scores that fall above 86 show good alliance.

Data Collection

Data collection occurred in three phases: a) baseline phase (A1), b) intervention phase (B), c) and follow-up phase (A2). Data collection points were once a week for a total of six weeks research weeks one through six corresponded to therapy sessions two through seven. For all self-report data the client remained in the room in which the therapy session had taken place and the therapist completed her data in another room. Baseline (A1 phase, research sessions one and two) data included the therapist and client completing the *Helping Alliance Questionnaire* (Haq-II) Client and Therapist versions. The first two sessions were collection of baseline and no supervision was used (phase A1). During both A1 and A2 the primary researcher provided generic structural supervision without “praise for effort”. Supervision with *praise for effort* was used during the third and fourth week of the study (phase B). The guidelines for supervision without *praise for effort* and supervision with *praise for effort* were strictly followed from the supervision checklists (see appendix D, E, and F).

Data Analysis

In this single-case study experimental design analysis, the “real difference” in observations examined looking for change from the two baseline points and the two intervention periods. The Percentage of Non-overlapping Data (PND) statistic is used to test for significant change (Anastas, 1999; Ray & Schottelcorb, 2010). The PND statistic analyses whether differences among the A1, B, and A2 data points represents no, low, medium, or high change. Data were then graphed to show the scores on each measure at every data collection point. These points were connected to create a line showing the trends in measurement over time and between baseline and intervention periods.

Baseline assessment. A preintervention level of performance (natural state) was defined for each of the research measures during A1 using highest baseline points in order to compare with the intervention phase (Kazdin, 2003; Anastas, 1999; Ray & Schottelcorb, 2010). If the baseline already clearly demonstrated a trend going upward or downward, this would indicate that the therapeutic alliance with the therapist was already getting better or worse, and the case could not have been used. This did not happen in this study.

Visual analysis of data. Although multiple methods of single-case analysis exist, visual analysis is the most widely accepted method (Kennedy, 2005; Ray & Schottelcorb, 2010). For the data analysis of the hypotheses, the single-case experimental researcher visually inspected the level, trend, and variability of the data of the baseline phase in comparison to the intervention phase. To assess for change, the researchers compared the level of the baseline with the level of the intervention phase. Finally, Kennedy, Ray and Schottelcorb observed and described the variability of the total scores from the research measures.

Percentage of non-overlapping data statistic (PND). A quantitative analysis as an adjunct to the visual analysis was used. For the analysis, the researcher used the calculation of the PND statistic, because it has been a widely accepted and utilized means of quantifying the single-case experimental design data (Anastas, 1999; Ray & Schottelcorb, 2010). The percentage of data in the intervention and follow-up phases that did not overlap with the highest data point of the baseline phase was calculated. The number of points with a numerical value higher than the highest baseline data points were added up and divided by the total number of points. This percentage was the effect size

statistic that was used to determine the effectiveness of the intervention. PND of less than 50% was considered ineffective, 50-70% indicated questionable effectiveness, 70-90% was an effective intervention, and greater than 90% was a very effective intervention.

Results

Participants

A total of five clients and five therapists were recruited. Throughout the research process two clients dropped out. Three female clients and three therapists completed all the phases of the study and met the inclusion criteria. All three completed single cases are discussed separately without being compared with each other in the results section. The study was conducted at a large Southwestern University.

Results for Case # 1

Establishing a baseline. As previously explained, two supervision sessions served as the two baseline data points. The client in week 1 scored 97.98, and in week 2, she scored 93.98 on the HAQ-II Client version. The therapist in week 1 scored 78.98, and in week 2, she scored 84.98 on the HAQ-II Therapist version. Because variability was minimal in scores up to week 2, and the baseline was stable at this point, the researcher decided to move forward with performing the intervention.

Visual analysis of data. Total scores from each of the research measures for the supervision case example were graphed and displayed with figures (Figure 1.1). The baseline for the client trended downward during week 2. When the intervention was performed, it trended upward. After the intervention was removed, it trended downward. The baseline for the therapist trended slightly upward and continued to trend upward during the intervention phase, but went downward when the intervention was removed.

PND statistic. PND statistic was used as an adjunct to the visual analysis (Anastas, 1999; Ray & Schottelcorb, 2010). For the client and therapist in case #1, the level of each phase increased over time. For the client, the level in phase A1 was 95.98, in phase B was 100.9, and in phase A2 was 100.48 (Table 1.1). For the therapist, the level in phase A1 was 81.98, in phase B was 89.48, and in phase A2 was 92.48 (Table 1.2). This increase in level for the client and therapist indicated that over time the therapeutic alliance increased. In addition, the trend of the data indicated a moderate upward trend and moderate variability. The highest data point of the baseline phase, which for the client was 97.98 and for the therapist was 84.98, were utilized for comparison. The researcher used the effect size to determine the effectiveness of the intervention. The effect size of 102% for the client and 91% for the therapist indicated that the supervision intervention was a very effective intervention for both the client and therapist and led to an increase in the level of therapeutic alliance.

Results for Case # 2

Establishing a baseline. Two supervision sessions served as the two baseline data points. The client in week 1 scored 98.98, and in week 2, she was 102.98 on the HAQ-II Client version. The therapist in week 1 scored 97.98, and in week 2, she was 96.98 on the HAQ-II Therapist version. Because variability was minimal in scores up to week 2, and the baseline was stable at this point, the researcher decided to move forward with performing the intervention.

Visual analysis of data. Total scores from each of the research measures for the supervision case example were graphed and displayed with figures (Figure 1.2). In this single-case experimental study, the baseline for the client trended upward during week 2.

When the intervention was performed, it continued to stay up. After the intervention was removed, it continued to stay consistently at the same level. The baseline for the therapist trended slightly downward in week 2 and went drastically upward during the intervention phase, but it went slightly upward when the intervention was removed in week 5 and went drastically down in week 6.

PND statistic. For the client in case #2, the level of data from phase A1 to B increased, but it remained the same from phase B to A2. The level in phase A1 was 100.98, in phase B was 102.98, and in phase A2 was 102.98 (Table 1.1). This increase in level for the client indicated that the therapeutic alliance with the therapist increased from phase A1 to phase B, but then it remained the same in phase A2 as compared to phase B. In addition, the trend of the data was a straight horizontal line and didn't indicate a moderate upward trend and moderate variability. For the therapist, the level of each phase increased over time. The level in phase A1 was 97.48, in phase B was 100.98, and in phase A2 was 100.48 (Table 1.2). This increase in level for the therapist indicated that over time the therapeutic alliance with the client increased. In addition, the trend of the data indicated a moderate upward trend and moderate variability. The highest data point of the baseline phase, which for the client was 102.98 and for the therapist was 96.98, were utilized for comparison. For the client, all the values after week 2 were again 102.98, so there were no higher values that could be added together. The effect size of 0% for the client and 101% for the therapist indicated that the supervision intervention was not an effective intervention for the client, but it was a very effective intervention for the therapist.

