Received 07/07/15
Revised 02/24/16
Accepted 02/26/16
DOI: 10.1002/ceas.12044

An Exploration of Supervisory and Therapeutic Relationships and Client Outcomes

Hope Bell, W. Bryce Hagedorn, and E. H. Mike Robinson

The authors explored the connection between the facilitative conditions present within the supervisory relationship, the therapeutic relationship, and client outcomes. A correlational research design was used with a sample of 55 counselors-in-training and 88 clients. Results indicated a significant positive relationship between the therapeutic relationship and client outcomes and a significant negative relationship between the supervisory relationship and client outcomes.

Keywords: therapeutic relationship, counselor supervision, client outcomes

The supervisory relationship parallels the therapeutic relationship in many ways, and as the therapeutic relationship is critical to counseling, the supervisory relationship is critical to supervision (Bernard & Goodyear, 2009). Conditions such as trust, empathy, respect, and genuineness form a foundational part of the supervisory relationship (Ladany, Ellis, & Friedlander, 1999; Moses & Hardin, 1978; Muse-Burke, Ladany, & Deck, 2001; Pearson, 2000). Thus, there is a strong similarity between the supervisory relationship and the therapeutic relationship. Counseling and supervision have an isomorphic relationship: The patterns, structure, and content repeat themselves in different but parallel domains (Liddle & Saba, 1983). This *parallel process*, as it is now known, is a strong indicator of the tie between supervision and counseling. Given the centrality of relationships to both the supervisory and therapeutic processes, it is important to understand how these processes interact on all the parties involved.

Although the influence of the therapeutic relationship on client outcomes has strong empirical support (e.g., Duncan & Moynihan, 1994; Horvath, Del Re, Flückiger, & Symonds, 2011; Lambert & Barley, 2001), little is known about the impact of the qualities of the therapeutic relationship (also known as the *facilitative conditions*) that may be present within the supervisory relationship and how these qualities may affect client outcomes. One might surmise that a strong presence of the facilitative conditions within the supervisory relationship would serve as a model for counselors-in-training. If the modeling of the facilitative conditions is present during supervision, it may increase the chance that a strong therapeutic relationship in counseling will be created, which, in turn, would increase the likelihood of positive client outcomes. However, this inference has up until this point been only

Hope Bell, Department of Counseling, University of Texas at San Antonio; W. Bryce Hagedorn and E. H. Mike Robinson, Department of Child, Family and Community Services, University of Central Florida, Orlando. Correspondence concerning this article should be addressed to Hope Bell, Department of Counseling, University of Texas at San Antonio, 501 West Cesar E. Chavez Boulevard, DB 4.328, San Antonio, TX 78207-4415 (e-mail: hope.bell@utsa.edu).

speculation. Using Rogers's (1957) facilitative conditions to characterize a therapeutic relationship, and grounding the study in his person-centered theory (Rogers, 1957), we examined the relationship between supervisees' perceptions of the facilitative conditions in the supervisory relationship, clients' perceptions of the therapeutic relationship, and how these relationships affected client outcomes.

Research on the Facilitative Conditions and the Therapeutic Relationship

Carl Rogers was the first to hypothesize and research the importance of the therapeutic relationship in detail, and he subsequently performed research on the components of the relationship (Kirschenbaum & Jourdan, 2005). To build a strong therapeutic relationship, Rogers (1957) proposed facilitative conditions he believed to be both necessary and sufficient for client change. These conditions included (a) psychological contact between a counselor and a client; (b) the counselor's congruence or genuineness; (c) the counselor's unconditional positive regard for the client; (d) the counselor's empathy for the client; and (e) the client's perceptions of the counselor's genuineness, unconditional positive regard, and empathy.

The facilitative conditions and their importance within the therapeutic relationship have been widely researched throughout the past 50 years (Kirschenbaum & Jourdan, 2005). Barrett-Lennard (1962) conducted one of the first studies that measured clients' and counselors' perceptions of empathic understanding, level of regard, congruence, and willingness to be known. His results showed that counselors viewed the therapeutic relationship slightly more positively compared with their clients, indicating that clients' perceptions of the therapeutic relationship were not as positive as those of counselors. These results lent initial support to the idea that the client's perception of the relationship is more central to client change than the therapist's perception. Overall, this seminal study set a precedent for studying clients' perceptions of the therapeutic relationship, launching decades' worth of research (Barrett-Lennard, 2002).

Following Barret-Lennard's research in the 1960s, Truax and Mitchell (1971) conducted a meta-analysis of 14 studies and found 66 statistically significant correlations between positive client outcomes and the facilitative conditions of empathy, unconditional positive regard, and genuineness. Later, Lambert and Barley (2001) examined 100 studies focused on client outcomes and concluded that common factors, made up of such things as empathy, warmth, and the therapeutic relationship, accounted for 30% of client outcomes, whereas other constructs such as therapeutic technique and client expectations each accounted for only 15% of client outcomes. More recently, in a meta-analysis focused solely on empathy and client outcomes, Elliott, Bohart, Watson, and Greenberg (2011) analyzed 224 tests of the empathy–outcome relationship and found an overall weighted correlation of .30. In addition, Horvath et al. (2011) conducted an in-depth meta-analysis of 200 research studies on the therapeutic alliance (which they

used as a synonym for the therapeutic relationship) and found a statistically significant correlation. They described the relationship between alliance and outcome as robust to emphasize the important role of the therapeutic relationship in client outcomes (Horvath et al., 2011). One can conclude from the aforementioned research that the importance of the therapeutic relationship—and the facilitative conditions used to build the relationship—remains central to client change.

