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USING REALITY THERAPY IN CLINICAL SUPERVISION:  
A PSYCHOTHERAPY-DRIVEN MODEL

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Submitted to the Faculty of the  
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in  
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University of Louisville  
Louisville, KY

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July 24, 2018

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## ABSTRACT

### USING REALITY THERAPY IN CLINICAL SUPERVISION: A PSYCHOTHERAPY-DRIVEN MODEL

Quentin Hunter

July 24, 2018

Clinical supervision is the signature pedagogy of counseling, with most professional counselors engaging in some type of supervision during their careers (Bernard & Goodyear, 2014). Psychotherapy-based models of supervision are the oldest models, originally intended to train supervisees to practice a specific psychotherapy (e.g., psychodynamic, behavioral; Watkins & Scaturro, 2013). Pearson (2006) indicated that contemporary clinical supervision could be informed by both the research in the role of development in clinical supervision and the tenets of a theory of psychotherapy. Although Pearson (2006) provided a conceptualization of psychotherapy-driven models of supervision, there is little research into the efficacy of such models.

Reality therapy is a psychotherapy designed to enhance client responsibility in making choices to meet needs by examining client wants and behaviors toward meet wants, then promoting client self-evaluation of behaviors to determine if new or modified actions may better meet personal wants (Wubbolding, 2011). Reality therapy is an established psychotherapy used with clients and can be conceptualized as a psychotherapy driven supervision model. A reality therapy driven supervision model is described in this paper as a model that applies the tenets of internal control psychology

and self-evaluation to both the client-counselor relationship and the supervisee-supervisor relationship to improve supervisee's practice of counseling and use of supervision.

This study is a single-case research design to evaluate the proposed reality therapy driven model of clinical supervision as an effective model for increasing supervisee report of counseling skill use and counseling self-efficacy. Three participant supervisees received reality therapy driven supervision during part of their semester-long clinical field experience. The findings indicated that for two of the three participants, self-report of skills and self-efficacy significantly increased during the reality therapy driven supervision phase, while accounting for the supervisees' predicted growth trend. The third participant did not have a significant change in self-report of skills or self-efficacy; however, all three participants evaluated the reality therapy driven supervision process positively, stating that the model promoted self-evaluation and accountability. The results may indicate that reality therapy driven supervision may be an effective model for some supervisees. Discussion includes implications for supervision practice and future research.

## TABLE OF CONTENTS

|  | PAGE |
|--|------|
| ACKNOWLEDGEMENTS.....  | iii  |
| ABSTRACT.....  | iv   |
| 1. INTRODUCTION.....   | 1    |
| Statement of the Problem.....  | 2    |
| Purpose of the Study.....  | 3    |
| Research Questions.....  | 3    |
| Research Design.....   | 4    |
| Assumptions and Limitation of the Study.....                                     | 5    |
| Definition of Key Terms.....   | 6    |
| Summary.....   | 7    |
| 2. REVIEW OF THE LITERATURE.....   | 8    |
| History of Clinical Supervision.....   | 8    |
| Current of Models of Clinical Supervision.....                                   | 12   |
| Psychotherapy-based Supervision Models and Psychotherapy-driven Supervision..... | 12   |
| Choice Theory and Reality Therapy.....   | 13   |
| Reality Therapy and Clinical Supervision.....                                    | 16   |
| A Contemporary Reality Therapy Driven Model of Clinical Supervision.....         | 18   |
| Wants.....   | 19   |
| Doing.....   | 19   |
| Evaluation.....  | 20   |
| Plan.....  | 20   |
| Supervisor Roles in Reality Therapy Driven Clinical Supervision.....             | 21   |



|   |    |
|---|----|
| Implications.....   | 23 |
| Summary.....  | 24 |
| 3. METHODS.....   | 25 |
| Method.....   | 26 |
| Design.....   | 26 |
| Participants.....   | 27 |
| Setting.....  | 28 |
| Measures.....   | 28 |
| Skilled Counseling Scale.....                                 | 28 |
| Counseling Self-Efficacy Scale.....                           | 29 |
| Baseline.....   | 29 |
| Intervention.....   | 30 |
| Procedural Fidelity.....                                      | 31 |
| Analysis.....   | 31 |
| Summary.....  | 32 |
| 4 RESULTS.....  | 33 |
| 5. DISCUSSION.....  | 44 |
| Implications to Clinical Supervision.....                     | 48 |
| Limitations.....  | 50 |
| Suggestions for Future Research.....                          | 50 |
| Conclusion.....   | 52 |
| REFERENCES.....   | 55 |
| APPENDIX A: Reality Therapy Driven Supervision Checklist..... | 65 |
| APPENDIX B: Subject Informed Consent Document.....            | 67 |
| APPENDIX C: List of Survey Instruments.....                   | 72 |
| CURRICULUM VITA.....  | 80 |

## CHAPTER 1

### INTRODUCTION

Corey, Hayes, Moulton, and Muratori (2010) defined clinical supervision as the observation and evaluation of the counseling process by an advanced professional. Clinical supervision is the signature pedagogy of counseling, with most professional counselors engaging in some type of supervision during their careers (Bernard & Goodyear, 2014). With roots in early social work practice and psychoanalytic training, clinical supervision has been practiced by mental health professionals since the early 19<sup>th</sup> century (Goodyear & Bernard, 1998). Despite this century of history, the study of clinical supervision remains relatively new and only recently became an area of training in mental health educational programs (Corey, Hayes, Moulton, & Muratori, 2010).

Clinical supervision has two central overlapping purposes: to promote counselor development and to ensure client welfare (Bernard & Goodyear, 2014). These purposes may be expanded to four goals: promote supervisee growth, protect client welfare, evaluate supervisee performance and act as gatekeeper for the profession, and empower supervisee to self-supervise (Corey, Hayes, Moulton, & Muratori, 2010). Clinical supervisors vary in their methods to achieve these goals, often utilizing a set of concepts and skills found in a model of clinical supervision. Among these models of clinical

supervision are models based in existing theories of psychotherapy. Psychotherapy-based models of supervision are the oldest models, originally intended to train supervisees to practice a specific psychotherapy (e.g., psychodynamic, behavioral; Watkins & Scaturro, 2013).

Reality therapy is a psychotherapy system designed to enhance client responsibility in engaging in healthful and/or fulfilling behaviors (Wubbolding, 2011). Choice theory is the foundational theory for reality therapy, conceptualizing individuals are needs-meeting and capable of creating and making choices that best meet their innate needs (Glasser, 2000). Reality therapy and choice theory were utilized under the term “lead management” in training supervisors in businesses to work with employees (Morris & Morris, 2003, p. 8), and Robert Wubbolding, a prominent choice theorist and reality therapist, argued that reality therapy/choice theory are appropriate for use in clinical supervision (Corey, Hayes, Moulton, & Muratori, 2010).

### **Statement of the Problem**

Pearson (2006) indicated that contemporary clinical supervision could be informed by both the research in the role of development in clinical supervision and the tenets of a theory of psychotherapy. In these models, the objective is not necessarily that the supervisee adopts the theory of counseling of the supervisor; rather, the supervisor utilizes his or her counseling theory as a means to maintain the supervision relationship and promote supervisee change. Although Pearson (2006) provided a conceptualization of psychotherapy-driven models of supervision, there is little research into the efficacy of such models.

Supervision research needs to be expanded (Bernard & Luke, 2015). Despite the description of supervision as the signature pedagogy of counseling and psychotherapy, some flagship journals in psychotherapy have gone years without publishing extensive research in supervision. For example, *The Counseling Psychologist*, a flagship journal for the counseling psychology profession, last dedicated an issue to supervision research in 1982 (Westefeld, 2009). *Counselor Education and Supervision*, the preeminent journal of the Association for Counselor Education and Supervision, publishes more regularly on supervision topics; however, a search of their online catalog produces few results focused on psychotherapy-based supervision and no articles on supervision based in reality therapy. Research into reality therapy-driven counselor supervision is also limited, and the handful of articles published on the subject since 1985 are conceptual pieces with no data on outcomes of using a reality therapy model.

### **Purpose of the Study**

The purpose of this study is to provide additional research into the efficacy of one model of psychotherapy-driven clinical supervision. Specifically, I sought to establish evidence of a functional relationship between reality-therapy-based clinical supervision interventions and supervisee reports of self-efficacy and counseling effectiveness as evidenced through basic counseling skills.

### **Research Questions**

The following research questions were addressed in the study:

- To what extent does reality-therapy-based clinical supervision affect supervisee self-report of counseling self-efficacy, and

- To what extent does reality-therapy-based clinical supervision affect supervisee report of use of basic counseling skills in session?

### **Research Design**

To address the research questions proposed, a single-case research design (SCRD) was selected. Single-case research designs were utilized previously to determine the relationship between supervision intervention and supervisee behavior (Holahan & Galassi, 1986) and are an accepted methodology for establishing evidence of best practices (Lenz, 2015). Single-case designs complement larger between-group designs by focusing on the function of an intervention on an identified outcome through continuous monitoring of the data of a few individuals. Well-designed single-case research provides an alternative to between-group designs when the setting or other factors make between-group designs difficult or unfeasible (Kazdin, 2011).

The purpose of this research is to investigate the change trend in supervisee self-efficacy and skill evaluation following supervision interventions. A longitudinal study would be appropriate for this type of research, particularly a multilevel model of repeated measures nested with individuals (Bauer, Gottfredson, Dean, & Zucker, 2014). However, accepted research of this type requires 30 to 50 participants (Maas & Hox, 2005). Although recent methodological researchers suggest that 10 individuals with five repeated measures instances can result in unbiased estimates (Maas & Hox, 2005), the additional statistical analysis necessary (e.g., bootstrapping or other estimation method) is prohibitive for many researchers. Single-case designs require fewer participants while still offering valuable data on the functional relationship between independent and dependent variables (Horner et al., 2005).

Beddoe (2011) commented that mental health services benefits from research that highlights the idiosyncrasies of counseling practice while maintain enough empirical rigor to add to the evidence-based practice literature base. Single-case research designs contribute to the knowledge base by providing causal knowledge concerning interventions while also providing data about how individuals (rather than groups) change (Kazdin, 2011). A multiple baseline across participants design will be used for this study. This design allows for multiple participants to be measured on the effect of the intervention on the dependent variables (Gast, Lloyd, & Ledford, 2014). This design was selected because the community mental health clinic available for the study receives multiple trainees each semester who are required to receive clinical supervision during their field experience. The research protocols could be implemented with minimal negative effect on the participants, who would already be receiving clinical supervision in some form throughout the length of the study. Because the dependent variable in this study is non-reversible, examining changes in the dependent variable across multiple participants will better allow the researchers to draw conclusions about the effect of the intervention.

### **Assumptions and Limitations of the Study**

Threats to internal validity for this study include maturation due to participants receiving some type of supervision before intervention and during the intervention phase. Participants may enter with prior supervision or mentorship experiences, and Farber and Hazanov (2014) found that beginning human helpers may engage outside sources including peers for supervision in addition to formal supervision during their training. One limitation to the study is the use of subjective self-report measures for the dependent

variables. Dependent variables in single-case research design are typically overt behaviors that may be directly observed in the environment (Kazdin, 2011). However, Wolf (1978) argued that single-case research designs do not require objective measurement of the dependent variable and that subjective measures at times may be the most appropriate. Another consideration, the design does not provide intra-subject replication of effect. Inconsistent effect across participants is another threat to internal validity related to this type of design as subjects may respond differently to both baseline treatment and the intervention resulting in variation in the dependent variable (Gast, Lloyd, & Ledford, 2014). In order to enhance the validity of the study results, the maximum number of participants for the available resources will be recruited to increase inter-subject replication. Single-case research design also requires documentation of fidelity in the implementation of the independent variable to ensure adequate implementation for the duration of the treatment condition (Horner, et al., 2005).

### **Definitions of Key Terms**

Several terms are relevant to this study. Provided here are brief definitions of the major terms. Elaboration on each term will occur in subsequent pages. Counseling self-efficacy is defined as the human helper's beliefs about their ability to perform counseling-related behaviors or to negotiate clinical situations (Larson & Daniels, 1998). Basic counseling skills encompasses many intentional behaviors of the counselor to enhance the helping relationship. These skills can include attending behaviors such as eye contact and verbal tracking and action responses including suggestions and self-disclosure (Sommers-Flanagan and Sommers-Flanagan, 2015).