Results for Case # 3

Establishing a baseline. Two supervision sessions served as the two baseline data points. The client in week 1 scored 95.98, and in week 2, she was 96.98 on the HAq-II Client version. The therapist in week 1 scored 72.98, and in week 2, she was 74.98 on the HAq-II Therapist version. Because there was no great variability in scores up to week 2 and the baseline was stable at this point, the researcher decided to move forward with performing the intervention.

Visual analysis of data. Total scores from each of the research measures for the supervision case example were graphed and displayed with figures (Figure 1.3). In this single-case experimental study, the baseline for the client trended slightly upward during week 2. When the intervention was performed, it trended downward for week 3, and it went upward for week 4. After the intervention was removed, it trended slightly upward for week 5 and went slightly down for week 6. The baseline for the therapist trended slightly upward in week 2, went down during the intervention phase for week 3, and went drastically upward during week 4. It continued to trend upward when the intervention was removed in week 5 but went downward in week 6.

PND statistic. For the client in this study, the level of each phase increased over time. The level in phase A1 was 96.48, in phase B was 97.48, and in phase A2 was 100.98 (Table 1.1). This increase in level for the client indicated that over time the therapeutic alliance that the client perceived to have with the therapist increased. In addition, the trend of the data indicated a moderate upward trend and moderate variability. For the therapist, the level decreased during the intervention phase and increased again once the intervention was removed. The level in phase A1 was 73.98, in phase B was 71.98, and in phase A2 was 78.98 (Table 1.2). This decrease in level for the therapist

indicated that throughout the intervention phase the therapeutic alliance that the therapist perceived to have with the client decreased. In addition, the data indicated a moderate downward trend during the first week of the intervention. The highest data point of the baseline phase, which for the client was 96.98 and for the therapist was 74.98, were utilized for comparison. The effect size of 101% for the client and 81% for the therapist indicated that the supervision intervention used in this study was an effective intervention for both the client and therapist.

Discussion

The purpose of this study was to investigate if MFT live supervision, utilizing Dweck's (1999) *praise for effort*, makes a difference in both the therapist's and client's perception of their therapeutic alliance. A carefully controlled single-case experimental study design was used. It was hypothesized that clients working with a novice family therapist who received supervision utilizing Dweck's (1999) *praise for effort* would report a stronger therapeutic alliance with their therapist on the *Helping Alliance Questionnaire* (HAQ-II) than in phase A1 of the single-case experimental design. It was also hypothesized that a novice family therapist who received supervision with *praise for effort* would report having a stronger therapeutic alliance with their clients on the *Helping Alliance Questionnaire* (HAQ-II) than in phase A1. The alliance in both hypotheses was expected to go up and stay up due to the supervision intervention. Because cases in single-case experimental design could not be compared with each other the three different cases were discussed separately.

Case #1 provided strong support for both hypotheses. This case showed a significant upward trend for both the therapist and client on the HAQ-II and an increase in

terms of their therapeutic alliance over time. It also showed that the supervision intervention utilizing Dweck's (1999) *praise for effort* was a very effective intervention. It was interesting that after the intervention was removed for the client, the therapeutic alliance went down and then went slightly up for the last session. The PND statistic showed that this was an effective change due to the intervention. For the therapist, when the intervention was removed, the therapeutic alliance stayed up and went slightly up, which could be due to some intervention residual effects. However, the alliance went down in the last session, and the PND statistic discovered that this was a very effective difference for the therapist.

Case # 2 provided a partial support for the hypotheses of the researcher. The client's trend went up during the intervention stage and stayed up, which was hypothesized by this researcher. However, the client continued to provide the highest alliance score possible according to the HAQ-II in every session, so this researcher could not calculate the PND statistic and received an effect size of 0%. This showed an increase in the level of alliance the client and therapist had, but did not show that the intervention used in this study was effective. This might be due to the fact that the client wanted to rate her therapist's work with the highest scores possible after every session. The therapist showed a significant upward trend in terms of her level of alliance with the client. It was interesting that the trend for the therapist went slightly up right after the intervention was removed. This could be due to some intervention residual effects. The trend clearly went down and drastically down during the last session. As a result, this researcher could argue that the supervision intervention was very effective for the therapist.

Case #3 provided partial support for the research hypotheses. According to the PND statistic, the *praise for effort* intervention used in supervision was found to be a very effective intervention for both the client and therapist. However, the visual analysis of data showed a slight downward trend in terms of the therapeutic alliance for both the client and therapist during the first week when the intervention was introduced. So, the researcher could not argue that this was an effective intervention. This slight downward trend could be a result of any number of factors, such as an uncomfortable session or the need of the therapist to warm up to the intervention. The PND statistic took this slight downward shift into an account and still showed that the intervention was effective for the therapist. This was an extremely interesting finding.

The findings from these three separate cases revealed that Dweck's (1999) *praise for effort* utilized in supervision helped clients and therapists build a strong therapeutic alliance over just two intervention sessions. Case #1 strongly supported both hypotheses of this study. Both the client and therapist reported having a stronger therapeutic alliance on the HAq-II. The supervision intervention was found to be a very effective one.

Interpreting the effect size of this study as compared to previous ones was complicated. There were numerous effect size measures used in single-case experimental studies, but these have not had similar interpretations (Parker et al., 2005). The literature was examined for supervision studies utilizing the PND statistic, but no other supervision-related studies were found using the PND statistic in order to measure the effect size of supervision interventions. Furthermore, there have not been other studies that have clearly supported the effectiveness of such interventions used in MFT supervision. While there has been research on the benefits of live supervision for

therapists' training, research that examines whether supervision can directly alter therapists' behaviors and whether therapists' and clients' perceptions of their alliance can be influenced by live supervision are still lacking (Cheon et al., 2009). Many helping professions have been using supervision for more than forty years, but researchers have not found a statistically significant support for its effectiveness (Silverthorn et al., 2009; Watkins, 2011). The PND statistic revealed that the supervision intervention utilizing Dweck's (1999) *praise for effort* was a very effective intervention for both the client and therapist, and it led to an increased level of therapeutic alliance.

For all the three different cases we looked at the clinical and teaching significance of PND statistic by looking at the scales' scores, whether they started with a low, medium or high score of therapeutic alliance. Looking at the scales' cutoff score of 86, below 86 is considered poor alliance and above is considered good alliance. For the clients, in all three cases the baseline scores started in the 90s, so they started with good therapeutic alliance. Hence, even when the PND score showed effective intervention it is hard to interpret whether there is a clinical significance. For the therapist, in two of the cases the baseline score started in the 70s range, so these therapists started with poor alliance and moved into good alliance after the intervention. Hence, for these two therapists the intervention showed an improvement in therapeutic alliance in a manner that demonstrated teaching significance (an idea parallel to clinical significance).

Researchers have found that making positive comments and using encouraging statements during supervision strengthened the therapeutic relationship (Duffy-Roberts, 1999). However, no previous researchers have examined Dweck's (1999) *praise for effort* in MFT supervision. This study revealed that for the participants *praise for effort*

added to supervision facilitated a stronger therapist-client relationship. Prior researchers have found that a strong therapeutic alliance helps clients achieve their goals, rate the treatment process in a more positive way, and be more willing to complete the whole treatment process (Bambling et al., 2006).