Research on the Supervisory Relationship

Although the facilitative conditions are not the only dynamics making up the supervisory relationship, researchers in supervision have suggested that the qualities of the therapeutic relationship are a necessary and critical component for building a supervisory relationship in counselor supervision and development (Bernard & Goodyear, 2009; Rønnestad & Skovholt, 1993). Researchers have consistently illustrated the importance of the supervisory relationship to supervisees (e.g., Bernard & Goodyear, 2009; Lambie & Sias, 2009; Rønnestad & Skovholt, 1993). When asked about the significant incidents in supervision (i.e., the incidents that most critically influenced their development), most supervisees focused on aspects of the supervisory relationship (Ellis, 1991), thus indicating that the supervisory relationship is an important part of supervision.

Many factors can influence the development of the supervisory relationship, such as supervisor and supervisee personalities, cultural factors, and gender (Bernard & Goodyear, 2009). Although every relationship is distinctive, several authors have suggested that the techniques used to build the therapeutic relationship (i.e., empathy, unconditional positive regard, and respect) may also be used to build the supervisory relationship (Rønnestad & Skovholt, 1993). For example, McCarthy, Kulakowski, and Kenfield (1994) found that more than 40% of their sample of supervisees rated supervisory characteristics such as empathy, trustworthiness, unconditional positive regard, and genuineness to be the most helpful aspects of supervision. In addition, Shanfield, Mohl, Matthews, and Heatherly (1992) found supervisor empathy to be the greatest predictor of effective counselor supervision. Therefore, a more in-depth focus on the elements of therapeutic relationship building during supervision may be key to unlocking the counselor's potential to deliver sound therapeutic services.

Research on Client Outcomes

Measuring the effectiveness of counseling has progressed over the decades and is now a much more complex concept than simply comparing clients in treatment with those not receiving treatment. Beyond the aforementioned research on the therapeutic relationship and client outcomes, many factors were examined in searching for connections between extratherapeutic variables and counseling effectiveness, such as counselor attributes, anxiety levels of clients, social support, and the aforementioned therapeutic relationship

(Ahn & Wampold, 2001; Barrett-Lennard, 1962; Leibert, Smith, & Agaskar, 2011). In addition, given that counselors often overestimate client progress (Walfish, McAlister, O'Donnell, & Lambert, 2012), more formal feedback mechanisms are needed to accurately assess for therapeutic gains. Such client outcome measures would allow counselors to monitor client progress and bring attention to those clients whose progress may be stuck or declining. This process, in turn, would spur counselors to use new interventions or address relationship ruptures that may be contributing to client decline, thus decreasing the likelihood of continued decline and increasing the chance of positive outcomes (Lambert & Shimokawa, 2011). Therefore, measuring client outcomes is essential to client welfare and for furthering research on factors that may affect client outcomes. However, client outcomes, as they are affected by supervision, remain an area rarely explored and one ripe for investigation.

Purpose of the Study

Given the importance of the therapeutic relationship on client outcomes, and the potential impact of the supervisory relationship on such outcomes, the purpose of this study was to examine the connections between three variables: qualities of the therapeutic relationship between supervisors and counselors-in-training, the therapeutic relationship between counselors-in-training and their clients, and client outcomes. We used a correlational research design to assess for bivariate correlations and the predictive ability of the independent variables of supervisory relationship and therapeutic relationship on the dependent variable of client outcomes (Fraenkel & Wallen, 2009). The four research questions guiding the study were as follows:

Research Question 1: Is there a relationship between the quality of the supervisory relationship (as perceived by supervisees) and the quality of the therapeutic relationship (as perceived by the clients of these supervisees)?

Research Question 2: Is there a relationship between the quality of the therapeutic relationship and client outcomes?

Research Question 3: Is there a relationship between the quality of the supervisory relationship and the supervisees' client outcomes?

Research Question 4: How well do the quality of the supervisory relationship and the quality of the therapeutic relationship predict client outcomes?

Method

Procedure

The institutional review board (IRB) of the university at which the research was conducted approved this study. Participation was voluntary for both clients and counselors-in-training. All participants were recruited in person: We recruited the counselors-in-training (who received no incentive), and clients were recruited through their counselors-in-training after we offered

training on client recruitment. In addition, counselors-in-training were given the informed consent document to present to clients when requesting their participation. The university's IRB, clinic director, and faculty members of the affiliated counseling program approved this procedure. Beyond the data routinely collected by the clinic, data were not collected for counselors-in-training and clients who chose not to participate in this study. The identities of both groups of participants were protected by removing all of their identifying information. To qualify for this study, client participants attended at least five sessions but could have attended more. The five-session minimum was essential, because the instrument measuring symptom change was given during the first and the fifth sessions.