## **Summary**

The roots of counseling supervision trace back to training in specific forms of counseling based in theoretical orientations. Contemporary counseling supervision, with its responsibilities in client welfare and ethical counselor development, continues in these roots while also considering current research in learning theory and professional development. A psychotherapy-driven model of supervision combines the assets of the supervisor's theory of counseling while remaining open to adaptation and developmental considerations during the relationship. Reality therapy is a theory of psychotherapy focused on fostering internal control of behavior through critical self-evaluation of past, present, and future choices. Reality therapy may be adapted into a psychotherapy-driven model of supervision, and this study served as early data on supervision outcomes using the proposed model.



## CHAPTER 2

### REVIEW OF THE LITERATURE

Shulman (2005) described signature pedagogies in the professions as the instructional forms most often associated with the preparation of members of a particular profession. Shulman stated that signature pedagogies include three dimensions: surface structure, deep structure, and implicit structure. Surface structure includes the concrete techniques and methods used in teaching and learning. Deep structure consists of the assumptions about what constitutes good teaching and learning in the profession. Implicit structure includes the foundational beliefs concerning the values, dispositions, and ethics of the profession. A signature pedagogy represents the primary mode used within a profession to perpetuate its legacy. In counseling, this signature pedagogy is clinical supervision (Bernard & Luke, 2015).

#### **History of Clinical Supervision**

A brief history of clinical supervision is provided here to establish the context from which the modern models of clinical supervision emerged. Moving from general, unspecified practices to theories to established models, clinical supervision continues to evolve with the professions it serves. Note that this history is focused on the evolution of supervision in the human helping professions (e.g., counseling, social work, counseling

and clinical psychology) and the term *clinical supervision* is used here in reference to the supervision specific to the development of professionals in those fields. The term clinical supervision is used to describe the observation and training practices of other disciplines, including teacher education (Anderson, 1993).

While the term *supervision* emerged in the mid-17<sup>th</sup> century (Corey, Hayes, Moulton, & Muratori, 2010), there is a lack of historical research into the origins of supervision. Thakral (2015) attributes the lack of investigation into the history of supervision to a combination of factors including amorphous definitions of supervision, a focus on practice-oriented research in education and the social sciences, a lack of interest in historical inquiry (ahistoricism) among education and social science researchers, and the general marginalization of supervision as a field of study. While supervision undoubtedly occurred during this period and even long before the term supervision emerged, the origins of clinical supervision as a discipline are much more current.

Goodyear and Bernard (1998) traced the history of clinical supervision to the 19<sup>th</sup> century when charitable organizations would hire social workers to supervise treatment of impoverished individuals by visitors and volunteers. Clinical supervision of professional human helpers developed further in the early 20<sup>th</sup> century with the popularity of psychoanalysis (Goodyear & Bernard, 1998). Doctors seeking consultation and practice with Sigmund Freud resulted in a formalized process in psychoanalytic supervision in the 1920s to meet this need for training and evaluation of new psychotherapy practitioners (Goodyear & Bernard, 1998). This early form of clinical supervision, termed dynamic supervision, focused on interpersonal conflict between the supervisee and supervisor (Leddick & Bernard, 1980). In this early model, the supervisor

acted as an antagonistic counselor-teacher during the working stage of supervision before moving into an encourager role as the supervisee gained more authority and independence.

Following the dynamic supervision of the early 20<sup>th</sup> century, additional psychotherapy-based types of supervision emerged as differing theories of counseling came into prominence. Two major types were based on facilitative theory and behavioral theory (Leddick & Bernard, 1980). Based on the humanistic approaches of Carl Rogers, facilitative theory focused on a nondirective approach to supervision wherein the therapeutic factors of empathy, warmth, and genuineness would promote supervisee development. In effect, the supervisor modeled the humanistic approach for the supervisees in their supervision work, and supervisees translated the factors into their own counseling. Behavioral theory supervision was based on the principles established by Pavlov and Skinner as well as the work of Krumboltz and Lazarus in incorporating learning theory principles into the supervisory relationship (Leddick & Bernard, 1980). These three distinct approaches made up the majority of supervision practices until the early 1970s.

New approaches that combined principles from dynamic, facilitative, and behavioral theories began to emerge in the 1970s. These approaches, termed skills training approaches, focused on establishing minimum skills necessary to be a counselor and evaluating supervisees on their acquisition of those skills (Leddick & Bernard, 1980). From this combination of theory and skill focuses came the integrative models of clinical supervision of the late 1970s and the 1980s, models utilizing technical eclecticism and/or theoretical integration to create new systems of supervisee training and evaluation

(Corey, Hayes, Moulton, & Muratori, 2010). The discrimination model (Bernard, 1979), a popular supervision model, emerged during this period. Supervisors using the discrimination model focus on supervisees skills in three areas: intervention, conceptualization, and personalization (Corey, Hayes, Moulton, & Muratori, 2010), and the model remains one of the most widely known and discussed today (Borders & Brown, 2005).

From the 1980s into recent years, clinical supervision received additional attention as professional organizations attempted to expand research in supervision and codify effective practices in supervision. The American Association of Marriage and Family Therapy first developed supervision standards in 1983, then the American Counseling Association in 1989, followed by the National Association of Social Workers in 1994 and the National Board of Certified Counselors in 1999 (Corey, Hayes, Moulton, & Muratori, 2010). The American Psychological Association began including ethics related to supervision in its professional codes of ethics beginning in 1992 with a dedicated section of the code devoted to clinical supervision appearing in 2002 (Hess, 2008). Recently, the American Psychological Association (2014) produced guidelines for clinical supervision of health service psychology. Models of supervision continue to be developed based in discipline philosophies such as wellness (e.g., Smith & Lenz, 2010), based on counseling context such as schools (e.g., Wood & Rayle, 2006), and on the synthesis of existing evidence of supervision best practices (e.g., Milne, Aylott, Fitzpatrick, & Ellis, 2008).

## **Current Models of Clinical Supervision**

Current research and education in clinical supervision focuses on common models used to meet supervision objectives. The most common models of clinical supervision discussed in training programs fall into one of three categories: psychotherapy-based models, developmental models, and process models (Bernard & Goodyear, 2014). Psychotherapy-based models extend the supervisor's theory of counseling into the supervisory relationship, relying almost exclusively on the processes and techniques featured in their preferred theory of psychotherapy to also serve as instruments of change in supervision. Developmental models incorporate theories of development and learning into the supervisory relationship to evaluate and respond to the developmental needs of the supervisee. Many developmental models are stage-based and are pan-theoretical (Bernard & Goodyear, 2014). Process models attempt to describe the process of supervision itself, focusing on the relationship between supervisor and supervisee as it pertains to meeting supervision objectives.

### **Psychotherapy-based Supervision Models and Psychotherapy-driven Supervision**

Psychotherapy-based supervision models have received criticism in the past as being too solely focused on the counseling theory and insufficiently focused on accommodating the developmental needs of the supervisee (Pearson, 2006). Each theory of counseling highlights certain psychological traits over others (e.g., psychoanalytic focuses on insight, behavioral focuses on empirical responses), and psychotherapy-based supervision models may do the same when supervisors rely too heavily on a counselor role in the supervision relationship, rather than moving across roles to meet supervision objectives. Pearson (2006) offered an integrated category of supervision called

psychotherapy-driven models. In these models, the psychotherapy theory of the supervisor remains the primary approach for supervision; however, supervisors using psychotherapy-driven models are also intentional in occupying multiple supervisory roles during the supervisory relationships. Pearson (2006) conceptualized psychotherapy-driven models as utilizing the three roles described by Bernard (1979): teacher, counselor, and consultant. Pearson's idea of psychotherapy-driven models does not account for psychotherapy-based models devised initially with supervisory roles in mind. Reality therapy supervision represents a psychotherapy-driven model in that it integrates the premises of reality therapy with the concepts of role-based supervision.

### **Choice Theory and Reality Therapy**

A discussion of reality therapy requires an introduction to choice theory, the conceptual framework closely associated with reality therapy. As the name suggests, choice theory focuses on the role of personal choice in the behaviors of the individual. Rather than viewing the individual as shaped solely by external forces, William Glasser, the founder of choice theory, argued that individuals are agents in their own lives and continually make choices they perceive will best meet their needs (Wubbolding & Brickell, 2015). Glasser (1998) described all behaviors as attempts to meet one or more of five basic human needs: survival, love and belonging, power, freedom, and fun. According to choice theory, each individual possesses a quality world, an internal mental image of the people, things, and ideas believed to be the most satisfying of the five needs (Glasser, 1998). All behavior - a term defined in choice theory as including actions, thoughts, feelings, and physiological changes - are considered an individual's best attempt to match the real world to the quality world (Glasser, 1984). Today, the William

Glasser Institute provides education and training on choice theory based on the ten axioms of choice theory:

1. The only person whose behavior we can control is our own.
2. All we can give another person is information.
3. All long-lasting psychological problems are relationship problems.
4. The problem relationship is always part of our present life.
5. What happened in the past has everything to do with what we are today, but we can only satisfy our basic needs right now and plan to continue satisfying them in the future.
6. We can only satisfy our needs by satisfying the pictures in our Quality World.
7. All we do is behave.
8. All behavior is Total Behavior and is made up of four components: acting, thinking, feeling, and physiology.
9. All Total Behavior is designated by verbs and named by the part that is the most recognizable
10. All Total Behavior is chosen, but we only have direct control over the acting and thinking components. We can only control our feeling and physiology indirectly through how we choose to act and think. (Glasser, 1998).

Reality therapy is a psychotherapy system designed to enhance client responsibility in making choices to meet needs (Wubbolding, 2011). The practice of reality therapy predates choice theory, though the two are strongly linked (Wubbolding, 2011). While choice theory offers a theory of the nature of people and their presenting issues, reality therapy provides the process for creating solutions for presenting issues. As

reality therapist Robert Wubbolding (2011) stated, “If choice theory is the train track, reality therapy is the train” (p. 15).

The essential elements of reality therapy were distilled into the acronym WDEP: Wants, Doing, Evaluation, and Plan (Wubbolding & Brickell, 2015). Wants refer to exploring with clients their quality world to understand what they would like in their lives and their level of commitment to having those elements met. Also during this phase, client perceptions are explored, meaning the counselor seeks to understand how the client takes information from the world and labels, values, and forms relationships with that information. In the Doing phase, clients explore their total behaviors (actions, thoughts, feelings, and physiology) that they engage in to meet their wants. Wubbolding (2011) stated that actions and thoughts are usually more easily discussed than feelings or physiology; however, they are all components of the total behavior chosen by clients and should be explored as much as possible with clients. The evaluation phase is considered the heart of reality therapy (Wubbolding & Brickell, 2015). In this phase, clients are encouraged to self-evaluate their behavior or their wants on their viability, appropriateness, and effectiveness. The counselor may encourage evaluative questions (e.g., “Are the current actions helping or hurting my chances of getting what I want?”), but it is the responsibility of the client to make the final judgment. In the plan phase, clients and counselors work together to determine what is the plan moving forward. Clients can choose to continue current behavior or choose to change their behavior or their quality world wants. This phase also allows the counselor an opportunity to educate the client on choice theory and the WDEP system as a tool for choosing effective behaviors.



## **Reality Therapy and Clinical Supervision**

The earliest discussion of reality therapy in clinical supervision came from Appel (1985). Appel outlined a process of reality therapy supervision based in four guiding principles: counselors are internally motivated; counselors are motivated by their needs; counselors will choose behaviors in counseling and supervision to meet their needs; and the supervisor teaches supervisees to use flexible behaviors to help clients meet needs. According to Appel, regardless of the theoretical orientation of supervisees, supervisors using reality therapy supervision adopt the roles of counselor, consultant, teacher, and evaluation to help supervisees clarify their client-related goals and behaviors through self-evaluation and committed planning. This early conceptualization of reality therapy supervision already incorporated roles into the model, appearing more like Pearson's (2006) psychotherapy-driven models.