Implications for Practice

Given that this is a pilot study, the findings and implications of this study should be interpreted tentatively:

1. Supervisees are often disappointed and demotivated by direct identification of performance deficits during supervision (Briggs et al., 1999). Dweck's (1999) *praise for effort* can help students focus their efforts on particular skills and recognize that they are making progress in a specific area such as building the therapeutic alliance with their clients. That is why it is so important that MFT supervisors attend to the way they praise their supervisees.
2. It has been found that supervision could enhance clients' therapeutic progress by directly influencing the working alliance between therapist and client (Patton & Kivlighan, 1997). Dweck's (1999) *praise for effort* could lead to clients' treatment progress by increasing the level of therapeutic alliance. Clinicians should attend to the positive effects of this supervision intervention for both the therapist and client.
3. Supervision researchers usually do not have the funding nor the time for extensive large-scale research studies. In addition, many practicing professionals are more interested in observing if an intervention makes a change for their individual client. So, researchers could use single-case experimental study design in order to

investigate the effectiveness of a supervision intervention and the more meaningful clinically significant change for an individual person.

Limitations and Recommendations for Future Research

The participants were asked to complete a questionnaire where the supervisees and clients answered questions about their therapeutic relationship based on self-perception. The supervisees and clients might have given an overly positive response called social desirability bias. Volunteers are often different from non-volunteers (Patel, Doku, & Tennakoon, 2003). Participation in research has been found to improve client outcomes. A combination of self-reported questionnaire and microanalysis is recommended for future studies in order to avoid such a bias. Microanalysis is defined as detailed and reliable examination of observable communication sequences as these are taking place, moment to moment, in video-recorded dialogue (McGee, Del Vento, & Bavelas, 2005).

A final limitation of this study was the researcher's involvement in the research project. This introduced some level of experimenter bias. The lead researcher participated in the selection of the instrument, collection of data, delivery of the intervention, and data analysis. The lead researcher strongly believed in the effectiveness of the supervision intervention, which may have introduced bias.

In conclusion, despite the limitations of this study it is still meaningful; because when Dweck's (1999) *praise for effort* is used in supervision it can improve therapists' and clients' therapeutic alliance.

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Table 1.1

Final Phase Protocol for Supervision with Praise for Effort for the Therapist HAq-II scores

Demographics	Week	1	2	3	4	5	6
Therapists	Intervention	No	No	Yes	Yes	No	No
Caucasian	Case #1	78.98	84.98	88.98	89.98	93.98	90.98
AfricanAmerican	Case #2	97.98	96.98	100.98	100.98	101.98	98.98
Caucasian	Case #3	72.98	74.98	66.98	76.98	84.98	72.98

Table 1.2

Final Phase Protocol for Supervision with Praise for Effort for the Client HAq-II scores

Demographics	Week	1	2	3	4	5	6
Clients	Intervention	No	No	Yes	Yes	No	No
Hispanic	Case #1	97.98	93.98	99.98	101.98	97.98	102.98
Caucasian	Case #2	98.98	102.98	102.98	102.98	102.98	102.98
Hispanic	Case #3	95.98	96.98	93.98	100.98	101.98	99.98

Figure 1.1 Case 1 Direct Observation Form Ratings of the Supervision with Praise for Effort Intervention Across all the Three Phases

Figure 1.2 Case 2 Direct Observation Form Ratings of the Supervision with Praise for Effort Intervention Across all the Three Phases

Figure 1.3 Case 3 Direct Observation Form Ratings of the Supervision with Praise for Effort Intervention Across all the Three Phases

CHAPTER III

ARTICLE 2: HOW PRAISE FOR EFFORT IN SUPERVISION CAN LEAD TO A SUPERVISEES' PERCEPTION OF HIGH COMPETENCY

Abstract

The researchers examined whether live supervision, which included Dweck's (1999) *praise for effort*, would make a difference in the therapist's perception of her competency level. The researchers used single-case experimental design. For the outcome variable, items from the *Family Therapy Skills Checklist* (Briggs, Fournier, & Hendrix, 1999), shortened to the therapist-only perspective were used to measure beginning MFT therapists' competence level. Three separate single cases were explored and discussed in this research project. In all of these cases according to the visual analysis of data, there was an increase in the therapist's perceived competence level. However, the PND statistic yielded results with questionable effectiveness in all three cases. Suggestions for future research are discussed.

Keywords: clinical competency, praise for effort, supervision, supervisees, systemic training

Background

Live supervision is a training technique in which experienced therapists observe new therapists' performance in the therapy room with clients, and provide critiques and suggestions in order to help therapists develop their competence and ensure client's safety and progress (Mead, 1990). Researchers have found that live supervision helps trainees to learn new techniques, understand the process of therapy, and to address self-of-the-therapist and family of origin issues (McCollum & Wetchler, 1995). Supervision was designed to help supervisees develop a theory of "good therapeutic practice" (Duffy-Roberts, 1999). Supervisors and senior trainers have specified competencies that trainees had to acquire at each level of their professional development (intervention, diagnosis, assessment, attention to diversity and ethics, and program evaluation) (Nelson & Johnson, 1999).

Some researchers have demonstrated that live supervision was effective for both trainees and clients (Kivlighan, Angelone, & Swafford, 1991; McCollum & Wetchler, 1995). While others have suggested that live supervision could negatively impact trainees' development (Lee & Everett, 2004). There is a limited body of research for the empirical benefits of supervision on therapists' training (Ellis & Ladany, 1997; Milne & James, 2000). Hence, there remains a need for more research on the supervision-therapy process. This study examined *praise for effort* as a supervision intervention.

Praise for Effort

In 1998 Muller and Dweck defined praise for effort as praising people for their efforts rather than their inner abilities or skills. In their research, students who were praised for their effort when faced with failure, and chose to see it as a challenge, showed

increased motivation and persistence. Later in 2007 Cimpian, Arce, Markman, and Dweck found that students, who had been praised for their efforts exhibited fewer helpless behaviors after failure, and were more likely to continue to upgrade their skills. Kadieva and Kuehl (2011) conducted a survey of MFT students' perceptions of their supervisors' use of praise (praise for effort and praise for ability). Students who had received praise for effort (e.g., praise for using specific behaviors or words) reported more plans for continued therapy training than were those who had been praised for their innate talents (praise for ability). Let us now examine the research on therapist's self-perception of competence.

Therapist Competence Level

Definition. Some of the components revealing MFT students' competence level were: students demonstrating proficiency in areas such as theoretical foundations of family therapy with a focus on systems perspective, human development and family studies with emphasis on individual and family development, sexual functioning and psychopathology, the many therapeutic models and approaches, MFT values and ethics, supervised practicum experience, and practical work with clients utilizing a systems perspective (Becvar & Becvar, 2009).

Other researchers looked at some of the skills that MFT students and practicing professionals valued as important in the field (Cornille, McWey, Nelson, & West, 2003). MFTs underlined the importance of using diversity of therapeutic skills and taking on both a collaborative and expert position. Some of the additional skills that the MFTs found important were intellectual curiosity, accepting feedback from colleagues and supervisors, accepting other's perspective, changing treatment plans with new

information, and being flexible. This study showed that an important part of MFT students' competence level was accepting their supervisor's feedback, being flexible, and upgrading their skills in combining an expert and collaborative position.