Participants

The two participant groups for this study consisted of (a) counselors-in-training enrolled in a clinical course in which they met with clients in a university-based clinic and (b) clients seen by these counselors-in-training. The sample for this study was purposive and contained 55 counselors-in-training and 88 clients. Power was calculated per Cohen (1992); thus, the sample size exceeded the 67 minimum number of participants necessary to produce a medium effect size at the .05 significance level in a multiple linear regression analysis with two independent variables and one dependent variable (Cohen, 1992).

Counselor-in-training demographics. A total of 55 counselors-in-training participated in the study over the course of two semesters, with seven counselors-in-training participating in both semesters. We retained these seven participants in the sample because they completed assessments each semester specific to their current supervisor. Of the counselors-in-training, 48 (87.3%) were female and seven (12.7%) were male. With regard to race/ethnicity, 37 participants (67.3%) were European American, four (7.3%) were African American, five (9.1%) were Hispanic, four (7.3%) were Asian or Asian American, two (3.6%) were biracial or multiracial, and three (5.5%) designated "other." (Percentages may not total 100 because of rounding.) The age of the counselors-in-training ranged from 22 to 59 years, with the modal age being 23 years. One counselor-in-training chose not to report his or her age.

Client demographics. A total of 88 clients participated in this study over the course of two semesters. Of these clients, 58 (65.9%) were female and 29 (33.0%) were male. One participant (1.1%) did not report his or her gender. With regard to race/ethnicity, 46 participants (52.3%) were European American, 15 (17.0%) were African American, 16 (18.2%) were Hispanic, six (6.8%) were Asian or Asian American, and five (5.7%) were biracial or multiracial. The study was limited to adults; therefore, clients' ages ranged from 18 to 59 years, with the modal age being 21 years. Of the sample, 22 clients had previous counseling experience with the specific counselor-in-training seen during the semester in which the data were collected. The city from which the sample was drawn reports slightly different demographics,

with females representing 51.4% of the population during the 2010 census year. In addition, European Americans represented 57.6% of the city population, African Americans represented 28.1%, Asians or Asian Americans represented 3.8%, other individual races represented 7.3%, and individuals with a biracial or multiracial background represented 3.4%. (Percentages do not total 100 because of rounding.) Finally, persons not of Hispanic or Latino origin accounted for 74.6% and persons of Hispanic or Latino origin represented 25.4% of the population (U.S. Census Bureau, n.d.).

Measures

We used three instruments to assess the following constructs: (a) the supervisee's perceptions of the supervisory relationship, (b) the supervisee's clients' perceptions of the therapeutic relationship, and (c) client outcomes. Both the supervisory and therapeutic relationships were measured with the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962, 2002). Client outcomes were measured using a self-report instrument called the Outcomes Questionnaire–45 (OQ-45; Lambert et al., 1996).

BLRI. The BLRI was developed in the early 1960s to measure Rogers's (1957) theory of the facilitative conditions of client change (i.e., the therapeutic relationship; Barrett-Lennard, 1962). The BLRI measures four constructs: empathic understanding, level of regard, unconditionality, and congruence. Although the main version of the BLRI has 64 items, there is also a shorter form with 40 items, which was used for this study. The 40-item instrument contains 10 items for each of the four subscales and has consistent test validation and reliability with the 64-item version. Alpha coefficients for the subscales of the 40-item BLRI were reported to be .91 for Empathic Understanding, .87 for Regard, .82 for Unconditionality, and .88 for Congruence (Barrett-Lennard, 2002). In addition, test–retest reliability was drawn from 10 samples, with alpha coefficients ranging from .61 to .95 (Gurman, 1977). For the current study, the BLRI scores for both the clients ($\alpha = .91$) and the counselors-in-training ($\alpha = .95$) had high reliabilities (Strauss, Sherman, & Spreen, 2006). These reliabilities were higher than the recommended maximum value of .90 (Streiner, 2003), thus indicating a possibility of unnecessary items. Sample items from the BLRI include "_____ respects me" and "_____ nearly always sees exactly what I mean," with the name of the counselor (or supervisor) inserted into the blank spaces. Respondents then rate each item on a Likert-type scale ranging from –3 to 3 to show their degree of agreement with the statement. For this study, we used the BLRI to measure both the supervisees' perceptions of the facilitative conditions within the supervisory relationship and the clients' perceptions of the therapeutic relationship. We used the total score to illustrate the overall state of the relationships.