Appel (1985) stated that the process for reality therapy supervision mirrors the original, eight-step process of reality therapy developed by Glasser. The first step is supervisor involvement with the supervisee. Supervisors explore the goals and expectations of the supervisory relationship and of the supervision session. The second step involves the discussion of supervisee behaviors to meet goals. Supervisees are encouraged to detail the actions, thoughts, feelings, and physiological events that were used by the supervisee to meet goals. Step three involves value judgment of the supervisee behavior in relation to meeting desired goals. Congruent with reality therapy practice, the judgments may be guided by the supervisor, but the supervisee makes the primary determination on the efficacy of the behavior. Exceptions to this would be in instances where behaviors may explicitly harm clients. In step four, the supervisor and

supervisee develop two plans for future behavior, one for the supervisee and one for the supervisor. The supervisee should devise a simple and specific plan of action for working with the client during the next sessions and develop with the supervisor a plan of action for supervision. Supervision action plans may involve a request by the supervisee for additional education or consultation which is then fulfilled by the supervisor in a way deemed most beneficial for the supervisee. Step five focuses on the supervisee commitment to enact the plan and anticipate any roadblocks. Steps six, seven, and eight are the follow-up steps that occur in subsequent sessions. Step six is the evaluation of results without excuses or blame. Step seven is acceptance of the consequences of the engaged behaviors. Step eight is to ensure the supervisee is not discouraged and will continue to engage in the process.

Peterson and Parr (1989) described a five-step cycle of reality therapy supervision. In the first step, pre-observation, the supervisor and supervisee develop rapport while establishing a contract of expectations. The supervisor and supervisee establish their expectations and needs for the supervision process and also the assessment procedures that will be used (e.g., counseling evaluation forms, review of recorded sessions). Also during this step, the supervisor solicits the supervisee to evaluate which strengths the supervisee brings to counseling so that these strengths may serve as the foundation for feedback and continued growth. In the second step, observation, the supervisor observes the supervisee in practice, either directly or via methods established in pre-observation. The supervisor intentionally focuses on supervisee-identified strengths, areas of growth discussed in pre-observation, and client-harming behaviors. Analysis is the third step in which the supervisor organizes data obtained in observation

to provide feedback for the supervisee. Peterson and Parr (1989) suggested that supervisors begin by asking the supervisee to self-evaluate to give the supervisee practice in self-evaluation and to ensure that supervision continues to be a cooperative process. In the fourth step, feedback, the supervisor provides feedback. In this step, the supervisor provides feedback on supervisee-identified strengths followed by supervisor-identified strengths and areas of improvement. Also during the feedback step, a plan for continued growth and development is devised by the supervisor and supervisee, preferably with specific objectives (e.g., skills acquisition, planned therapy behaviors for next session). The fifth and final step is a critique of the supervision process. Peterson and Parr (1989) described this step as one of the most crucial, as it provides both the supervisor and supervisee an opportunity to evaluate the supervision process and plan any additional behaviors that might improve the process. This is also the step wherein plans for the next supervision session are determined. With an added focus on process, this form of reality therapy supervision incorporated elements of process models to become a psychotherapy-driven model.

### **A Contemporary Reality-Therapy-Driven Model of Clinical Supervision**

More recent discussions of reality therapy supervision have focused primarily on ways in which advanced reality therapists can assist emerging reality therapists in their development. Wubbolding recently described the process of reality therapy supervision from this context, describing the process by which reality therapists become certified rather than speaking more generally on reality therapy-based clinical supervision (Corey, Hayes, Moulton, & Muratori, 2010). However, a supervision model founded in reality

therapy can be used to foster the development of emerging human helpers working from any theory of psychotherapy.

In this conceptualization of reality-therapy-driven supervision, both the individual supervision sessions and the overall supervisory relationship follow the steps described in Wubbolding's (2011) WDEP model. Utilizing the WDEP model reduces the steps in the supervision processes described previously and encourages the reality therapy supervisor to conceptualize the supervision process as a natural extension of their counseling while also adding the necessary supervisory elements.

### **Wants**

Reality Therapy supervisors discuss with their supervisees their wants for the client counseling sessions. This may include the supervisees' objectives entering sessions and emergent wants during the sessions. The supervisees also discuss wants related to the supervision relationship, and supervisors invite the supervisees to frankly explore their perceptions of the relationship and ideas for what comprises quality, needs-meeting supervision.

### **Doing**

The supervisor solicits from supervisees' detailed reviews of their total behaviors in client sessions. Per choice theory, this can include any action, thought, feeling, or physiological event. Supervisees also detail the total behaviors related to the supervision relationship, providing a nonjudgmental account of what they have been doing to make supervision satisfactory.

## **Evaluation**

During evaluation of behaviors related to counseling, supervisees self-evaluate the total behaviors from the doing step and determine if the behaviors were effective or ineffective in meeting their own wants for the session. The supervisor guides the supervisees in the process of self-evaluation but resists providing an evaluation for the supervisees. This should not include behaviors which may jeopardize client safety; in these situations, the supervisory role is to protect client welfare and provide corrective action (e.g., education). Supervisor roles in reality therapy supervision are discussed further below. Supervisees also self-evaluate the total behaviors related to the supervision relationship, making a judgment as to whether the behaviors are bringing them closer to or farther from their quality world image of supervision and of themselves as effective human helpers.

## **Plan**

In the plan stage, the supervisor and supervisee collaborate on a plan to implement in future client sessions. As choice theory posits that individuals are limitlessly creative (Glasser, 1984), supervisees are encouraged to devise a plan that fits their theoretical orientation and that they predict will meet their wants for the counseling session. Ideas may be solicited from the supervisor by the supervisee, but the creativity of the supervisee should be the primary force for planning. The supervisor assists the supervisee in ensuring the plan is realistic using the reality therapy plan mnemonic SAMMIC (simple, attainable, measurable, mindful, immediate, controlled by the planner, consistent, and committed to; Wubbolding and Brickell, 2015) and inquires about the supervisee's commitment to implementing the plan.

As stated, applying the WDEP model to the supervisor relationship, supervisors reserve time in session to discuss the supervisees wants for supervision, what the supervisor and supervisee have been doing to meet those wants, evaluation of those actions, and planning to maintain effective behaviors and/or implement new behaviors which may be more effective. While the process of supervision may often move through the WDEP stages linearly, stages may be revisited or occur in differing order as needed in the supervision session. Supervisors are responsible for asking questions that guide the supervisee through the WDEP stages, and, in time, the supervisee may initiate the process with little prompting. Additionally, supervisors using reality therapy supervision should exhibit the tonic behaviors described by Wubbolding (2011) as conducive to effective reality therapy – specifically, being consistent in the process, courteous and calm toward supervisees as they work through the process, determined that supervisees can be responsible in their choices and improve, and enthusiastic about the process of change occurring.

### **Supervisor Roles in Reality-Therapy-Driven Clinical Supervision**

Robey and Cosentino (2012) indicated that reality therapy clinical supervision requires the supervisor to occupy four roles discussed in previous role-based models of supervision: teacher, counselor, consultant, and evaluator. Supervisors provide instruction in skills and theory, counsel supervisees to examine their behavior using WDEP, consult with supervisees on resources and dilemmas, and evaluate the supervisee progress in their function as a competent human helper. Supervisors must use their professional judgement to determine which roles are most salient within session. Robey and Cosentino added a fifth role, manager, to include the supervisor's duty to ensure the safety and ethical

treatment of clients. By incorporating these roles into the process of reality therapy supervision, reality-therapy-driven supervision addresses the two main criticisms of psychotherapy-based supervision: not addressing educational needs of the supervisee and not monitoring client welfare (Pearson, 2006).

One role the reality therapy supervisor need not occupy is psychotherapy theory ideologue. Current literature in the area of reality therapy-based supervision lacks a specific discussion of the model's implementation with supervisees of other theoretical orientations (Robey & Cosentino, 2012) or has focused primarily on the supervision of developing reality therapists (Corey, Hayes, Moulton, & Muratori, 2010). Putney, Worthington, Jr., and McCullough (1992) found that supervisee perception of supervision effectiveness was impacted by their perception of theoretical matching. Putney et al. (1992) argued that the effect may be explained by supervisees' recognizing the supervisor's supervision style as being theoretically driven while also being attuned to the content and methods of the theoretical orientations of the supervisees. While reality-therapy-driven supervision may best suit a supervisor who conceptualizes counseling through choice theory, supervisees may adopt any theory of counseling and expect supervision that will enhance their effectiveness within that theory. For example, if the supervisee wants to be a competent cognitive-behavioral therapist, the supervisor assists the supervisee in examining their image of the competent cognitive-behavioral therapist, in describing their behaviors in client session and in supervision to achieve that want, in engaging in self-evaluation to determine if current behaviors are effectively moving the supervisee toward the want, and in designing a plan to maintain existing helpful behavior

or plan new ones. The supervisor operates within the reality therapy framework but does not require the supervisee to treat clients with reality therapy.

### **Implications**

As the helping fields place increased emphasis on supervisee competencies, it is not enough to engage in supervision; supervisors must serve as evaluators of supervisees and implement strategies that maximize supervisee growth (Falender & Shafranske, 2012). However, the field of clinical supervision has been criticized for lacking research on how supervision interventions relate to supervisee outcomes (Borders, 1989). In response to this dearth of research, Goodyear and Bernard (1998) called for improved supervision research that relies less on supervisee self-reports of what works in supervision and more on results in descriptive supervision strategies that can be more easily transferred into reproducible protocols or even manualized.

Reality-therapy-driven clinical supervision offers a structure that is adapted from the established reality therapy framework described in numerous texts. The process of supervision in this model can be easily defined for research purposes, and supervisee outcomes can be observed behaviorally or through self-report. Conducting research on supervisee outcomes using reality-therapy-driven clinical supervision would contribute to both the evidence base for psychotherapy-driven models of supervision and choice theory as a framework for counseling and supervision. Researchers may consider single-case research designs as they are more easily implemented in counseling environments than quantitative methods, and these designs are considered rigorous in counselor education and supervision (Ray, Barrio Minton, Schottelkorb, & Garofano Brown, 2010). Reality therapists engaged in clinical supervision should consider ways to implement reality-



therapy-driven clinical supervision and engage in research to determine its effectiveness in future-human-helper development.

### **Summary**

As the signature pedagogy of counseling, clinical supervision has a long history in the education and preparation of counselors. While there are many models of supervision, most may be categorized as psychotherapy-based, developmental, or process models (Bernard & Goodyear, 2014). As a theory of counseling, reality therapy has been adapted to be used in the supervision relationship, though primarily in the development of new reality therapists. I proposed the use of a reality therapy-driven model of supervision that fosters the development of a supervisee operating from any theoretical orientation. The model utilizes Wubbolding's (2011) WDEP system to move the client-counselor relationship toward goal-meeting behaviors while also attending to the supervisee-supervisor relationship in the same way. A core tenet of reality therapy is that the client takes the primary role in evaluating current behaviors and determines which behaviors must be sustained or changed. Similarly, the supervisee in a reality therapy-driven supervisory relationship develops an internal control psychology wherein information is gathered and evaluated, and goal-meeting behaviors are chosen.

## CHAPTER 3

### METHODS

With research indicating that many supervisees receive inadequate supervision (Ellis, et al., 2014), exploring psychotherapy-based models of supervision may provide relief by capitalizing on potential supervisors' existing knowledge of theory while adding crucial elements that support supervisee development. More recently, other types of supervision models have taken the forefront, and psychotherapy-based supervision may be integrative and provide a more seamless and effective supervisory experience for helpers-in-training (Falender & Shafranske, 2010). As a model that incorporates supervisor role elements with the strengths of an established theory of psychotherapy, reality-therapy-driven clinical supervision may provide some with the tools for a beneficial supervision experience.

The purpose of this study is to describe the functional relations between reality-therapy-driven supervision intervention and counseling training outcomes, specifically supervisee reports of use of basic counseling skills and reports of self-efficacy. The following research questions were addressed in the study:

- To what extent does reality-therapy-driven clinical supervision affect supervisee self-report of counseling self-efficacy, and

- To what extent does reality-therapy-driven clinical supervision affect supervisee report of use of basic counseling skills in session?

## **Method**

### **Design**

A multiple baseline across participants design, a form of single case research design (SCRD), was used for this study. SCRD was highlighted as a research method suitable for determining the effect of independent variables in counseling research, but few counselors implement SCRD due to unfamiliarity with the methods (Lenz, 2015). Single-case designs have been utilized previously to determine the relationship between supervision intervention and supervisee behavior (Holahan & Galassi, 1986; Milne & Westerman, 2001) and are an accepted methodology for establishing evidence of best practices (Lenz, 2015).