Other significant themes showing the competence level of MFT students were found to be the integration of personal and professional selves, increased motivation for learning, using resiliency skills, balancing different strategies and awareness, and maintaining boundaries (Coward, 1996). The interaction between events, awareness, developmental motivation, and resiliency showed MFTs higher competence level. In addition, Coward's (1996) study showed that MFT supervision served as a map for therapists during their journey of upgrading their competence level.

Without first insuring that therapists were delivering competent treatment, clinicians cannot contribute any differences in client outcome to the treatment clients received (Roth, Pilling, & Turner, 2010). The impact of deviation in treatment has been widely recognized by researchers and clinicians, who have taken steps to address this deviation by offering ongoing supervision and monitoring the delivery of specific interventions (Roth & Fonagy, 2005). Avis and Sprenkle (1990) did an extensive review of the MFT training literature, after which they stated, "One of the most urgent needs is for the development of more valid and reliable instruments with which to measure changes in trainees' skills" (p.262). Considering that all other trainees' measures have focused on the supervisor's perception of the therapist's competency level (Pinsof 1979; Piercy, Laird, & Mohammed, 1983; Brenlin, Schwarts, Krause, & Shelby, 1983; Nelson & Johnson, 1999; Eriksen & McAuliffe, 2003), the current study's purpose is to contribute to the efforts of researchers and clinicians by focusing closely on the

therapist's perception of her/his competency level. It also has the goal to observe one individual case over time and investigate if MFT live supervision, which utilized Dweck's (1999) *praise for effort*, would make a difference in the therapist's perception of her/his competency level. The researcher is interested to see if a MFT therapist in training who received *praise for effort* would show higher levels of competence on the *Family Therapy Skills Checklist* (Briggs et al., 1999), which has been shortened to the therapist-only perspective (modified FTSC). This study hypothesized that a MFT who received supervision utilizing *praise for effort* would show higher level of competence on this modified FTSC. The therapist's competency level in this hypothesis is expected to go up and stay up due to the supervision intervention. Phase A2 scores would either go down below phase B scores or would stay the same as in phase B, after the supervision intervention is withdrawn.

Method

Participants

The project was approved by the university's Internal Review Board (IRB). Then the therapist participants were recruited. Therapists were currently enrolled full time in a large Southwestern American MFT master's program. They had provided between 50 and 300 hours of therapy. Therapists were informed about this study from an email sent to them from the program's administrative assistant. Volunteers emailed their interest to the researcher. The researcher conducted the informed consent. The first five therapists who agreed to the informed consent became participants. Two therapists did not complete the protocol and their results were not examined. Therapists received no incentives for their participation. See table 2.1 for demographic information.

Procedure

Supervision discussions between the researcher and the therapists were done directly before the session, in the middle of the session, and after the session. Each supervision session was digitally recorded. The dissertation chair relabeled each session name and deleted the date stamp. Sessions were renamed so that a third research team member would evaluate the pre, mid, and post sessions, but not know the date. This third member of the team evaluated each group of supervision sessions for the presence or absence of the supervision intervention using the form located in Appendix F and followed the rules found in Appendices D and E. The third team member affirmed all session one, two, five, and six supervision sessions had no “praise for effort” intervention and that all sessions three and four displayed the “praise for effort” intervention.

Research Design

The researchers used single-case experimental study design to attain experimental control within each of the three cases (Kennedy, 2005). Researching therapists’ interventions with clients, Dickey (1996, p. 266) found “a strong basis upon which to assert the benefits of therapy” Hence, single case experimental design fit well to examine whether a supervision intervention would influence the therapist (Oka & Whiting, 2013). Each individual case served as its own control. In the two supervision sessions before and after the intervention sessions all conditions were controlled as much as possible. Although in single-case experimental design individual cases in single-cases are not compared, several cases were recruited to ensure at least one case completed all of the research protocol. Since three cases completed, all three cases are reported.

This study utilized three phases: A-B-A (Anastas, 1999; Ray & Schottelcorb, 2010). In this A-B-A design, A1 served as the two session baseline prior to intervention, B was the two session intervention phase, and A2 was the two session follow-up phase (Trepper, 1990; Morgan & Morgan, 2003; Kennedy, 2005).

Measures

Family Therapy Skills Checklist. The *Family Therapy Skills Checklist* (FTSC) created by Briggs et al. (1999) and shortened to therapist-only perspective (modified FTSC) was used to evaluate therapists' competency level. This scale had 20-items. These had for purpose to measure the trainees' therapeutic proficiency on a 5-point Likert-type Scale, ranging from 1 (Work Area) to 5 (Strength), with 3 (Acceptable). This checklist was comprised of three domains: Conceptual, Behavioral, and Professionalism. Sample statements included, "Recognizes family strengths," "Formulates systemic hypotheses," "Appropriately uses AAMFT ethical guidelines," and "Comes prepared for individual and group supervision." The internal consistency reliability of the scale was $\alpha=.98$. The first subscale, Conceptual Skills, consisting of six items had $\alpha=.95$. The second subscale, Behavioral Skills, consisting of seven items had $\alpha=.94$. The seven items of the third subscale, Professionalism had $\alpha=.93$. The author used the cutoff point of 13 times 3 which equals 39 as the cut off score of acceptable. Scores can range from 13 to 65 with higher scores indicating better perceived therapist competence level.

Data Collection

This single-case experimental design used three data collection phases: a) baseline (A1), b) intervention (B), and c) follow-up (A2). Data collection points were once a week for a total of 6 weeks. Baseline collection started after the intake session and was

measured following the therapist-only portion of the *Family Therapy Skills Checklist* (FTSC, see Appendix B). Structural supervision without the intervention was used in this phases A1 and A2. Supervision with *praise for effort* was used during phase B. The rules for supervision without *praise for effort* and supervision with *praise for effort* were strictly followed from the supervision checklists (see appendices D and E). After every therapeutic session, starting at phase A1 the therapists completed the therapist portion of the FTSC. The first time they filled out this questionnaires, they provided their gender, ethnic identity and year in the program.

Data Analysis

The “real difference” between the baseline, intervention, and follow-up phases was examined by the visual analysis and the percentage of non-overlapping data statistic (PND) to determine whether the intervention produced evidence of an effective change in the outcome variable (Anastas, 1999; Ray & Schottelcorb, 2010). Data were graphed to show the score on the FTSC measure at each data collection point. These points were connected by a line to show the trend over time among baseline, intervention, and follow-up phases.

Visual analysis of data. Several types of single-case analysis exist; visual analysis is the most widely and accepted method (Kennedy, 2005; Anastas, 1999; Ray & Schottelcorb, 2010). The level, trend, and variability of the data across baseline, intervention, and follow-up phases were visually inspected. There was a noticeable upward trend. The researcher will describe the variability of the total scores from the research measure for each case in the results section.

PND statistic. The calculation of the PND statistic was performed by the researcher for each case. This statistical method allows for comparison of research data within the case and guards against low reliability and Type I error (Campbell & Herzinger, 2010). The PND analysis examines the number of points higher than the highest baseline A1 data point. These points were added up and divided by the total number of points. This percentage produced an effect size and was used to measure the effectiveness of the supervision intervention. A PND below 50% is ineffective, between 50-70% is questionably effective, between 70-90% reflects an effective intervention, and higher than 90% denotes a very effective intervention.