OQ-45. We used the OQ-45 to collect data on client outcomes in counseling. The OQ-45 was developed by Lambert et al. (1996) and is one of the most commonly used instruments in assessing client outcomes in psychological research (Hatfield & Ogles, 2004). This instrument asks specifically about the past week of the client's life. Respondents rate each of the 45 items on a

5-point Likert-type scale ranging from 0 (*never*) to 4 (*almost always*). Sample items include "I feel no interest in things" and "I feel lonely." The OQ-45 has a test–retest reliability coefficient of .84 and a coefficient alpha of .93 (Mueller, Lambert, & Burlingame, 1998). Because the OQ-45 was a standard instrument already in use at the clinic in which this research was conducted, and given that counselors documented only total scores, we had access only to the total scores of the OQ-45, and thus were unable to run a reliability analysis. The OQ-45 has also shown change in clients over short periods of time (Vermeersch, Lambert, & Burlingame, 2000). We chose this instrument because it is a widely used outcome measure, has received strong research support, and assesses client change over shorter periods of time. The OQ-45 was administered during the first session and the fifth session. We used the changes from the first to the fifth sessions as the client outcome variable.

Data Analysis

We used a regression analysis because of its ability to explore bivariate relationships between the independent variables and the dependent variable, while also predicting the dependent variable from the independent variables (Fraenkel & Wallen, 2009). The regression analysis yielded Pearson product–moment correlation coefficients to determine the extent of the relationships between the supervisory relationship and the therapeutic relationship (Research Question 1), the therapeutic relationship and client outcomes (Research Question 2), and the supervisory relationship and client outcomes (Research Question 3). Finally, the regression results revealed the extent to which the qualities of the therapeutic relationship present within the supervisory relationship and the therapeutic relationship predict client outcomes, as well as the percentage of variance explained by the two independent variables (Research Question 4).

Results

Descriptive Statistics, Tests of Normality, and Assumptions

All 88 clients completed the BLRI that examined the therapeutic relationship. Of the 88 clients, 85 completed both the first- and the fifth-session OQ-45. We excluded the three clients who did not have both first- and fifth-session OQ-45 scores from the final data analysis because of our inability to calculate change over time. Scores for the client BLRI ranged between –16 and 121 ($M = 71.11$, $SD = 28.49$). The data presented as slightly negatively skewed, with a skewness value of –0.52 and a kurtosis value of 0.25; both values fell into an acceptable range of –2 to +2 (George & Mallery, 2010). The Kolmogorov–Smirnov goodness-of-fit test reported a value of .06, $p = .20$, which indicated that the data for this instrument were normally distributed. Thus, the client BLRI data did not violate any assumptions of normality. With regard to the OQ-45, which measured symptom change in clients, we used the difference in the scores from the first session to the fifth session to indicate client change over time. Eighty-five clients completed the OQ-45 during the first and the fifth sessions. Client OQ-45 scores from the final

session, a third data point, were collected optionally, with 37 scores reported. First-to-fifth-session score changes ranged from –34 to 41 (M = 2.92, SD = 14.33), with a mode of 9; the skewness and kurtosis values (–0.35 and 0.24, respectively) fell within the normal range (George & Mallery, 2010).

All 55 counselors-in-training completed the counselor BLRI. The range of scores on the counselor BLRI was between –31 and 107 (M = 64.66, SD = 27.17). The skewness value indicated a slightly negative skew of –1.13, and the kurtosis value was reported as 1.54. Although the values fell within the normal range (George & Mallery, 2010), the Kolmogorov–Smirnov goodness-of-fit test indicated nonnormality, with a value of .16, $p < .01$. Thus, the assumption of normality may have been violated by these data. Histogram and box plots of the counselor BLRI data showed a slightly nonnormal distribution of the data, despite skewness and kurtosis values falling in the normal range.

Connection Between the Supervisory Relationship and the Therapeutic Relationship

Results from the correlation analysis indicated a statistically significant negative relationship between the therapeutic relationship (as measured by the client BLRI) and the supervisory relationship (as measured by the counselor BLRI), $r(88) = -.22$, $p < .05$. Although the correlation was significant at the .05 significance level, the effect size was small.

Client Outcome Correlations

The correlation between the therapeutic relationship (as measured by the client BLRI) and client outcomes (as measured by change in OQ-45 scores) was significant, $r(85) = .25$, $p < .05$. The effect size of this correlation was between small (.20) and medium (.30). However, the supervisory relationship (as measured by the counselor BLRI) was not found to have a significant correlation with client outcomes, $r(85) = -.15$, $p = .083$.

Predicting Client Outcomes Based on the Supervisory and Therapeutic Relationships

We used a regression analysis to answer how well the supervisory relationship and the therapeutic relationship predicted client outcome change. The model summary for this regression showed an R of .27, an R^2 of .07, and an adjusted R^2 of .05. Thus, the model explained 5% of the variance in client outcomes. Results from an analysis of variance indicated a significant regression equation, $F(2, 84) = 3.19$, $p < .05$ (see Table 1). Individual contributions of the variables are shown in Table 2, with client BLRI making the only significant contribution.

Discussion

The purpose of this study was to examine the connections between the quality of the supervisory relationship, the quality of the therapeutic relationship, and client outcomes. As we examined the relationships between these

TABLE 1

Analysis of Variance of the Multiple Linear Regression

Variable	*df*	*MS*	*F*	*p*
Regression	2	623.53	3.19	.046*
Residual	82	195.23		

*p = .05, two-tailed.

variables, along with the predictive ability of the independent variables on client outcomes, the results produced several points of discussion. These include the finding of a negative correlation between the supervisory and therapeutic relationships, as well as the validation of the importance of the therapeutic relationship.