Ray (2015) indicated that multiple baseline across participants design is the best SCRD design for rigorous counseling research. Multiple baseline across participants design allows for multiple participants to be measured on the effect of the intervention on the dependent variables (Gast, Lloyd, & Ledford, 2014). Multiple baseline across participants design was also selected because the community mental health clinic available for the study received multiple trainees each semester who were required to receive clinical supervision during their field experience. The research protocols could be implemented with minimal negative effect on the participants who received clinical supervision in some form throughout the length of the study. Because the dependent variable in this study was non-reversible and because the supervisees began their clinical experience at the same time (i.e., the beginning of the academic semester), examining

changes in the dependent variable across multiple participants across time better allowed the researcher to draw conclusions about the effect of the intervention by examining the dependent variables across differing baselines and without withdrawing the intervention (Kazdin, 2011).

Threats to internal validity for this study include history due to participants receiving some type of supervision before intervention or during the intervention phase. Participants may have entered with prior supervision or mentorship experiences, and Farber and Hazanov (2014) found that beginning human helpers may engage outside sources including peers for supervision in addition to formal supervision during their training. Additionally, the design did not provide intra-subject replication of effect. Inconsistent effect across participants was another threat to internal validity related to this type of design as subjects may respond differently to both baseline treatment and the intervention resulting in variation in the dependent variable (Gast, Lloyd, & Ledford, 2014). To enhance the validity of the study results through inter-subject replication, the maximum number of participants for the available resources were recruited.

### **Participants**

Participants were current human-helpers-in-training engaged in a clinical field experience at a local community mental health clinic. Participants were required to receive supervision as part of their placement; however, participants were not required to participate in the study as a requirement for receiving supervision. Students with an existing supervision remediation plan were excluded to increase inter-subject consistency. Students with clinical supervision experience from a previous placement were eligible for the study, and their prior experience was detailed in the participant

description. Prior experience with clinical supervision as well as whether supervisees were in a first or second clinical field experience was expected to impact participant's baselines; however, prior contact with a non-reality-therapy driven model of supervision may serve to demonstrate that any effect on the dependent variables was a function of the new supervision model.

### **Setting**

The setting for the supervision intervention was a community mental health clinic located in an urban setting in the Southern United States. Supervision interventions occurred in one of two treatment rooms proposed for use in the study, each a 10 ft x10 ft room with two arm chairs, an office chair, and a desk with a desktop computer and one window. Participants received supervision sessions in the same rooms for every session in all phases of the study. The rooms also were equipped for video recording, and intervention sessions were recorded for procedural fidelity checks.

### **Measures**

**Skilled Counseling Scale.** Basic counseling skills encompasses many intentional behaviors of the counselor to enhance the helping relationship. These skills can include attending behaviors such as eye contact and verbal tracking and action responses including suggestions and self-disclosure (Sommers-Flanagan & Sommers-Flanagan, 2015). This study measured basic counseling skills using the total score of supervisee self-report on the Skilled Counseling Scale (SCS; Urbani et al., 2002). The SCS is an 18-item, Likert-type measure with total score ranges from 18 to 90. Each item reflects a different skill used in professional counseling, including eye contact, paraphrasing, and immediacy, organized into three stages: exploring, understanding, and action. Initial

items focus on foundational skills, and more advanced skills appear in later items. Initial examination of interrater reliability of the SCS resulted in a correlation coefficient of .90 (Urbani et al., 2002). Later researchers obtained intraclass correlation coefficients between .79 and .88 (Schaeffle, Smaby, Maddux, & Cates, 2005). Validity evidence for the SCS is weak; however, researchers suggested that the SCS has good evidence of test content in that the items directly reflect the skills taught in most counseling skills training models (Eriksen & McAuliff, 2003). While originally designed as a supervisor assessment instrument, the SCS was recommended for use as a self-evaluation of supervisee counseling skills (Smaby, Maddux, LeBeauf, & Packman, 2008).

**Counseling Self-Efficacy Scale.** Supervisee counseling self-efficacy was defined as supervisee's perceived sense of being capable and effective in counseling practice. This was measured via total score on the Counseling Self-Efficacy Scale (CSES; Melchert, Hays, Wiljanen, & Kolocek, 1996). The CSES is a 20-item, Likert-type self-report measure with total score ranges from 20 to 100. Internal consistency analysis of the CSES conducted by the measurement creators resulted in a Cronbach alpha of .91, and the test-retest reliability coefficient was .85. Evidence of validity based on relations to other variables was established by comparing the CSES scores of 60 participants with their scores on the existing Self-Efficacy Inventory, resulting in a correlation of .83 (Melchert, Hays, Wiljanen, & Kolocek, 1996).

### **Baseline**

Informed consent was obtained from all participants. Participants were asked to complete the CSES and SCS at the start of each supervision session. The baseline phase was intentionally staggered across participants as part of the multiple baseline across

participants research design (Gast, Lloyd, & Ledford, 2014). During the baseline phase, the supervisee received clinical supervision based in the role supervision model described by Fall and Sutton, Jr. (2004). During this form of supervision, supervisees bring counseling issues to the supervisor which are then discussed. The supervisor adopts the role of teacher, counselor, or consultant to respond to the supervisees need (Fall & Sutton, Jr., 2004). Sessions began with administrative check-in to ensure administrative duties were completed. Next, supervisee discussed clients while the supervisor offered appropriate role support. The researcher was intentional in not using reality-therapy-driven supervision during this time. The baseline phase for each participant continued until data trends in the condition appeared steady. The first participant began intervention in the next session following the establishment of a reliable trend, with subsequent participants beginning intervention at minimum two sessions after the start of the previous participant's interventions phases, assuming steady baseline.

### **Intervention**

During the intervention phase, participants received reality-therapy-driven supervision in a model described elsewhere utilizing the Reality Therapy Driven Supervision Checklist (Appendix A). Measurement of the dependent variables (CSES and SCS) occurred in both the baseline and intervention phase and were completed at the start of the supervision session. During supervision sessions, the supervisor followed the same structure for each session. Sessions began with a brief check-in that included identification of current client cases needing attention and determination of plan for the supervision session, using the Supervisor-Supervisee Relationship guiding questions. Next, the supervisor and supervisee discussed client cases with the supervisor using the

Counselor-Client Relationship questions. Next, the supervisor returned to the Supervisor-Supervisee Relationship guiding questions to attend to any additional supervision needs, including additional education, role-play, transference/countertransference, etc. Sessions were between 30 and 40 minutes in length.

### **Procedural Fidelity**

Procedural fidelity data to the supervision model protocols was collected using two methods. First, the supervisor completed the end-of-session checklist designed by the researcher. Second, supervision sessions were reviewed for fidelity. For the checklist, a simple percentage was calculated by dividing the total number of objectives listed for the session by the number of objectives completed in session. An average of all percentages for all completed sessions was calculated and evaluated weekly to determine procedural fidelity and adjust as needed. Additionally, the researcher reviewed recordings of the supervision sessions to determine adherence to the protocol. The research reviewed 50% of each participant's supervisory sessions and completed an additional reality therapy driven supervision checklist to determine fidelity. Protocol fidelity was 100%.

### **Analysis**

Analysis of the data was conducted using visual analysis, the most frequently used method of analysis in single-case research (Gast & Spriggs, 2014). This visual analysis included calculation of percent of nonoverlapping data (PND). A Tau-U (Parker, Vannest, Davis, & Sauber, 2011) statistic was calculated to determine significance and effect size while accounting for baseline trend. Tau-U calculation can result in important changes to the effect size, compared to PND, and is appropriate for smaller data sets while also discriminating at the upper and lower limits (Vannest & Ninci, 2015). Results



were represented graphically with relevant changes in the data reported and any data abnormalities discussed (e.g., participant attrition).

### **Summary**

Two research questions served to guide the study: To what extent does reality therapy driven clinical supervision affect supervisee self-report of counseling self-efficacy, and to what extent does reality therapy driven clinical supervision affect supervisee report of use of basic counseling skills in session? A multiple baseline across participants design was used to evaluate the effect of reality therapy-driven supervision session on supervisee self-reports of counseling self-efficacy and counseling skills, as measured by the Counseling Self-Efficacy Scale and the Skilled Counseling Scale, respectively. Baselines were established for each individual, followed by intervention phases.

## CHAPTER 4

### RESULTS

This study was designed to evaluate if a newly conceptualized reality-therapy-driven model of clinical supervision was an effective model of supervision for increasing supervisee self-report of counseling skills and supervisee self-report of counseling self-efficacy. A multiple baseline across participants single case research design was used to measure two dependent variables: total score on the Skilled Counseling Scale (SCS) and total score on the Counseling Self-Efficacy Scale (CSES).

To evaluate whether functional relations existed between the independent variable (reality-therapy-driven clinical supervision, as delivered via checklist) and change in the dependent variables (SCS and CSES), data from three participants were visually analyzed for evidence of three demonstrations of effect at three different points of time. Further analysis was conducted through calculation of a nonoverlap index, specifically Tau and Tau-U. Tau and Tau-U calculations were selected for their flexibility in controlling for baseline trend and statistical power (Parker, Vannest, Davis, & Sauber, 2011). The Tau-U is also a preferred index for determining effect size and provides indices suitable for future metanalysis (Tincani, & De Mers, 2016; Whalon, Conroy, Martinez, & Werch, 2015). This chapter presents the results of this study, including

visual analysis and statistical analysis of the data, response to research questions, and a summary.

Participants were three white, female graduate students attending programs at a university in the south. All three participants completed the study.

**Participant 1.** Katelyn was a third-year graduate student in a counseling psychology master's program. This was her last clinical placement before graduation and her third semester delivering counseling services.

**Participant 2.** Shaun was a second-year graduate student in an art therapy master's program. This was her first clinical placement and her first semester delivering counseling services.

**Participant 3.** Olivia was a second-year graduate student in an art therapy master's program. This was her first clinical placement and her first semester delivering counseling services.

Overall results via visual analysis indicated mixed results on self-report of skills, with little change on level and trend for all three participants. Two participants' data demonstrated a decrease in variability during the intervention phase. On self-report of counseling self-efficacy, there was little to no change to level and trend for all three participants. One participant's data demonstrated a slight increase in trend during intervention phase.

Percent of nonoverlapping data (PND) statistic was calculated for each participant. The PND represents the percent of data points in the intervention phase that are outside the range of values found in the baseline phase for given participant (Gast & Spriggs, 2014). This is one of the most commonly reported statistics for single subject

research and, for that reason, was calculated. However, PND does not account for increasing trend in the dependent behavior that make occur during baseline phase and continue into intervention (Gast & Spriggs, 2014). Additional statistics are necessary to determine the trend of the baseline data and determine if the trend is significantly changed during intervention.

Tau-U (Parker, Vannest, Davis, & Sauber, 2011) is a nonoverlap statistic that uses pairwise comparison of baseline and intervention data points to determine intervention effect while also correcting for existing baseline trend, if one is present (Vannest & Ninci, 2015). The term Tau-U analysis refers to both the Tau computation, the pairwise comparison of data points, and the Tau-U, the comparison adjusted to account for baseline trend. Tau is calculated by calculating the percentage of nonoverlapping data minus the percentage of overlapping data. To determine trend, intervention data is compared to itself. The number of pairwise comparisons showing improvement in score is subtracted from the number of pairwise comparisons showing decline in score, and this difference is divided by the total number of pairs for comparison. This percentage is the intervention trend. To account for the intervention trend, this percentage is subtracted from the Tau, resulting in the Tau-U (Vannest & Ninci, 2015). The baseline trend is corrected, as a general rule, when the baseline trend ratio is .20 or higher (Vannest & Ninci, 2015). Tau-U was also used to determine effect size. Vannest and Ninci (2015) recommend .20-.60 be considered moderate change, .60-.80 a large change, and .80-1.00 a very large change. Tincani and De Mers (2016) identified effect size cutoffs for Tau-U as .00-.65 for small effect, .66-.92 for moderate effect, and .93-1.00 for large effect. Tincani and De Mers (2016) cutoffs were used for this study.