Results

Participants

The study took place in a family therapy master's program in a large Southwestern American University. Five therapists started the research protocol. Three female therapists of whom two were White and one identified as African American completed all three phases of the study. All the three completed single cases will be discussed separately in the results section.

Results for case # 1

Establishing a baseline. As it was explained in the methods section, two supervision sessions served as the baseline points. The therapist in week 1 scored 55, and in week 2, scored 54 on the FTSC. There was no great variability in scores up to week 2 and the baseline was stable at this point, so the researcher decided to move forward with performing the intervention.

Visual analysis of data. The graphed total scores from the research measure were displayed with figures (Figure 2.1). In this single-case experimental study, the baseline for the therapist was trending downward during week 2. When the intervention was performed it trended upward for week 3 and 4. After the intervention was removed it trended downward for week 5 and went upward in week 6. As a result, this researcher could argue that the supervision intervention was effective and led to an increased competency level for the therapist.

PND statistic. For the therapist, the level of each phase increased over time. In phase A1, the level was 54.5, in phase B was 57.5, and in phase A2 was 60.5 (see dotted line in Figure 2.1). This increase in level for the therapist indicated that over time the competency level that the therapist perceived to have increased. In addition, the trend of the data indicated a moderate upward trend and moderate variability. The highest data point of the baseline phase, which was 55, was utilized for comparison. The values of week 4-60, week 5-59, and week 6-62 were added together and divided by the total number of higher numbers (in this case 3) and the researcher received an effect size percentage of 60% (Table 2.1).The effect size of 60% indicated that the supervision intervention had questionable effectiveness.

Results for case # 2

Establishing a baseline. Two supervision sessions served as a baseline phase. The therapist in week 1 scored 54, and in week 2, scored 57 on the FTSC. There was no great variability in scores up to week 2 and the baseline was stable at this point, so the researcher decided to move forward with performing the intervention.

Visual analysis of data. The graphed total scores from each of the research measures for the supervision case example were displayed with figures (Figure 2.2). In this single-case experimental study, the baseline for the therapist started trending upward during week 2. When the intervention was performed it continued to trend upward for week 3 and 4. After the intervention was removed it remained at the same level for week 5 and week 6. As a result, this researcher could not argue that the supervision intervention was effective and led to increased competency level for the therapist.

PND statistic. For the therapist, the level of each phase increased over time. In phase A1, the level was 55.5, in phase B was 62, and in phase A2 was 65 (see dotted line in Figure 2.2). This increase in level for the therapist indicated that over time the competency level that the therapist perceived to have increased. In addition, the trend of the data indicated a moderate upward trend and moderate variability. The highest data point of the baseline phase, which was 57, was utilized for comparison. The values of week 3-60, week 4-64, week 5-65, and week 6-65 were added together and divided by the total number of higher numbers (in this case 4) and the researcher received an effect size percentage of 63.5% (Table 2.1). The effect size of 63.5% for the therapist indicated that the supervision intervention had questionable effectiveness.

Results for case # 3

Establishing a baseline. Two supervision sessions served as a baseline phase. The therapist in week 1 scored 52, and in week 2, scored 56 on the FTSC. There was no great variability in scores up to week 2 and the baseline was stable at this point, so the researcher decided to move forward with performing the intervention.

Visual analysis of data. The graphed total scores from each of the research measures for the supervision case example were displayed with figures (Figure 2.3). In this single-case experimental study, the baseline for the therapist trended upward during week 2. When the intervention was performed it trended downward for week 3 and went drastically upward for week 4. After the intervention was removed it went downward for week 5 and slightly upward for week 6. As a result, this researcher could not argue that the supervision intervention was effective and led to increased competency level for the therapist.

PND statistic. For the therapist, the level of each phase increased over time. In phase A1, the level was 54, in phase B was 55.5, and in phase A2 was 56.5 (see dotted line in Figure 2.3). This increase in level for the therapist indicated that over time the competency level that the therapist perceived to have increased. In addition, the trend of the data indicated a moderate upward trend and moderate variability. The highest data point of the baseline phase, which was 56, was utilized for comparison. The values of week 4-63 and week 6-59 were added together and divided by the total number of higher numbers (in this case 2), and the researcher received an effect size percentage of 61% (Table 2.1). The effect size of 61% for the therapist indicated that the supervision intervention had questionable effectiveness.

Discussion

The purpose of this study was to investigate if the therapist competency level increased as a result of Dweck's (1999) *praise for effort* used in MFT supervision. A carefully controlled single-case experimental study design was utilized. It was hypothesized that an MFT who received supervision with Dweck's (1999) *praise for*

effort would show higher levels of perceived competence on the *Family Therapy Skills Checklist* (Briggs et al., 1999), shortened to the therapist-only portion. The PND statistic in all three single cases showed questionable effectiveness and could not provide a strong support for the research hypothesis. As a result, this researcher could not argue that the supervision intervention was effective.

Reviews of the training and supervision literature have revealed a need for establishing the therapists' competency level in order to allow supervisors to provide supervisees with the specific feedback they need. In 1983, Piercy, Liard and Mohammed formulated the *Family Therapist Rating Scale* as an evaluation tool to be scored by supervisors. Since then a lot of different scales have measured therapists' competency level from the supervisors' perspective. However, this study focused closely on the therapist's perception of her competency level. It also observed one individual case over time to see how Dweck's (1999) *praise for effort* intervention influenced the competency level of the therapist. *Praise for effort* intervention has not been used before in MFT supervision and there were no previous findings that it can lead to an increase in the therapist's competency level. More research is needed to discover why this supervision intervention had questionable effectiveness in terms of the therapist's perceived competency level.

Implications for Practice

Given that this is a pilot study, the findings and implications of this study should be interpreted tentatively. Students who were *praised for effort* were found to be interested in upgrading their skills (Dweck, 1999; 2006; 2007). Hence, MFT supervisors should consider using *praise for effort* in order to help therapists learn and upgrade their

skills. Supervisees were often disappointed by direct identification of performance deficits during supervision (Briggs et al., 1999). They reported that the best supervisors provided specific feedback on their strengths and limitations. *Praise for effort* could help students focus their efforts on particular skills. While supervisees still might have the sense that they have so much more to learn, *praise for effort* could help them recognize that they are making some progress in specific skill areas. That is why it is so important that MFT supervisors attend to the way they praise their supervisees. Effective supervision is considered critical by trainers and educators in order to establish an individual's therapeutic proficiency and competency level.

Limitations and Recommendations for Future Research

The participants completed a self-reported questionnaire and their responses might have reflected social desirability bias. A second limitation was the researcher's involvement in this study and limited research team involvement. A team of trained researchers who can split the work on the project is recommended for future studies in order to minimize bias in the study.

In conclusion, the *praise for effort* intervention and the interaction between the supervisor and therapist led to a somewhat higher perceived competency level for the therapist, but not enough to indicate meaningful significance. The goal of the present study was to fill a gap in the MFT supervision research literature. More research is needed in order to produce effective findings.