The Supervisory and Therapeutic Relationships

The correlation between the clients' view of the therapeutic relationship and their counselors' view of the qualities of the therapeutic relationship within the supervisory relationship showed a statistically significant negative relationship (r = –.22). In other words, the higher the score was for the therapeutic relationship, the lower the score was for the supervisory relationship. Although this is a small correlation, in the scope of social science research, in which many client variables outside the counseling session are difficult to ascertain, a small-to-medium effect size may be of note (M. Lambert, personal communication, May 11, 2013). The presence of a significant negative relationship was interesting, leading to several potential hypotheses that could account for the relationship. These include (a) differences in priorities between the supervisory relationship and the therapeutic relationship, (b) the supervisor's theory of supervision and role usage, (c) demographic differences among supervisors, and (d) limitations of the BLRI in measuring only one aspect of the supervisory relationship. All of these hypotheses lead to the conclusion that much more research is needed in examining the role and aspects of the supervisory relationship as it may relate to the supervisee's therapeutic relationships.

With regard to the first conjecture, the priority in most therapeutic relationships, regardless of theoretical orientation, is establishing rapport (and thus, the relationship) with the client. On the other hand, within counselor supervision, supervisors may attend to other factors before building a relationship

TABLE 2

Multiple Linear Regression Analysis Predicting Client Outcomes From the Supervisory and Therapeutic Relationships

BLRI	*B*	*SE B*	β	*t*	*p*
Client	.11	.06	.23	2.09	.040*
Counselor	–.05	.06	–.10	–0.95	.347

Note. BLRI = Barrett-Lennard Relationship Inventory.
*p = .05, two-tailed.

with the supervisee (e.g., logistics, grading, parameters). In a nationwide study of supervision within programs ($N = 329$) accredited by the Council for Accreditation of Counseling and Related Educational Programs, Freeman and McHenry (1996) found that supervisors rated their highest goal of supervision to be the development of clinical skills in counselors-in-training. In addition, they found that supervisors described themselves as filling the primary roles of teacher, challenger, and supporter. It is interesting that building the relationship did not appear to be a focus of supervision in the Freeman and McHenry study. Therefore, the differences in priorities may have resulted in the negative correlation found in the current study. An alternative possibility is that when the therapeutic relationship is going well for counselors-in-training, they may not need to draw as much from their supervisors' support, thus changing the priorities and needs of supervisees in supervision.

Another explanation for the negative relationship may relate to the supervisor's theory of supervision, particularly if he or she focuses more on evaluation, teaching, or consulting rather than on creating a strong relationship with the supervisee. In Freeman and McHenry's (1996) study, the highest ratings of important functions of supervision were both teaching related: teaching professionalism and ethics and teaching client conceptualization. With regard to the third conjecture, we did not collect specific demographics for the supervisors because they were not considered participants in the study. In the training program where the study was conducted, a variety of individuals serve in supervisory roles, ranging from doctoral students, to core counselor education faculty, to adjunct faculty. Years of supervision experience, previous academic experiences with the supervisees through other courses, or even the personality of the supervisor could have affected the development of a positive supervisory relationship and thus influenced the negative correlation found for these relationships. Finally, it may be that the BLRI does not capture a complete enough picture of the supervisory relationship, because it measures only the facilitative conditions present and does not account for the many other aspects of the supervisory relationship.

The Therapeutic Relationship and Client Outcomes

A statistically significant positive correlation was found between the therapeutic relationship and client outcomes ($r = .25$). Although this correlation reflects a small-to-medium effect size (Cohen, 1992), the estimate of the importance of the therapeutic relationship in counseling outcomes is in line with previous research indicating that the relationship accounts for approximately 30% of client outcomes (Duncan & Moynihan, 1994). Horvath et al. (2011) called this a "moderate but robust relationship" (p. 9), and Castonguay, Constantino, and Holtforth (2006) stated that "the effect size is substantial for a variable being measured within the complex entity of psychotherapy" (p. 272), agreeing with earlier assessments of the importance of the moderate effect size of the relationship in client outcomes. These

results indicate that the relationship between the client and the counselor is connected to the client's therapeutic outcomes; in other words, the more positive the therapeutic relationship, the greater the likelihood of positive outcomes. Although outcomes are predominantly determined by factors outside the counseling session (e.g., stressful life situations, client personality), the therapeutic relationship is a powerful realm in which the counselor has the ability to influence outcomes (Horvath et al., 2011; Lambert & Barley, 2001; Lutz et al., 2006). Thus, it is essential for counselors to be educated in how to build a strong therapeutic relationship, how to assess the quality of the relationship, and how to repair the relationship when ruptures occur. It is also possible that some counselors may be missing one or more of these aspects because of a potential lack of focus on the therapeutic relationship within current counselor education programs (Glauser & Bozarth, 2001).