For this study, Tau-U was calculated using the web-based Tau-U calculator developed by Vannest, Parker, Gonen, and Adiguzel (2016). Using Tau-U analysis to compare baseline and intervention phases while controlling for baseline trend, changes in self-report of counseling skills were significant for two of three participants. Using Tau analysis to compare baseline and intervention phases without controlling for baseline trend, changes in self-report of counseling self-efficacy were significant for two of three participants.

### **Skilled Counseling Scale (SCS)**

Findings from the data collected on the SCS are reported. Table 1 presents a summary of the sample means and standard deviations and Tau-U statistics for participants 1-3. Visual analysis of the data across participants is also presented in Figure 1.

**Table 1**

*Descriptive Statistics, Percent of Nonoverlapping Data (PND), and Tau-U Effect Sizes for Skilled Counseling Scale (SCS) and Counseling Self-Efficacy Scale (CSES)*

| Participant | SCS Mean      | SCS Mean             | SCS<br>PND | SCS<br>Tau-U   | CSES Mean        | CSES Mean            | CSES<br>PND | CSES<br>Tau-U   |
|-------------|---------------|----------------------|------------|----------------|------------------|----------------------|-------------|-----------------|
|             | (SD) Baseline | (SD)<br>Intervention |            |                | (SD)<br>Baseline | (SD)<br>Intervention |             |                 |
| Katelyn     | 63.20 (4.44)  | 70.50 (1.31)         | 87.5%      | .85, $p < .05$ | 79.80 (1.92)     | 83.50 (1.60)         | 87.5%       | .88*, $p < .05$ |
| Shaun       | 64.29 (3.35)  | 75.83 (4.26)         | 100%       | .81, $p < .05$ | 78.00 (2.16)     | 84.50 (5.01)         | 83.33%      | .76*, $p < .05$ |
| Olivia      | 63.30 (5.08)  | 65.88 (3.14)         | 0%         | .09, $p = .76$ | 70.30 (1.89)     | 70.88 (3.27)         | 12.5%       | .02*, $p = .93$ |

\* Tau

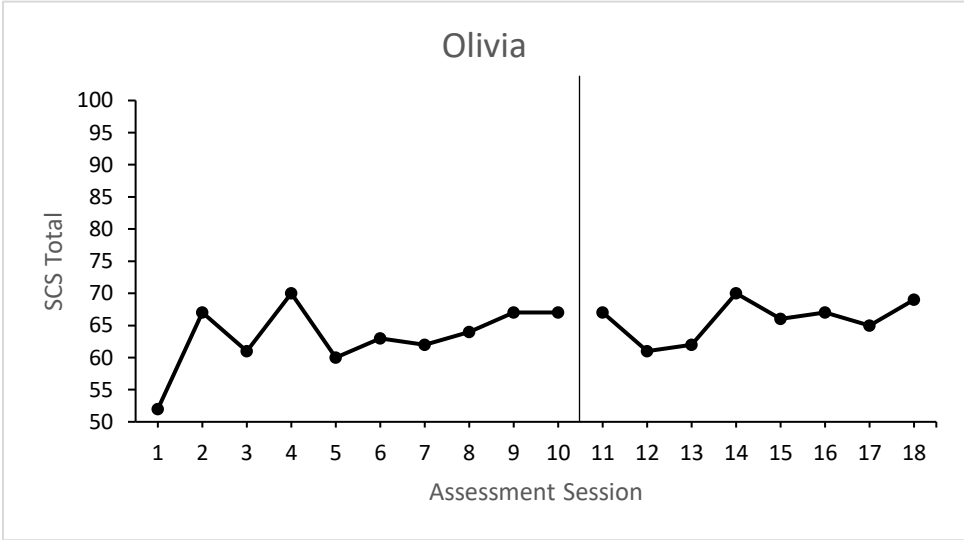
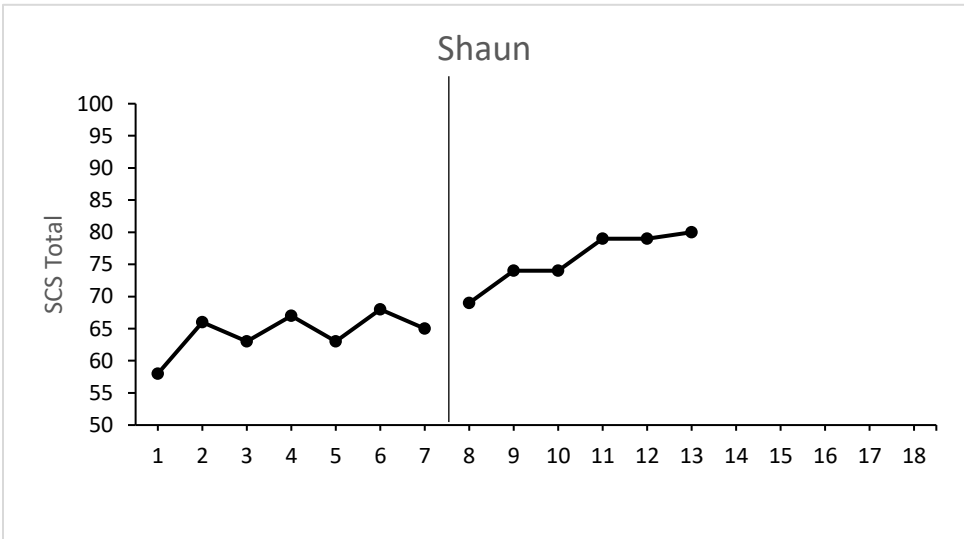
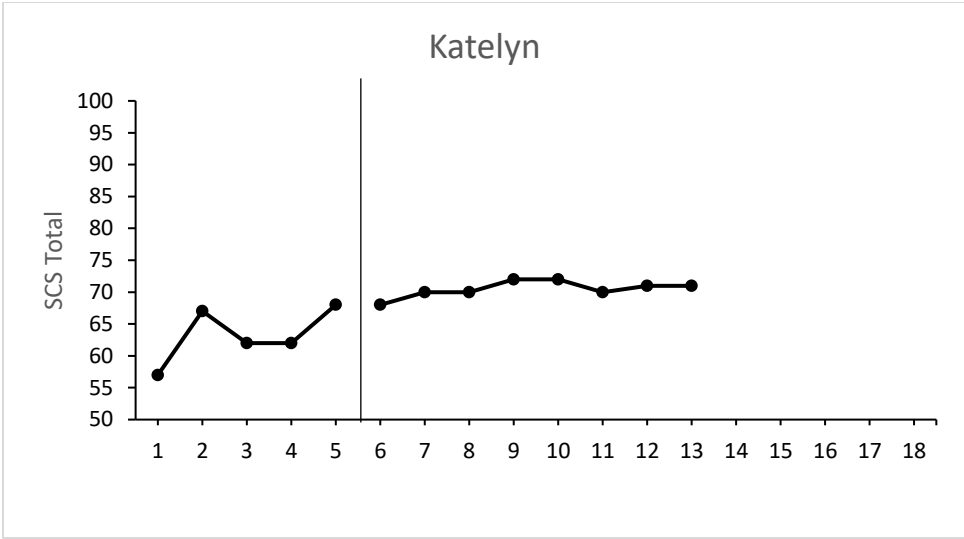


Figure 1. Skilled Counseling Scale (SCS) scores for the three participants across assessment sessions.

Participant 1, Katelyn, had a mean SCS score of 63.20 ( $SD = 4.44$ , range 57-68) during baseline phase. After four sessions of reality-therapy-driven clinical supervision, Katelyn's mean SCS score increased to 70.50 ( $SD = 1.31$ , range 68-72). These results indicated an increase in Katelyn's report of competent use of counseling skills during the intervention phase. PND statistic (87.5%) indicated an overall increase in SCS score from baseline to intervention. Tau-U statistic (Tau-U = .85, 90% CI = [.29, 1.00],  $p < .05$ ) indicated a moderate effect of the intervention on SCS score trend when accounting for baseline trend.

Participant 2, Shaun, had a mean SCS score of 64.29 ( $SD = 3.35$ , range 58-68) during baseline phase. After four sessions of reality-therapy-driven clinical supervision, Shaun's mean SCS score increased to 75.83 ( $SD = 4.26$ , range 69-80). These results indicated an increase in Shaun's report of competent use of counseling skills during the intervention phase. PND statistic (100%) indicated an overall increase in SCS score from baseline to intervention. Tau-U statistic (Tau-U = .81, 90% CI = [.26, 1.00],  $p < .05$ ) indicated a moderate effect of the intervention on SCS score trend when accounting for baseline trend.

Participant 3, Olivia, had a mean SCS score of 63.30 ( $SD = 5.08$ , range 52-70) during baseline phase. After four sessions of reality-therapy-driven clinical supervision, Olivia's mean SCS score increased to 65.88 ( $SD = 3.14$ , range 61-70). These results indicated a slight increase in Olivia's average report of competent use of counseling skills during the intervention phase; however, the upper limit of her score range did not



increase. PND (0%) did not indicate an increase. Tau-U statistic (Tau-U = .09, 90% CI = [-.38, .55],  $p = .76$ ) did not indicate a significant effect of the intervention on SCS score trend.

### **Counseling Self-Efficacy Scale (CSES)**

Findings from the data collected on the CSES are reported. Table 1 presents a summary of the sample means and standard deviations and Tau-U statistics for participants 1-3. Visual analysis of the data across participants and variables is also presented in Figure 2.

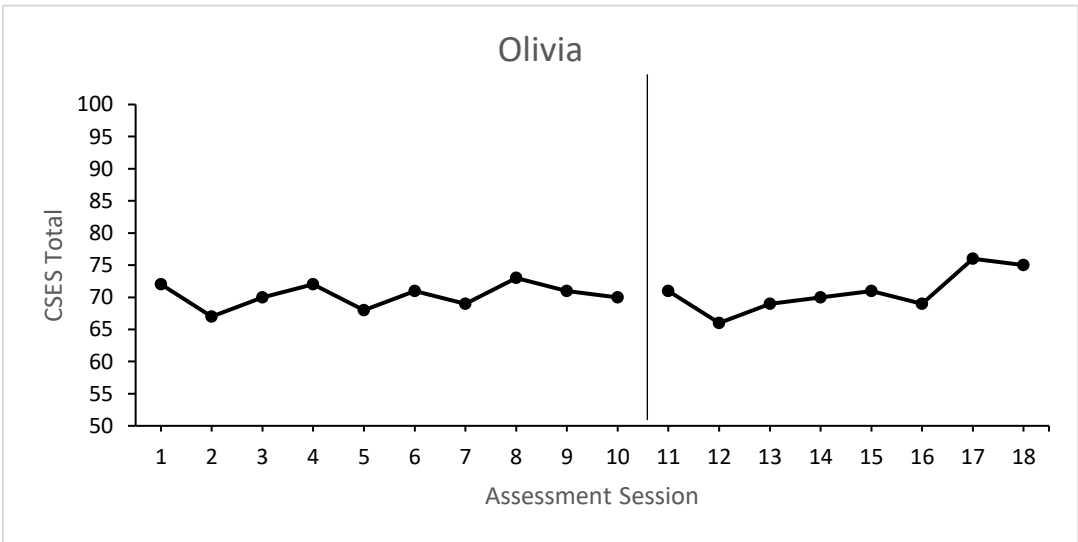
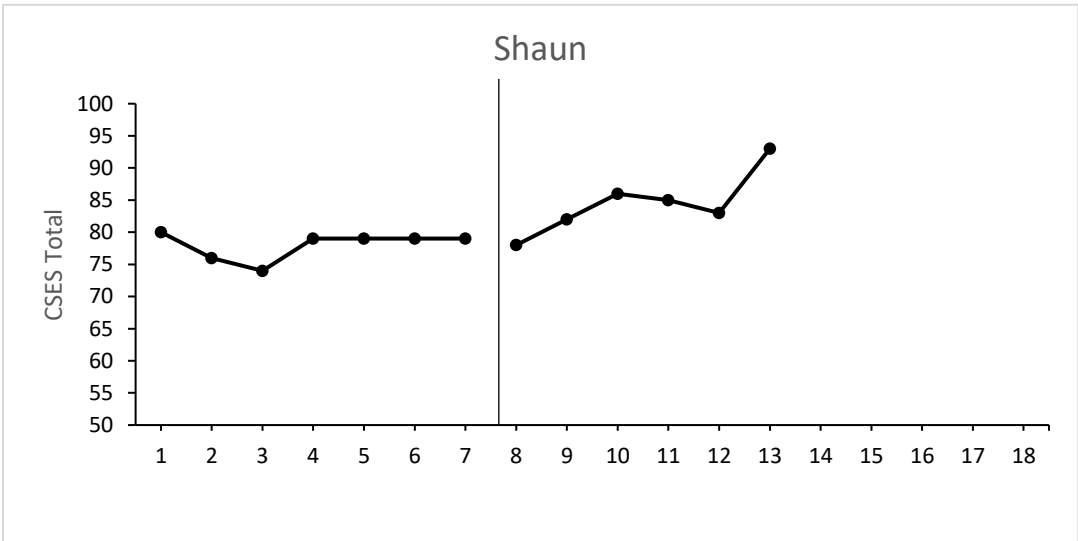
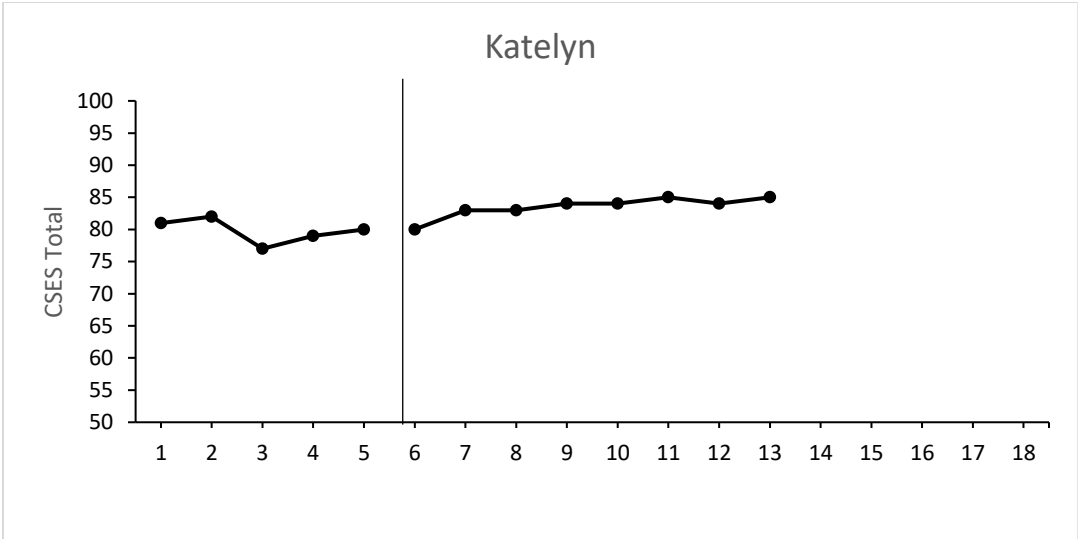