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Table 2.1

Final Phase Protocol for Supervision with Praise for Effort for the Therapist FTSC-scores

Demographics	Week	1	2	3	4	5	6
Therapists	Intervention	No	No	Yes	Yes	No	No
Caucasian	Case #1	55	54	55	60	59	62
AfricanAmerican	Case #2	54	57	60	64	65	65
Caucasian	Case #3	52	56	48	63	54	59

Figure 2.1 Case 1 Direct Observation Form Ratings of the supervision with Praise for Effort Intervention Across all Three Stages

Figure 2.2 Case 2 Direct Observation Form Ratings of the supervision with Praise for Effort Intervention Across all Three Stages

Figure 2.3 Case 3 Direct Observation Form Ratings of the supervision with Praise for Effort Intervention Across all Three Stages

CHAPTER IV

CONCLUSION

In order to help fill the research gap mentioned in the introduction of this dissertation, two studies were conducted. These provided relevant theoretical and clinical information about the effectiveness of an intervention utilizing Dweck's (1999) *praise for effort* in MFT supervision and its influence on the therapeutic relationship and therapist's competency level. The first study explored whether clients working with a novice family therapist who received supervision utilizing *praise for effort* would report a stronger therapeutic alliance with their therapist on the *Helping Alliance Questionnaire* (HAQ-II) than in either phases A1 or A2 of the single-case experimental study design. The second study examined whether MFT live supervision utilizing *praise for effort* would make a difference in the therapist's perception of her/his competency level. The therapeutic alliance and therapist's competency level were expected to go up and stay up due to the supervision intervention. This was a pilot study, which revealed that *praise for effort* is an effective supervision intervention for the therapist when examining therapeutic alliance.

Supervisors and therapists have used positive comments and encouraging statements in order to strengthen the therapeutic relationship (Duffy-Roberts, 1999). However, Dweck's (1999) *praise for effort* intervention has not been used before in MFT supervision. No other studies have supported the effectiveness of such an intervention used in MFT supervision. In addition, no other supervision studies have used the PND statistic in order to measure the effect size of a supervision intervention. This was a unique discovery that helps to begin to fill a gap in the research literature.

There was a clear need in the research literature for establishing whether or not using a supervision intervention could lead to a stronger therapeutic alliance that could result in clients' positive treatment outcomes and retention rate. Supervision has been used for more than forty years, but there was little empirical evidence that it works (Silverthorn et al., 2009; Watkins, 2011). There was also a need for establishing the therapists' competency levels in order to allow supervisors to provide supervisees with the specific feedback they need. There have been a lot of different scales used for measuring therapists' competency levels from the supervisor's perspective. However, this study had for its purpose to focus closely on single-case experimental study design and observe one therapist over time to see how the *praise for effort* intervention influenced the competency level of this therapist. This intervention has not been used before in MFT supervision and there were no previous findings that it could lead to an increase in the therapist's competency level.

The findings of this study are meaningful for supervisors, therapists, and clients. This study revealed that supervision utilizing Dweck's (1999) *praise for effort* directly influences the working alliance between therapist and client, which could potentially lead to clients' treatment progress by increasing the level of therapeutic alliance. More research is needed in this direction. This researcher plans to explore in the future the effects of *praise for effort* on clients' outcomes and observe if supervision utilizing *praise for effort* positively influences clients' treatment progress in fewer therapeutic sessions.

Although the *praise for effort* supervision intervention didn't yield clear effectiveness in increasing the therapist's competency level, this researcher strongly believes it could help students focus their efforts on particular skills and recognize that

they are making progress in a specific area. That is why it is so important that MFT supervisors attend to the way they praise their supervisees. This researcher plans to repeat this study in the future and observe if the *praise for effort* supervision intervention would yield different results.

General Systems Theory (GST) was used as a guiding framework for both studies. Ludwig von Bertalanffy (1973), introduced the idea that the system functions due to the interactions of its parts and their arrangements. In this dissertation, Dweck's (1999) *praise for effort* intervention and the interaction between the supervisor, therapist, and client led to a stronger therapeutic alliance and questionable higher competency level for the therapist. Bertalanffy's concept of the organism as an open system that achieves a new equilibrium through constant interaction with its environment was also supported by the findings of this study mentioned above.

This dissertation suggested that supervision interventions such as Dweck's (1999) *praise for effort* can be very effective interventions for both the therapist and client and can lead to a stronger therapeutic alliance. This may result in better therapeutic environments, more positive treatment outcomes for the clients, lower dropout rates, and better therapeutic progress over fewer sessions (Bambling et al., 2006). This dissertation is a part of a long-term goal of researching more about MFT supervision, different supervision interventions, and how these influence both the clients and therapists, and could potentially lead to more positive treatment outcomes over fewer therapeutic sessions. There is a huge gap in the literature in terms of supervision research and I would like to contribute by using unique intervention ideas, which could help to fill this gap.

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APPENDIX A: Informed Consent Forms

SUPERVISION, THERAPIST COMPETANCY, AND THERAPIST-CLIENT ALIANCE

INFORMED CONSENT FORM FOR THE THERAPISTS

INSTITUTION: MFT Doctoral Program, Department of Community, Family, & Addiction Services, Texas Tech University, Lubbock, Texas 79409-1250

Principal Investigator: Anne M. Prouty, Ph.D.

Co-Principal Investigator: Violeta Kadieva, Ph.D. Candidate

Co-Principal Investigator: Douglas Smith, Ph.D.

1. Why is this study being done?

The researcher wishes to examine whether supervision utilizing praise for effort can make a difference in therapists' perception of competency and whether therapist's and client's perception of their alliance can be influenced by live supervision utilizing praise for effort.

2. What will happen during this study?

We are completing the informed consent now. After this, we will arrange to begin the research of six therapy sessions, **all six will focus on the therapist's receiving live supervision with praise for effort**. All six therapy sessions must be done in "Bay" room in the FTC. In the beginning of the research process the researcher will collect demographic data such as gender, age, ethnic identity, year in program, # therapy hours completed do date.

Research Therapy "supervision as usual" Session 1:

The pre-session supervision "as usual" will be conducted and videotaped. At the end of the session, with about 5 to 10 minutes left of the hour Ms. Kadieva will administer the two research questionnaires to the therapist and the single research questionnaire to the clients. The clients are then free to leave. The post-session supervision "as usual" session will be conducted.

Research Therapy "supervision with praise for effort" Session 2:

The pre-session supervision will be conducted and videotaped by Ms. Kadieva. The 30-minute therapy break for supervision will be conducted and videotaped by Ms. Kadieva. Ms. Kadieva will administer the three research questionnaires as per Session #1. The post-session supervision will be conducted by Ms. Kadieva.

Research Therapy "supervision as usual" Session 3: Repeat of Session 1.

3. How much time will this study take?

It would be done using six therapeutic sessions. The supervision and therapy session will follow the same time-frame as already outlined by the practicum course. The two questionnaires will be completed at the 50-minute mark and should not extend the session beyond the usual therapist break time prior to the normally scheduled post-session supervision.