The Supervisory Relationship and Client Outcomes

The lack of a significant connection between the supervisory relationship and client outcomes was not a surprising finding after learning that the supervisory and therapeutic relationships were negatively correlated. Together, these two findings indicate a chasm between the interpersonal interactions in supervision and the interpersonal interactions in counseling. One may also infer from these findings that the therapeutic relationship can be positively established and affect client outcomes regardless of the presence of the facilitative conditions in the supervisory relationship. Thus, a supervisory relationship that contains the facilitative conditions may not be necessary for counselors to establish quality therapeutic relationships. In addition, there is a small possibility (based on the effect size of the correlation between the supervisory relationship and the therapeutic relationship) that the supervisory relationship is not associated with client outcomes and could even negatively affect the client. Our findings may also have been influenced by the study's small sample size from one university and the lack of supervisor demographics. The one definitive conclusion that can be drawn from our study is that more research is needed to ascertain the influence of the supervisory relationship on client outcomes.

Predicting Client Outcomes

The regression using client and counselor BLRI data resulted in a significant regression equation, which explained 5% of the variance in client outcomes. Upon careful examination, the client BLRI (i.e., the therapeutic relationship) was the only independent variable that contributed significantly to the model. Both the correlations and the regression analysis indicated a nonsignificant relationship between the supervisory relationship and client outcomes. These findings support the results of previous researchers in that the quality of the therapeutic relationship significantly contributed to client outcomes. However, our study calls for additional research into how the supervisory relationship may affect client outcomes.

Changes in Symptomatology Over Time

Although not specifically addressed in any research question in this study, the change in client outcomes between the first and fifth sessions, compared with the change in client outcomes between the first session and the next-to-last session (which was a site-specific data collection requirement), showed a significant positive correlation. Because participants' third and final OQ-45 scores (collected prior to termination) were an optional part of the study, only 37 client scores were submitted. However, 37 was larger than the sample size of 28 needed to run a correlation at the .05 significance level (Cohen, 1992). Thus, we conducted a correlation between the two changes in OQ-45 scores, which resulted in a significant positive correlation, $r(37) = .53$, $p < .01$. This result is considered a large correlation and effect size (Cohen, 1992) and indicated that if clients showed improvement at the fifth session, they were likely to continue improving by the final session. This finding may be surprising considering the counseling adage that "clients get worse before they get better." Winterman (2014) echoed this sentiment when he wrote that "most client symptoms get worse before they get better. That's just part of the process" (para. 9). Our findings offer the opposite view—that clients will continue to get better if they are already progressing early in treatment. Similarly, research conducted by Lutz et al. (2006) indicated that if clients decline early, they most likely will continue to decline. Therefore, it is important for counselors to learn to assess and interpret outcomes, whether positive or negative, throughout the therapeutic process. Given that counselors' contributions to client decline are often due to ruptures in the therapeutic relationship (Safran, Muran, Samstag, & Winston, 2005), client outcomes should be examined early and often to highlight clients whose progress is declining and the effects of the therapeutic relationship throughout the counseling process. Furthermore, counselor educators and supervisors should consider providing students with methods for assessing client progress.

Limitations

Our study was an initial investigation into the relationships between the constructs of the therapeutic relationship, the facilitative conditions in the supervisory relationship, and client outcomes. Given the study's broad constructs and sampling methods, several limitations arose related to sampling and history. One such limitation was related to the use of a purposive sample, which was drawn from one university in the southeastern United States. Therefore, caution should be exercised when generalizing these results to the larger population. In addition, because this was a two-semester study, seven counselors-in-training were represented twice as participants. Furthermore, several clients were seen by multiple counselors during their time in treatment, and these data were not separated or analyzed outside the larger sample to ascertain any differences. Another complication related to sampling was that the supervisor and supervisory relationships changed and were measured in both semesters to minimize the impact of the limitation of

counselors-in-training being represented twice. However, the development of different supervisory relationships over time could potentially affect the view of a counselor-in-training about his or her current supervisory relationship.

History was another contributing limitation in this study. Several events occurred during the first semester of data collection. First, two additional research studies were occurring simultaneously in the same location, and, thus, the participants may have been overexposed to research. Second, one supervisor left midsemester because of a family crisis, and although this event did not affect data collection, such an abrupt change may have contributed to difficulties adjusting to a new supervisor and the formation of a new supervisory relationship. Finally, we did not collect supervisor demographics; therefore, supervisor training, educational experience, and supervisory theory may have affected the goals and development of the supervisory relationship within supervision. However, none of these limitations severely impaired the findings of this study or the implications produced as a result of the findings.

Implications for Counselor Education and Supervision

Our results yield several implications for the practices of both counselor education and supervision and the practice of counseling. Supervision remains a relatively young area for research within counselor education, and the supervision implications from our study center on assessing the supervisory relationship and further exploring the negative correlation between the therapeutic relationship and the supervisory relationship. Building on the knowledge that the relationship is a determining factor in the satisfaction and effectiveness of supervision (Bernard & Goodyear, 2009; Ellis, 1991; Lambie & Sias, 2009), supervisors may consider introducing the concept of the supervisory relationship when beginning supervision and assessing the supervisory relationship throughout the supervision process. Possible interventions include facilitating discussions during supervision about the quality of the relationship, determining whether counselors-in-training feel that their needs are being met, and noting the parallels and differences between the supervisory and therapeutic relationships. Discussions that bring the relationship into the here and now can be powerful modeling tools for counselors-in-training not only in the forming, building, and repairing of ruptures in the relationship, but also in modeling the practice for use with clients.