Figure 2. Counseling Self-Efficacy Scale (CSES) scores for the three participants across assessment sessions.

Participant 1, Katelyn, had a mean CSES score of 79.80 ( $SD = 1.92$ , range 77-82) during baseline phase. After four sessions of reality-therapy-driven clinical supervision, Katelyn's mean CSES score increased to 83.50 ( $SD = 1.60$ , range 80-85). These results indicated an increase in Katelyn's report of counseling self-efficacy during the intervention phase. PND statistic (87.5%) indicated an overall increase in CSES score from baseline to intervention. Tau statistic was calculated as no significant baseline trend was found. Tau statistic (Tau = .88, 90% CI = [.31, 1.00],  $p < .05$ ) indicated a moderate effect of the intervention on CSES score trend when compared baseline.

Participant 2, Shaun, had a mean CSES score of 78.00 ( $SD = 2.16$ , range 74-80) during baseline phase. After four sessions of reality-therapy-driven clinical supervision, Shaun's mean CSES score increased to 84.50 ( $SD = 5.01$ , range 78-93). These results indicated an increase in Shaun's report of counseling self-efficacy during the intervention phase. PND statistic (83.33%) indicated an overall increase in CSES score from baseline to intervention. Tau statistic was calculated as no significant baseline trend was found. Tau statistic (Tau = .76, 90% CI = [.21, 1.00],  $p < .05$ ) indicated a moderate effect of the intervention on CSES score trend compared to baseline.

Participant 3, Olivia, had a mean CSES score of 70.30 ( $SD = 1.89$ , range 67-73) during baseline phase. After four sessions of reality-therapy-driven clinical supervision, Olivia's mean CSES score barely increased to 70.88 ( $SD = 3.27$ , range 66-76). These results indicated that no meaningful increase in Olivia's report of counseling self-efficacy occurred during the intervention phase. PND statistic (12.5%) indicated no consistent

increase in CSES score from baseline to intervention. Tau statistic was calculated as no significant baseline trend was found. Tau statistic (Tau = .02, 90% CI = [-.44, .49],  $p = .93$ ) did not indicate a significant effect of the intervention on CSES score trend compared to baseline.

## CHAPTER 5

### DISCUSSION

The purpose of this study was to develop and evaluate a reality therapy driven model of clinical supervision. To this end, the following research questions were addressed in the study: To what extent does reality-therapy-driven clinical supervision affect supervisee self-report of counseling self-efficacy, and to what extent does reality-therapy-driven clinical supervision affect supervisee report of use of basic counseling skills in session?

Tau-U statistical analysis indicated a significant moderate effect for two of the three participants, and visual analysis of the data level and trend indicated a small positive effect. For Katelyn and Shaun, SCS scores increased during intervention and the variance in scores decreased during intervention. Similarly, CSES score for Katelyn and Shaun increased during intervention. In CSES scores, Katelyn appeared to continue the trend established during baseline with reduced variance. Shaun's trend increased following a near zero trend at the end of the baseline phase. Olivia's scores on both SCS and CSES did not change significantly during intervention.

The experience of the third participant, Olivia, requires additional comment. Olivia began her clinical field experience with a considerable level of anxiety. When

asked, Olivia identified work-school-life balance as a significant stressor. Additionally, during the study, Olivia characterized her clinical experience as “just keeping my head above water.” Despite her personal stressors, Olivia participated fully in supervision and clinical duties, and she positively evaluated the supervision experience.

These results may serve as preliminary evidence that a reality therapy driven model of supervision, as operationalized through a reality therapy driven supervision checklist, may be a suitable mode of clinical supervision, with the caveat that additional study is required. Although no participant changed greatly in level or trend, all participants appeared to be improving in skills and self-efficacy, according to self-report, and the supervision model did not impair the supervisees’ positive increase in self-report of counseling skills use and counseling self-efficacy. Evidence of limited functional relations can be established from the available data, and the results offer preliminary evidence that the reality therapy driven model used does not impede supervisee growth and may be as effective as the Fall and Sutton, Jr. (2004) supervision method used during baseline.

The statistical findings compare favorably with the visual analysis of data. For the SCS data, both analyses indicated an increase in level for Katelyn and Shaun, and no change in level for Olivia. The trend for Katelyn continued to increase during intervention, but she appeared slower compared to the baseline trend. For Shaun, the trend increased from baseline; for Olivia, there was trend maintained only a slight acceleration in both baseline and intervention phases. For the CSES data, both analyses indicated an increase in level for Katelyn and Shaun. Katelyn’s trend remained similar from baseline to intervention from the visual analysis; however, the statistical analysis

revealed a significant difference. Shaun's trend was near zero-celerating during baseline and became accelerating during intervention. Olivia's trend and level remained the same from baseline to intervention according to both visual and statistical analysis.

In single case designs, statistical analysis must be considered in the context of the behavior being studied and the change desired in the setting (Vannest & Ninci, 2015). Supervisee skills and self-efficacy are traits developed over multiple years of coursework and hundreds of hours of clinical field experience. This study presents an eight-week depiction of that development, which in the context of the supervision experience may be considered quite abbreviated. The gains in reported skills and self-efficacy during this brief time are encouraging and may result in greater gains for the participants as they increase their clinical contact. Although positive increases in skills and self-efficacy are expected during clinical field experience, utilizing interventions like reality therapy driven supervision may create the conditions for increased supervisee growth and may mean the difference between a successful and unsuccessful clinical field experience for some.

During their final supervision sessions, each participant was asked to informally evaluate the experience of using the reality therapy supervision checklist during the intervention phase. All three participants reported that they valued the structure the form provided for discussing clients and the supervision relationship. Two of the three participants, Shaun and Olivia, reported thinking about the questions outside of supervision as a tool to prepare for counseling and to prepare for the supervision session. Olivia was the most outspoken proponent of the reality therapy supervision checklist, stating that she wished it had been used throughout the semester. Olivia indicated she

received value from the reality therapy supervision process that was not captured on the dependent variable measures in this study.

The existing literature concerning reality therapy and clinical supervision is almost exclusively conceptual and focused primarily on the training of reality therapists (Appel, 1985; Peterson & Parr, 1989; Robey & Cosentino, 2012). This study presents outcome data from a reality therapy driven supervision intervention conducted in a clinical mental health setting with supervisees of differing theories of counseling. This makes the study a unique contribution to the research literature on the efficacy of reality therapy.

The current study supports early findings that clinical supervision results in supervisee improvement in counseling skills and increase in counseling self-efficacy (Cashwell & Dooley, 2001; Wheeler & Richards, 2007). However, determining the effectiveness of models of supervision has been an elusive task in the counseling literature (Goodyear & Bernard, 1998; Westefeld, 2009), and there is only modest evidence that supervision causes lasting changes in supervisee behavior or client outcomes (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001; Watkins, Jr., 2011). Similarly, this study provides only limited support for the reality therapy driven model as effective for some supervisees and not for others. This is consistent with current movements toward differentiation and individualization in the development of the supervision relationship (Watkins, Jr., 2012).

This study does improve on previous research by addressing one of the barriers to rigorous supervision research identified by Goodyear and Bernard (1998), lack of supervision protocol when conducting supervision efficacy studies, with the use of the



Reality Therapy Driven Supervision Checklist. Use of a protocol not only ensured fidelity in the study but also provides a specific account of the reality therapy elements used in the supervision sessions. Participants reacted favorably to the structure, which is consistent with evidence that supervisees early in their clinical work prefer consistent structure and didactic approaches (Barnett, Erickson Cornish, Goodyear, & Lichtenberg, 2007; Heppner & Roehlke, 1984).

### **Implications to Clinical Supervision**

The study established a format for conducting reality therapy driven supervision using a questions checklist. Additionally, the study provided preliminary evidence that supervisees can positively increase in their self-report of counseling skills and counseling self-efficacy while under reality therapy driven supervision.

The study also provided evidence of positive supervisee experiences while under the supervision of a counselor of a different theoretical orientation. The supervisor, a reality therapist, used a different theoretical orientation of counseling than all the participants (cognitive-behavioral, person-centered, and Adlerian). Theoretical orientation dissimilarity did not appear to negatively impact the supervisees' growth trend, even after the implementation of the supervision model more closely aligned with the supervisor's theory of counseling. During this study, the supervisor and supervisee were able to discuss client conceptualization and progress using the supervisee's theoretical orientation. This ability to work within a supervisee's frame of reference for therapy may be more important to supervision quality than the orientation matching and mirrors existing calls in the counseling literature to integrate clients' theory of change into the counseling process (Duncan & Miller, 2000). Reality therapy driven supervision,

as conceptualized in this study, relies and promotes supervisees' expertise in their theoretical orientations. Reality therapy driven supervision provides a structure for supervisees to self-evaluate their performance in using theory and making growth plans aligned to their theories, including preparing theory-informed client interventions or acquiring additional content knowledge about their theory.

The results of this study may also support existing research on the effect of techniques and methods on the outcomes of helping relationships. Evidence exists indicating that counseling techniques and methods account for very little of the change in clients' outcomes (Wampold & Imel, 2015), and some counselors argue that the development of a caring, professional, goal-oriented relationship matters far more to positive client outcomes (Kottler & Balkin, 2017). Counseling theory, then, should be considered a framework to organize the counselor in their development of a beneficial relationship (Kottler, 2018). This may also apply to the supervisory relationship. Bambling and King (2014) found that supervisor interpersonal skills predicted supervision alliance and supervision outcome, and Kilminster and Jolly (2000) also concluded from their review of supervision literature across the fields of medicine, education, psychology, and counseling that the supervision relationship was a more important factor than supervision methods for the effectiveness of supervision. The supervisor's model of supervision may matter less to supervisee outcomes than the helping relationship established between supervisor and supervisee. Supervision models, then, are valuable when they are meaningful to the supervisor and aligned to supervisor strengths. Reality therapy driven supervision presents one way to develop a quality supervision relationship.