4. What are the risks or discomforts to me if I join this study?

The risks to people are no more than you would encounter in everyday life and a typical practicum class.

5. Are there any benefits to me if I take part in this study?

There are no personal benefits.

6. What other choices do I have if I don't take part in the research study?

Taking part in this study is your choice. You do not have to take part in this study. If at any time you decide not to be in the study, it will not affect you or your training experience in any way.

7. What about confidentiality and the privacy of my records?

Beyond being observed to participate with the class by any peers who are present, we will keep your involvement in this research study confidential to the extent permitted by law. The videotaped data will be kept on the MFT server in this researcher's M-drive folder and if that is not enough for FERPA then on the P drive under Dr. Prouty's named folder. In addition to the staff carrying out this study, others may learn that you are in the study if you tell them and if the study materials are audited by the TTU Human Rights Committee. The auditor will see your signature but will not have access to more information.

Study results that are used in publications or presentations will not use your name.

All transcripts and Consent to Participate forms will be kept confidentially in Dr. Anne Prouty's office in a locked cabinet for 4 years. No one beyond the research team and the IRB ethics review team will have access to these materials. Data will be deidentified (no names or case numbers) before analysis proceeds and will be kept on password protected computers in Dr. Prouty's and Ms. Kadieva's offices.

8. Will I receive anything for taking part in this research study? No

9. Does anyone on the research staff have a personal financial interest in this study? No

10. What if I have questions?

For questions about this study, contact the Investigators, Ms. Violeta Kadieva, at (608) 738-6403, Dr. Anne Pouty (voice mail only) (806)742-3060 extension477, or Dr. Doug Smith at 742-3060 extension 224.

If you would like to speak to someone who is not involved in the study about your rights as a participant, or any other matter related to the study, you can call the TTU Research Protection Chair, Dr. Rosemary Peggram: (806)742-3050 ext. 264

Your signature indicates that this research study has been explained to you, that you've been given the opportunity to ask questions, and that you agree to take part in this study. You will be given a signed copy of this form.

Printed Name of Therapist

Signature of Therapist

Date

Violeta Kadieva, Ph.D. Candidate and Co-PI

Date

SUPERVISION, THERAPIST COMPETANCY, AND THERAPIST-CLIENT ALIANCE

INFORMED CONSENT FORM FOR THE CLIENTS

INSTITUTION: MFT Doctoral Program, Department of Community, Family, & Addiction Services, Texas Tech University, Lubbock, Texas 79409-1250

Principal Investigator: Anne M. Prouty, Ph.D.

Co-Principal Investigator: Violeta Kadieva, Ph.D. Candidate

Co-Principal Investigator: Douglas Smith, Ph.D.

1. Why is this study being done?

Ms. Kadieva is doing a brief research study about therapist training and the therapist-client relationship.

2. What will happen during this study?

Your therapist will continue to work on the goals you have agreed upon together. At the end of each of the six therapy sessions, you and your therapist will complete a very brief set of questions about how you feel about the session and your therapist. This should only take 1-2 minutes. Also, you will be asked to give permission for your anonymous demographic information from the FTC intake assessment to be used in this research.

3. How much time will this study take?

Your participation will not exceed the time it takes to do six 50-minute therapy sessions plus the two minutes to complete the brief end-of-session questionnaire at the end of all six therapy sessions.

4. What are the risks or discomforts to me if I join this study?

The risks to people are no more than they encounter in everyday life and an average therapy session.

5. Are there any benefits to me if I take part in this study?

There are no personal benefits.

6. What other choices do I have if I don't take part in the research study?

Taking part or not in this study is your choice. You do not have to take part in this study. If at any time you decide not to be in the study, it will not affect the therapy offered to you by the Family Therapy Clinic nor affect any of your rights.

7. What about confidentiality and the privacy of my records?

We will keep your involvement in this research study confidential to the extent permitted by law. In addition to the staff carrying out this study, others may learn that you are in the study if you tell them and if the study materials are audited by the TTU Human Rights Committee. The auditor will see only your signature but will not have access to any more information about your participation.

Study results that are used in publications or presentations will not use your name(s).

All data and Informed Consent to Participate forms will be kept confidentially in Dr. Anne Prouty's office in a locked cabinet for 4 years. No one beyond the research team and the IRB ethics review team will have access to these materials. Data will be deidentified (no names or

case numbers) before analysis proceeds and will be kept on password protected computers in Dr. Prouty's and Ms. Kadieva's offices.

8. Will I receive anything for taking part in this research study?

There will be six free sessions of therapy provided for clients/couple who complete the six sessions of the research study and all six "therapy alliance" brief research questionnaires. These six sessions are to use at your discretion, within three months, at the Family Therapy Clinic at Texas Tech.

9. Does anyone on the research staff have a personal financial interest in this study? No

10. What if I have questions?

For questions about this study, contact the Investigators, Ms. Violeta Kadieva, at (608) 738-6403, Dr. Anne Pouty (voice mail only) (806)742-3060 extension477, or Dr. Doug Smith at 742-3060 extension 224.

If you would like to speak to someone who is not involved in the study about your rights as a participant, or any other matter related to the study, you can call the TTU Research Protection Chair, Dr. Rosemary Peggram: (806)742-3050 ext. 264

Your signature indicates that "I give permission for my anonymous demographic information from the FTC intake assessment to be used in this research" and this research study has been explained to you, that you've been given the opportunity to ask questions, and that you agree to take part in this study. You will be given a signed copy of this form.

Printed Name of Therapist

Signature of Therapist

Date

Violeta Kadieva, Ph.D. Candidate and Co-PI

Date

APPENDIX B

Family Therapy Skills Checklist

Shortened due to Therapist-only Perspective

Name:
Semester:
Year:

	Work Area		Acceptable		Strength
	1	2	3	4	5
<u>During THIS session I was able to</u>					
_____ Focus the interview.					
_____ Control structure/interactions during session.					
_____ Establish the therapeutic contract with family.					
_____ Keep the family connected with the therapy process.					
_____ Handle toxic or high intensity issues sensitively.					
_____ Design and carry out appropriate interventions.					
_____ Recognize and comment on individual or family strengths					
_____ Language presenting problems in family terms with clients					
_____ Use systemic understanding of family problems to formulate interventions					
_____ Appropriately apply AAMFT ethical guidelines					
_____ Arrive prepared to use supervision before, during, and after my session					
_____ Incorporate input from supervision during session					
_____ Make use of mid-session break					
_____ Total for this session					

APPENDIX C

Client # _____ (assigned by Ms. Kadieva)