Counseling implications resulting from this study focus on the validation of the importance of the therapeutic relationship in counseling outcomes. Client outcomes were found to significantly correlate with the client's perception of the therapeutic relationship. The therapeutic relationship has been trumpeted for decades as a foundational piece of counseling and often blended into techniques and skills-based classes (Kirschenbaum & Jourdan, 2005). However, students may get lost in the vague language of concepts such as unconditional positive regard and accurate empathy; therefore, a greater emphasis may be needed in making these relationship

building blocks more concrete for beginning counselors so that they may truly understand and strengthen their own therapeutic relationships. In addition, counselors should seek greater awareness and understanding of self to know if and when they may be affecting the therapeutic relationship. In doing so, they will be more accurately able to assess for ruptures in the relationship and "recognize their own contribution to alliance difficulties" (Castonguay et al., 2006, p. 273).

Another implication that speaks to both counseling and counselor education is the finding that client outcomes from the first to the fifth session correlated with client outcomes from the first to the last session. This finding suggests that clients who are progressing well early in the counseling process are prone to continue to do well. Other researchers' findings have supported the importance of early progression. Haas, Hill, Lambert, and Morrell (2002) found that clients who showed early treatment gains would continue those gains, and Lutz et al. (2006) noted that if clients were declining early in treatment, they were at a greater risk of continued decline. Thus, understanding how to track and interpret client outcomes is vitally important to predicting and treating clients as they progress through counseling.

Future Research

Future researchers in this area may consider separating participants more closely by demographics, such as experience level and the supervisor's theoretical orientation. Researchers may also add the dimension of asking counselors-in-training to fill out assessments of each of their previous supervisory relationships, then using the assessment scores in seeking a correlation with the therapeutic relationships of the counselors-in-training. Given that a negative correlation was found between the supervisory relationship and the therapeutic relationship, it may be important to assess the priorities of the supervisee within the supervisory relationship. Finally, although the supervisory relationship did not appear to affect client outcomes directly, there may be other aspects of supervision and the supervisory relationship that may be affecting client outcomes, such as the supervisor's clinical expertise, the supervisory role most often used, the supervisor's theoretical orientation, the supervisory interventions used, and the supervisory evaluation methods used. In addition, because the BLRI measured only the facilitative conditions within the supervisory relationship, an alternative measure could be used that was developed specifically for assessing the supervisory relationship. Future research may consider examining these and other aspects of supervision to further determine the relationship of supervision to client outcomes. Client outcome research continues to be an important research topic as mental health becomes accepted into the model of managed health care worldwide.

References

Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology, 48,* 251–257. doi:10.1037/0022-0167.48.3.251

Barrett-Lennard, G. T. (1962). Dimensions of therapist response as causal factors in therapeutic change. *Psychological Monographs: General and Applied, 76,* 1–36. doi:10.1037/h0093918
Barrett-Lennard, G. T. (2002). Perceptual variables of the helping relationship: A measuring system and its fruits. In G. Wyatt & P. Sanders (Eds.), *Rogers' therapeutic conditions: Evolution, theory and practice. Vol. 4: Contact and perception* (pp. 25–50). Ross-on-Wye, England: PCCS Books.
Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Boston, MA: Allyn & Bacon.
Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training, 43,* 271–279. doi:10.1037/0033-3204.43.3.271
Cohen, J. (1992). A power primer. *Psychological Bulletin, 112,* 155–159. doi:10.1037/0033-2909.112.1.155
Duncan, B. L., & Moynihan, D. W. (1994). Applying outcome research: Intentional utilization of the client's frame of reference. *Psychotherapy: Theory, Research, Practice, Training, 31,* 294–301. doi:10.1037/h0090215
Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48,* 43–49. doi:10.1037/a0022187
Ellis, M. V. (1991). Critical incidents in clinical supervision: Assessing supervisory issues. *Journal of Counseling Psychology, 38,* 342–349. doi:10.1037/0022-0167.38.3.342
Fraenkel, J. R., & Wallen, N. E. (2009). *How to design and evaluate research in education* (7th ed.). New York, NY: McGraw-Hill.
Freeman, B., & McHenry, S. (1996). Clinical supervision of counselors-in-training: A nationwide survey of ideal delivery, goals, and theoretical influences. *Counselor Education and Supervision, 36,* 144–158. doi:10.1002/j.1556-6978.1996.tb00382.x
George, D., & Mallery, M. (2010). *SPSS for Windows step by step: A simple study guide and reference, 17.0 update* (10th ed.). Boston, MA: Allyn & Bacon.
Glauser, A. S., & Bozarth, J. D. (2001). Person-centered counseling: The culture within. *Journal of Counseling & Development, 79,* 142–147. doi:10.1002/j.1556-6676.2001.tb01953.x
Gurman, A. (1977). The patient's perception of the therapeutic relationship. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 503–543). New York, NY: Pergamon Press.
Haas, E., Hill, R. D., Lambert, M. J., & Morrell, B. (2002). Do early responders to psychotherapy maintain treatment gains? *Journal of Clinical Psychology, 58,* 1157–1172. doi:10.1002/jclp.10044
Hatfield, D. R., & Ogles, B. M. (2004). The use of outcome measures by psychologists in clinical practice. *Professional Psychology: Research and Practice, 35,* 485–491. doi:10.1037/0735-7028.35.5.485
Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9–16. doi:10.1037/a0022186
Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person centered approach. *Psychotherapy: Theory, Research, Practice, Training, 42,* 37–51. doi:10.1037/0033-3204.42.1.37
Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development, 77,* 447–455. doi:10.1002/j.1556-6676.1999.tb02472.x
Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38,* 357–361. doi:10.1037/0033-3204.38.4.357
Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology & Psychotherapy, 3,* 249–258. doi:10.1002/(SICI)1099-0879(199612)3:4<249::AID-CPP106>3.0.CO;2-S
Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48,* 72–79. doi:10.1037/a0022238
Lambie, G. W., & Sias, S. M. (2009). An integrative psychological developmental model of supervision for professional school counselors-in-training. *Journal of Counseling & Development, 87,* 349–356. doi:10.1002/j.1556-6678.2009.tb00116.x
Leibert, T. W., Smith, J. B., & Agaskar, V. R. (2011). Relationship between the working alliance and social support on counseling outcome. *Journal of Clinical Psychology, 67,* 709–719. doi:10.1002/jclp.20800
Liddle, H. A., & Saba, G. W. (1983). On context replication: The isomorphic relationship of training and therapy. *Journal of Strategic & Systemic Therapies, 2,* 3–11.