## **Limitations**

One limitation is the dependent measures used in the study. The SCS and CSES were selected for their established evidence of validity and their widespread use in counselor training. However, these measures were not initially designed for the type of repeated use necessary for SCRD, and they have not been evaluated for their ability to reflect minute changes over short periods of time. Another consideration concerning the CSES measure is the content of the assessment and applicability to the specific supervision experiences of the supervisees in the study. The CSES contains five questions concerning group counseling self-efficacy; however, none of the participants were assigned group counseling work during the time of the study. As a result, participants were asked to evaluate their self-efficacy in group counseling without obtaining practical experience that may impact their self-efficacy.

Another limitation of the study is its lack of evaluation of observed supervisee behaviors in session and client outcomes. The dependent variables in the current study were supervisee reports of skill use and self-efficacy rather than direct count of skill use in session. Due to resource limitations, supervisee behavior with clients was not directly observed. Such direct observations may offer additional insight into the direct translation of supervision experiences into practice.

## **Suggestions for Future Research**

The study offers preliminary evidence for the benefits of a reality therapy driven model of clinical supervision for supervisees. Replication studies should be done to strengthen validity and reliability of the results of the study. Suggestions for future

research presented here focus on enhancing the rigor and applicability of research on reality therapy driven supervision.

Studies with dependent variables that are observable behaviors (basic listening sequence, response to opportunity) would be a next step in establishing further evidence of functional relations between supervision and supervisee counseling behavior.

Behaviors such as reflecting content, reflecting feeling, paraphrasing, summarizing, and asking open ended questions can be operationalized and observed in future studies to determine if reality therapy driven supervision increases these behaviors in session or increases the appropriate response to opportunity to use skills in session.

One test of reality therapy driven supervision as a useful model across theoretical orientations would be to use the model in the supervision of specific development of treatment skills from other orientations. For example, a design where supervisees work with a reality therapy driven supervisor to become competent in cognitive processing therapy for posttraumatic stress disorder would provide additional data on the effectiveness and process of working across orientations to develop supervisee competencies.

Another avenue of research would be in the development of a supervision assessment specific to reality therapy. Psychotherapy based supervision evaluation instruments have already been developed for cognitive behavioral therapy-based supervision (Milne, Reiser, Cliffe, & Raine, 2011), and an assessment could be designed for reality therapy driven supervision that incorporates more elements of the model than did the checklist presented in this study. With the heads of the William Glasser Institute – United States seeking to increase the impact of reality therapy on the counseling,

coaching, and teaching professions (K. Olver, personal communication, March 21, 2018), evidence-based assessments and protocols will become increasingly important.

All the supervisees in this study were in supervision to complete their graduate program before seeking licensure. Future studies should also be conducted with supervisees at different points in their supervision experience. Most counselors and therapists undergo multiple years of supervision, many completing supervision post-degree as counselor associates or counselor interns, among other titles. Supervisees at different points in their development will have differing supervision needs (Heppner & Roehlke, 1984), and future studies should focus on the process of supervision at those different points.

### **Conclusion**

This single case research design study evaluated a proposed reality therapy driven model of clinical supervision as an effective model at increasing supervisee report of counseling skill use and counseling self-efficacy. The findings indicated that for two of the three participants, self-report of skills and self-efficacy significantly increased during the reality therapy driven supervision phase while accounting for the supervisees' predicted growth trend. The third participant did not have a significant change in self-report of skills or self-efficacy; however, all three participants evaluated the reality therapy driven supervision process positively, stating that the model promoted self-evaluation and accountability. Overall, while the study did not provide three demonstrations of experimental effect, the study offers preliminary evidence that warrants further study.

Kilminster and Jolly (2000) concluded from their research that more effective supervision feature the supervisee demonstrating control over and input into the supervision process. Reality therapy driven clinical supervision promotes supervisee control and input by promoting an internal control psychology within the supervisee in which the supervisee uses self-evaluation to determine which needs should be met in supervision. Then, in conjunction with the supervisor, the supervisee devises a plan to meet those needs successfully. Reality therapist Robert Wubbolding stated that participant self-evaluation is central to the supervision process, and the supervisor co-verifies the supervisees' proficiency while providing a safe atmosphere for supervisees to take risks and receive feedback (Corey, Hayes, Moulton, & Muratori, 2010).

Paul (1967) offered that outcome research in counseling should answer “*What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?* (p. 111).” Reality therapy driven supervision should be viewed as one possible model of a multitude of clinical supervision models. The aim of this study was not to establish reality therapy as the gold standard of theoretical orientations. Rather, the purpose was to characterize the process of reality therapy driven supervision, provide a proposed structure for conducting reality therapy driven supervision using a question checklist, and connect the use reality therapy driven supervision with supervisee outcomes, namely, self-report of counseling skills and counseling self-efficacy. While the results of the study do establish only limited relations between reality therapy driven supervision and supervisee outcome, the positive trends in the participants' data and the supervisees' posttreatment reports of the benefit of reality

therapy driven supervision provide preliminary evidence that reality therapy driven supervision may be useful in creating a quality supervision relationship.

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## APPENDIX A

## Appendix A

### **Reality Therapy Driven Supervision Checklist**

#### The Counselor-Client Relationship

- What do you want for the client?
- What are you doing toward those wants?
- What is your evaluation of current actions/relationship?
- What would you like to do going forward?
- What will you do (specifics) to help the client address the want?

#### The Supervisor-Supervisee Relationship

- What do you, we, and I want for this supervision session?
- What have we, individually or together, done to meet that want?
- What is your evaluation of our current actions/relationship in service to that want?
- What would like from me, yourself and/or the relationship moving forward?
- What will you, we, and I do (specifics) to meet the want?

## APPENDIX B

## Appendix B

### **Subject Informed Consent Document**

#### **USING REALITY THERAPY IN CLINICAL SUPERVISION: A PSYCHOTHERAPY-DRIVEN MODEL**

Investigator(s) name & address: Ahmad Washington, PhD, NCC,  
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University of Louisville  
Louisville, KY 40292

Quentin Hunter, MEd, LPCA, NCC  
College of Education, Room 266  
Louisville, KY 40292

Site(s) where study is to be conducted: Cardinal Success Program @ Nia  
Center, 2900 W.

Broadway, Ste. 320, Louisville KY

Phone number for subjects to call for questions: 502-438-8579

#### **Introduction and Background Information**

You are invited to participate in a research study. The study is being conducted by Ahmad Washington, PhD, NCC and Quentin Hunter, MEd, LPCA, NCC at the University of Louisville. The study is sponsored by the University of Louisville, Department of Counseling and Human Development. The study will take place at Cardinal Success Program @ Nia Center. Approximately 12 subjects will be invited to participate, depending upon availability.

#### **Purpose**

The purpose of this study is to evaluate clinical supervision practices in the process of clinical supervision.

#### **Procedures**

During the study, you will receive standard clinical supervision for a period of now fewer than two sessions. Following this period, you will receive clinical supervision in a new format. During the study, you will be asked to complete two measures before each supervision session that will take no longer than 15 minutes total: The Skilled Counseling Scale and the Counseling Self-Efficacy Scale. You will also be asked to complete these measures at a time between your scheduled supervision sessions. Once you begin the new format supervision, this format will continue for the remainder of the study period (June

2018) unless you elect to discontinue the study. You can skip any question which may cause discomfort and may withdraw from the study at any time. Additionally, a video recording of the session will be made to review supervision practices. The videos are solely to ensure the new supervision format is being implemented correctly. Specific content related to clinical work conducted as part of the field experience will not be used in the study.

### **Potential Risks**

There are no foreseeable risks other than possible discomfort in answering personal questions.

### **Benefits**

The possible benefits of this study include obtaining information of supervision practices and receiving clinical supervision that is beneficial to counseling practice. The information collected may not benefit you directly. The information learned in this study may be helpful to others.

### **Payment**

You will not be compensated for your time, inconvenience, or expenses while you are in this study.

### **Confidentiality**

Total privacy cannot be guaranteed. We will protect your privacy to the extent permitted by law. If the results from this study are published, your name will not be made public. Once your information leaves our institution, we cannot promise that others will keep it private.

Your information may be shared with the following:

- Organizations that provide funding at any time for the conduct of the research.
- The University of Louisville Institutional Review Board, Human Subjects Protection Program Office, Privacy Office, others involved in research administration and compliance at the University, and others contracted by the University for ensuring human subjects safety or research compliance
- The local research team
- People who are responsible for research, compliance and HIPAA oversight at the institutions where the research is conducted
- Government agencies, such as:
  - Office for Human Research Protections

## **Security**

Your information will be kept private by using a four-digit code instead of names on all measures completed. Completed measures will be locked in a file cabinet, kept in a secure area.

## **Voluntary Participation**

Taking part in this study is voluntary. You may choose not to take part at all. If you decide to be in this study, you may stop taking part at any time. If you decide not to be in this study or if you stop taking part at any time, you will not lose any benefits for which you may qualify. Please note that participation or non-participation does not impact your receipt of clinical supervision, and non-participation will not affect your performance evaluations.

You will be told about any changes that may affect your decision to continue in the study.

Note: You are eligible to receive clinical supervision regardless of your participation in this study.

## **Contact Persons**

If you have any questions, concerns, or complaints about the research study, please contact Ahmad Washington at 502-852-0628 or Quentin Hunter at 502-438-8579

## **Research Subject's Rights**

If you have any questions about your rights as a research subject, you may call the Human Subjects Protection Program Office at (502) 852-5188. You may discuss any questions about your rights as a research subject, in private, with a member of the Institutional Review Board (IRB). You may also call this number if you have other questions about the research, and you cannot reach the study doctor, or want to talk to someone else. The IRB is an independent committee made up of people from the University community, staff of the institutions, as well as people from the community not connected with these institutions. The IRB has approved the participation of human subjects in this research study.

## **Concerns and Complaints**

If you have concerns or complaints about the research or research staff and you do not wish to give your name, you may call the toll free number 1-877-852-1167. This is a 24 hour hot line answered by people who do not work at the University of Louisville.





## APPENDIX C

## Appendix C

### **List of Survey Instruments**

Skilled Counseling Scale (SCS; Urbani, Smith, Maddux, Smaby, Torres-Rivera, & Crews, 2002)

Counselor Self-Efficacy Scale (Melchert, Hays, Wiljanen, & Kolocek, 1996)

**Skilled Counseling Scale**  
(Urbani, Smith, Maddux, Smaby, Torres-Rivera, & Crews, 2002)

This is a survey to assess counseling skills. Please rate to the following 18 skills item 1, 2, 3, 4 or 5 accordingly.

|                   |                 |                 |                     |               |
|-------------------|-----------------|-----------------|---------------------|---------------|
| <b>1</b>          | <b>2</b>        | <b>3</b>        | <b>4</b>            | <b>5</b>      |
| <b>Not at all</b> | <b>A little</b> | <b>Somewhat</b> | <b>A great deal</b> | <b>Always</b> |

Exploring Stage

***I. ATTENDING***

**1. Eye Contact**

Direct gaze with occasional breaks, the latter usually intentional.

1                      2                      3                      4                      5

**2. Body Language**

Open and relaxed posture. Leaning forward when talking, leaning back when client talks on target. Using head nods and body gestures.

1                      2                      3                      4                      5

**3. Verbal Tracking**

Repeating key feeling and content words. Helping client focus on main topics.

1                      2                      3                      4                      5

***II. QUESTIONS AND REFLECTING***

**4. Questions**

Asking open questions that encourage the client to continue talking.

1                      2                      3                      4                      5

**5. Paraphrasing**

Engages in brief, accurate, and clear rephrasing of what the client has expressed.

1                      2                      3                      4                      5

**6. Summarizing**

A statement that generally reflects what the client has expressed overall, regarding a topic.

1                      2                      3                      4                      5

## Understanding Stage

### ***III. INTERCHANGEABLE EMPATHY***

#### **7. Feeling and Content**

Stating succinctly the feeling and the content of the problem faced by the client. (“You feel \_\_\_\_\_ when \_\_\_\_\_.”)