Date: _____

Session Number at FTC _____

Session Number with this therapist _____

Helping Alliance Questionnaire- Client Version

These are ways that a person may feel or react toward another person-their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. Please mark everyone.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. I feel I can depend upon the therapist	1	2	3	4	5	6
2. I feel the therapist understands me.	1	2	3	4	5	6
3. I feel the therapist wants me to achieve my goals.	1	2	3	4	5	6
4. At times I distrust the therapist's Judgment.	1	2	3	4	5	6
5. I feel I am working together with the therapist in a joint effort	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of my problems.	1	2	3	4	5	6
7. I generally respect the therapist's views about me.	1	2	3	4	5	6
8. The procedures used in my therapy are not well suited to my	1	2	3	4	5	6

needs.						
9. I like the therapist as a person.	1	2	3	4	5	6
10. In most sessions, the therapist and I find a way to work on my problems together.	1	2	3	4	5	6
11. The therapist relates to me in ways that slow up the progress of the therapy	1	2	3	4	5	6
12. A good relationship has formed with my therapist.	1	2	3	4	5	6
13. The therapist appears to be experienced in helping people.	1	2	3	4	5	6
14. I want very much to work out my problems	1	2	3	4	5	6
15. The therapist and I have meaningful exchanges.	1	2	3	4	5	6
16. The therapist and I sometimes have unprofitable exchanges.	1	2	3	4	5	6
17. From time to time, we both talk about the same important events in my past	1	2	3	4	5	6
18. I believe the therapist likes me as a person.	1	2	3	4	5	6

19. At times the therapist seems distant.	1	2	3	4	5	6
---	---	---	---	---	---	---

Therapist ID _____ (Assigned by Ms. Kadieva) Date: _____

How many semesters of clinical experience did you complete prior to starting this program _____

Circle Practicum Semester:

M1- 1 2 3 4

D1- 1 2 3 4

M2- 1 2 3 4

D2- 1 2 3 4

Helping Alliance Questionnaire-Therapist Version

These are ways that a person may feel or react toward another person-their therapist. Consider carefully your relationship with your patient, and then mark each statement according to how strongly you agree or disagree. Please mark everyone.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. The patient feels he/she can depend upon me.	1	2	3	4	5	6
2. He/she feels I understand him/her.	1	2	3	4	5	6
3. The patient feels I want him/her to achieve the goals.	1	2	3	4	5	6
4. At times the patient distrusts my judgment.	1	2	3	4	5	6
5. The patient feels he/she is working together with me in a joint effort.	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of his/her problems.	1	2	3	4	5	6
7. The patient generally respects my views about	1	2	3	4	5	6

him/her.						
8. The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	1	2	3	4	5	6
9. The patient likes me as a person.	1	2	3	4	5	6
10. In most sessions, we find a way to work on his/her problems together.	1	2	3	4	5	6
11. The patient believes I relate to him/her in ways that slow up the progress of the therapy.	1	2	3	4	5	6
12. The patient believes a good relationship has formed between us.	1	2	3	4	5	6
13. The patient believes I am experienced in helping people.	1	2	3	4	5	6
14. I want very much for the patient to work out his/her problems.	1	2	3	4	5	6
15. The patient and I have meaningful exchanges.	1	2	3	4	5	6
16. The patient and I sometimes have unprofitable exchanges.	1	2	3	4	5	6

17. From time to time, we both talk about the same important events in his/her past.	1	2	3	4	5	6
18. The patient believes I like him/her as a person.	1	2	3	4	5	6
19. At times the patient sees me as distant.	1	2	3	4	5	6

APPENDIX D

Rules for Analysis of Supervision without Praise for Effort

Supervision without Praise for effort includes questions, statements, formulations, suggestions, etc. by the supervisor that focus on safety, context, process, and strengths. Examples of these can include the supervisors' comments or questions about:

- identifying behavior sequences between therapist and clients
- identifying behavior sequences between client and client
- directing the therapist to change the problematic process

The following are specific examples of supervision without praise for effort. The examples may fit in one or more of the above forms of safety, context, process, and strengths.

Example 1: identifying behavior sequences between therapist and clients

S: When the client does this.... what do you do?

T: I used this technique.

Example 2: identifying behavior sequences between client and client

S: How did this client react to what his/her partner said?

T: I noticed that the client reacted emotionally to....

Example 3: directing the therapist to change the problematic process

S: What do you see yourself doing here? Is it what you typically do in such situations? You want this to be different so how can things be different here? What can you do differently?

T: Yes, I noticed I do... I plan to do.... next time.

APPENDIX E

Rules for Analysis of Supervision with Praise for Effort Intervention

Praise for effort includes questions, statements, formulations, suggestions, etc. by the supervisor that focus on the therapist efforts (e.g. efforts in upgrading skills, using specific techniques, therapist's way of working with the client). Examples of these can include the supervisors' praise for effort comments or questions about:

- the therapist developing his/her skills
- the therapist working on a specific technique (s)
- the therapist working with the client on what has been helpful for the client
- the therapist working on providing hope and optimism for the clients
- the therapist working on helping the client achieve his/her therapeutic goals

The following are specific examples of praise for effort. The examples may fit in one or more of the above forms of praise for effort (e.g., efforts in upgrading skills, using specific techniques, therapist's way of working with the client).

Example 1: praise for effort about the therapist developing his/her skills

(Dweck, 1999, Ch. 16 "Praising intelligence: More Praise that Backfires")

T: I have been working on developing my.... (for example, "joining skills")

S: I can clearly see that "you must have worked hard" (Dweck, 1999, p.117)

Example 2: praise for effort about the therapist working on a specific technique (s)

(Weaver et al., 2003, "The effects of ability-and effort-based Praise on task persistence and task performance")

T: I have been working on practicing the way I use..... (for example, "sparkling moments")

S: "I can tell you are trying your best" (Weaver et al., 2004, p. 363)

Example 3: praise for effort for the therapist working on what has been helpful for the client

(Dweck, 2006, Ch. 7" Sending Messages about Process and Growth)

T: The client mentioned that has been useful for her, so we have been working more on...

S: "You put so much thought into this. It really makes me understand it in a new way" (Dweck, 2006, p.172)

Example 4: praise for effort about the therapist working on providing hope and optimism for the clients

(Dweck, 2006, Ch. 7” Sending Messages about Process and Growth)

S: “How do you feel when you” notice that you have succeeded to provide the clients with a sense of hope and optimism (Dweck, 2006, p.172)

T: I feel....

S: I can clearly see the hard work you put into this. (Dweck, 2006)

Example 5: praise for effort about the therapist working on helping the client achieve his/her therapeutic goals

(Dweck, 2006, Ch. 7” Sending Messages about Process and Growth)

S: Tell me about what treatment goals you have established with the clients and how you have started working on these!

T: We have been working on the following therapeutic goals....

S: It seems like these goals were somewhat broad in the beginning and the clients seemed a little bit uninvolved. “I really admire the way you” have succeeded to narrow these down and engaged the clients to start working on these. (Dweck, 2006, p.172)

APPENDIX F

Kadieva Dissertation Supervision Video Checklist

Evaluator: [graduate student's name here]

Date of evaluation:

Therapist Id: [1-3]

Video: [Dr. Prouty coded with nonsense name to disguise date of session; e.g. Tree Pre, Tree Mid, Tree Post]

Indicators of Supervision WITH Praise for Effort:

☐ Praise for effort about the therapist developing his/her skills

☐ Praise for effort about the therapist working on a specific technique (s)

☐ Praise for effort for the therapist working on what has been helpful for the client

☐ Praise for effort about the therapist working on providing hope and optimism for the clients

☐ Praise for effort about the therapist working on helping the client achieve his/her therapeutic goals

☐ **NONE of the above were observed – this session did not include *praise for effort* statements**