Lutz, W., Lambert, M. J., Harmon, S. C., Tschitsaz, A., Schürch, E., & Stulz, N. (2006). The probability of treatment success, failure and duration—What can be learned from empirical data to support decision making in clinical practice? *Clinical Psychology & Psychotherapy, 13,* 223–232. doi:10.1002/cpp.496

McCarthy, P., Kulakowski, D., & Kenfield, J. A. (1994). Clinical supervision practices of licensed psychologists. *Professional Psychology: Research and Practice, 25,* 177–181. doi:10.1037/0735-7028.25.2.177

Moses, H. A., & Hardin, J. T. (1978). A relationship approach to counselor supervision in agency settings. In J. Boyd (Ed.), *Counselor supervision* (pp. 437–480). Muncie, IN: Accelerated Development.

Mueller, R. M., Lambert, M. J., & Burlingame, G. M. (1998). Construct validity of the Outcome Questionnaire: A confirmatory factor analysis. *Journal of Personality Assessment, 70,* 248–262. doi:10.1207/s15327752jpa7002_5

Muse-Burke, J. L., Ladany, N., & Deck, M. D. (2001). The supervisory relationship. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd., pp. 28–62). Philadelphia, PA: Brunner-Routledge.

Pearson, Q. M. (2000). Opportunities and challenges in the supervisory relationship: Implications for counselor supervision. *Journal of Mental Health Counseling, 22,* 283–294.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95–103. doi:10.1037/h0045357

Rønnestad, M. H., & Skovholt, T. M. (1993). Supervision of beginning and advanced graduate students of counseling and psychotherapy. *Journal of Counseling & Development, 71,* 396–405. doi:10.1002/j.1556-6676.1993.tb02655.x

Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. *Psychotherapy: Theory, Research, Practice, Training, 42,* 512–531. doi:10.1037/0033-3204.42.4.512

Shanfield, S. B., Mohl, P. C., Matthews, K. L., & Heatherly, V. (1992). Quantitative assessment of the behavior of psychotherapy supervisors. *The American Journal of Psychiatry, 149,* 352–357. doi:10.1176/ajp.149.3.352

Strauss, E., Sherman, E. S., & Spreen, O. (2006). *Compendium of neuropsychological tests: Administration, norms, and commentary.* Oxford, England: Oxford University Press.

Streiner, D. L. (2003). Starting at the beginning: An introduction to coefficient alpha and internal consistency. *Journal of Personality Assessment, 80,* 99–103. doi:10.1207/S15327752JPA8001_18

Truax, C. B., & Mitchell, K. M. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 299–344). New York, NY: Wiley.

U.S. Census Bureau. (n.d.). *QuickFacts: Orlando, Florida.* Retrieved from http://www.census.gov/quickfacts/table/PST045215/1253000,00

Vermeersch, D. A., Lambert, M. J., & Burlingame, G. M. (2000). Outcome Questionnaire: Item sensitivity to change. *Journal of Personality Assessment, 74,* 242–261. doi:10.1207/S15327752JPA7402_6

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports, 110,* 639–644. doi:10.2466/02.07.17.PR0.110.2.639-644

Winterman, T. (2014, April). On being a 'successful' therapist. *Counseling Today.* Retrieved from http://ct.counseling.org/2014/04/on-being-a-successful-therapist/