1                      2                      3                      4                      5

#### **8. Self-Disclosure**

Self-discloses a problem that was earlier resolved that is related to the problem faced by the client. (“When I’ve helped others with the problem of \_\_\_\_\_ they changed their attitude and actions to \_\_\_\_\_ and this resulted in resolving the problem. What do you think about this possible solution?”)

1                      2                      3                      4                      5

#### **9. Concrete and Specific**

Asks for concrete and specific expressions. (“Tell me more about how you feel and behave when facing \_\_\_\_\_.”)

1                      2                      3                      4                      5

### ***IV. ADDITIVE EMPATHY***

#### **10. Immediacy**

Recognizes immediate feelings (verbal/nonverbal) expressed between the client and the counselor when discussing problem. (“As we talk about the \_\_\_\_\_ problem, I sense you are feeling \_\_\_\_\_ about me. In turn, I am feeling \_\_\_\_\_ about how you are viewing the problem right not.”)

1                      2                      3                      4                      5

#### **11. Situation, Action and Feelings**

Identifying general problem situation, action taken when facing the problem and feeling about one’s self after taking the action. (“In \_\_\_\_\_ situations, you do \_\_\_\_\_ and feel \_\_\_\_\_.”)

1                      2                      3                      4                      5

#### **12. Confronts Caringly**

Confronts caringly the discrepancy between self-expectation when facing the problem and actual attitude/behavior shown and how these are personally judged. (“You expect

yourself to do \_\_\_\_\_ when facing the problem of \_\_\_\_\_, but you do \_\_\_\_\_. When this happens you feel \_\_\_\_\_ about yourself.”)

1                      2                      3                      4                      5

### Action Stage

## ***V. DECISION-MAKING***

### **13. Deciding**

Defining the decision in terms of changing or not changing. (“You can choose to \_\_\_\_\_ or not to change. What would you like to do?”)

1                      2                      3                      4                      5

### **14. Choosing**

Recognizing the preferred choice and immediate feeling and implication when taking new actions. (“You have decided to \_\_\_\_\_ which means that when you do \_\_\_\_\_ you will feel \_\_\_\_\_.”)

1                      2                      3                      4                      5

### **15. Consequences**

Delineating the long-term goal achievement and associated benefits to one-self. (“By choosing to do \_\_\_\_\_ you will achieve your goal of \_\_\_\_\_ and feel \_\_\_\_\_ about yourself.”)

1                      2                      3                      4                      5

## ***VI. CONTRACTING***

### **16. Agreements**

Reaching agreement about actions to take and who is responsible for them. (“In deciding to \_\_\_\_\_ you will do \_\_\_\_\_, and \_\_\_\_\_ so things will change accordingly.”)

1                      2                      3                      4                      5

### **17. Deadlines**

Specifying a timetable for completing actions to fulfill responsibilities for the decisions. (“You will accomplish \_\_\_\_\_ by \_\_\_\_\_.”)

1                      2                      3                      4                      5

### **18. Review Goals and Action to Determine Outcome**

Reminding the client of the problem-solving goal that requires her/him to take specific actions to achieve the desired outcome. (“In aiming to achieve \_\_\_\_\_ you will take the following steps of \_\_\_\_\_, \_\_\_\_\_, and this can result in \_\_\_\_\_. How will you feel about this outcome?”)

1

2

3

4

5

**Counselor Self-Efficacy Scale  
(Melchert, Hays, Wiljanen, & Kolocek, 1996)**

Please rate to the following items 1, 2, 3, 4 or 5 accordingly.

| <b>1</b>                     | <b>2</b>                       | <b>3</b>                 | <b>4</b>                    | <b>5</b>                  |
|------------------------------|--------------------------------|--------------------------|-----------------------------|---------------------------|
| <b>Disagree<br/>Strongly</b> | <b>Disagree<br/>Moderately</b> | <b>Neutral/Uncertain</b> | <b>Agree<br/>Moderately</b> | <b>Agree<br/>Strongly</b> |

**1. My knowledge of personality development is adequate for counseling effectively.**

1                      2                      3                      4                      5

**2. My knowledge of ethical issues related to counseling is adequate for me to perform professionally.**

1                      2                      3                      4                      5

**3. My knowledge of behavior change principles is not adequate.**

1                      2                      3                      4                      5

**4. I am not able to perform psychological assessment to professional standards.**

1                      2                      3                      4                      5

**5. I am able to recognize the major psychiatric conditions.**

1                      2                      3                      4                      5

**6. My knowledge regarding crisis intervention is not adequate.**

1                      2                      3                      4                      5

**7. I am able to effectively develop therapeutic relationships with clients.**

1                      2                      3                      4                      5

**8. I can effectively facilitate client self-exploration.**

1                      2                      3                      4                      5

**9. I am not able to accurately identify client affect.**

1                      2                      3                      4                      5

**10. I cannot discriminate between meaningful and irrelevant client data.**

1                      2                      3                      4                      5

**11. I am not able to accurately identify my own emotional reactions to clients.**

1                      2                      3                      4                      5

**12. I am not able to conceptualize client cases to form clinical hypotheses.**

1                      2                      3                      4                      5

**13. I can effectively facilitate appropriate goal development with clients.**

1                      2                      3                      4                      5

**14. I am not able to apply behavior change skills effectively.**

1                      2                      3                      4                      5

**15. I am able to keep my personal issues from negatively affecting my counseling.**

1                      2                      3                      4                      5

**16. I am familiar with the advantages and disadvantages of group counseling as a form of intervention.**

1                      2                      3                      4                      5

**17. My knowledge of the principles of group dynamics is not adequate.**

1                      2                      3                      4                      5

**18. I am able to recognize the facilitative and debilitating behaviors of group members.**

1                      2                      3                      4                      5

**19. I am not familiar with the ethical and professional issues specific to group work.**

1                      2                      3                      4                      5

**20. I can function effectively as a group leader/facilitator.**

1                      2                      3                      4                      5



## CURRICULM VITA

Quentin Hunter

Doctoral Candidate, Counselor Education & Supervision  
Department of Counseling & Human Development  
College of Education & Human Development  
University of Louisville

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### Education

Ph. D. in Counselor Education and Supervision [In Progress], University of Louisville, expected completion August 2018

M. Ed. in Counselor Education, Augusta University (as Georgia Regents University), May 2015. CACREP Accredited. Specialty Area: Clinical Mental Health Counseling

B.A. in Psychology, University of Oklahoma, May 2006. Minor: Film & Video Studies.

B.A. in Russian, University of Oklahoma, May 2006. Minor: History.

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### Credentials

Licensed Professional Clinical Counselor Associate, September 2015-present,  
Commonwealth of Kentucky, License Number: 166737  
National Certified Counselor, June 2015-present, Certification Number: 645602

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### Professional Experience

**Editorial Assistant**, *Journal of Counseling and Development*, July 2016-present. Assist with the production of the official publication of the American Counseling Association

**Graduate Assistant**, Dept. of Early Childhood and Elementary Education, University of Louisville, Louisville, KY, January 2018-present. Assist with faculty research and programmatic needs.

**Graduate Teaching Assistant**, Dept. of Special Education, University of Louisville, Louisville, KY, July 2017-December 2017. Teach multiple sections of undergraduate education courses.

**Graduate Assistant**, Dept. of Counseling and Human Development, University of Louisville, Louisville, KY, August 2015-July 2017. Assist with faculty research, teaching, and operation of university-sponsored community clinic.

**Counselor Associate**, Frederick Law Olmsted Academy North (Middle School), Louisville, KY, August 2017 to present. Provided counseling services for children in individual, group, and classroom settings.

**Counselor Associate**, Cardinal Success Program, University of Louisville, Louisville, KY, August 2015 to present. Provided counseling services for child and adult clients in individual, couples, family, and group settings.

**Counseling Intern**, Charlie Norwood Veterans Administration Medical Center, Augusta, GA, June 2014 to May 2015. Provided therapy services in the PTSD clinic for adult clients in individual and group settings.

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#### Honors

Diversity Fellow, University of Louisville, 2015-2018

**Outstanding Graduate Student Award for Professional Excellence and Distinguished Service**, Kentucky Counseling Association, 2017

Mentoring Leadership Academy, Kentucky Counseling Association, 2016

**Invited Member**, Alpha Upsilon Phi Honor Society, 2015

**Outstanding Graduate Student in Clinical Mental Health Counseling**, College of Education, Augusta University (as Georgia Regents University), 2015

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#### Professional Affiliations

Chi Sigma Iota Counseling Honors Society (2013 – present)

American Counseling Association (2014 – present)

American School Counseling Association (2017 – present)

Association for Counselor Education and Supervision (2015 – present)

Association for LGBT Issues in Counseling (2014 – present)  
American College Counseling Association (2015 – 2017)  
Association for Humanistic Counseling (2018-present)  
Kentucky Counseling Association (2014 – present)  
Kentucky School Counseling Association (2017 – present)  
Kentucky Assoc. for LGBT Issues in Counseling (2016 – present)  
Kentucky Assoc. for Assessment and Research in Counseling (2016 - present)

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## Teaching

### Teaching Assistant

- ECPY 650 Group Process and Practice (Fa 2015, Fa 2016, Su 2017)
- ECPY 629 Theories and Techniques of Counseling and Psychotherapy (Sp 2016)
- ECPY 630 Theories and Techniques of School Counseling (Sp 2016)
- ECPY 793 Advanced Theory and Techniques – Family Therapy (Su 2016)
- ECPY 674 Practicum in School Counseling (Sp 2017, Fa 2017, Sp 2018)

### Instructor

- ECPY 540 Evaluation and Measurement in Education (Fa 2016)
  - ECPY 611 Learning Systems: Theory and Practice (Su 2016, Sp 2017)
  - EDTP 107 Human Development and Learning (Fa 2017)
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## Service

### National Professional Organizations

**Student Member, Professional Standards Committee**, American Counseling Association, 2016-2017

**Member, President's Target Task Group for LGBT Adult Lifespan Development**, American Counseling Association, 2016-2017

### State Professional Organizations

**Immediate Past President**, KY Assoc. for LGBT Issues in Counseling, 2017-present

**President**, KY Assoc. for LGBT Issues in Counseling, 2017-present

**Chair, Strategic Planning Committee**, KY Assoc. for LGBT Issues in Counseling, 2016-2017

**Chair, Educational Resources Committee**, KY Assoc. for LGBT Issues in Counseling, 2016-2017

### University Committees:

**Member, LGBTQ Safe Zone Program Executive Committee**, Georgia Regents University, 2012-2015.

**Member, Employee Advisory Committee**, Georgia Regents University, 2014

### College Committees:

**Member, Staff Advisory Council**, College of Education, Georgia Regents University, 2013-2015.

**Member, Department Chair Search Committee**, Dept. of Counselor Education, Leadership, and Research, College of Education, Georgia Regents University, 2014.

**Chair, Instructional Resource Center Manager Search Committee**, College of Education, Georgia Regents University, 2013.

Departmental Committees:

**Member, Student Travel and Professional Development Committee**, Dept. of Counseling and Human Development, College of Education and Human Development, University of Louisville, 2015-2016

**Member, Office Specialist Search Committee**, Dept. of Teacher Education, College of Education, Georgia Regents University, 2015

*Other Service*

**Reviewer**, Chi Sigma Iota International Chapter Grants, 2013-present.

**Proposal Reviewer**, Western Assoc. for Couns. Ed. and Supervision, 2016, 2018

**Member**, Chi Sigma Iota - Gamma Rho Omega Chapter, 2013-2015.

**Trainer**, LGBT Safe Zone Program Awareness Training, Georgia Regents University, 2013-2015.

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### **Publications (Peer Reviewed)**

Coma, M. T., & **Hunter, Q.** (2018). Empathy, humanism, and mindfulness in multicultural counseling and social justice work. *The William & Mary Educational Review*, 6 (1), 70-90. Available from <https://scholarworks.wm.edu/wmer/vol6/iss1/6>

Balkin, R. S., Reiner, S. M., Hendricks, L., Washington, A., McNeary, S., Juhnke, G. A., & **Hunter, Q.** (2018). Life balance and work addiction among African Americans. *Career Development Quarterly*, 66, 77-84. doi: 10.1002/cdq.12123

**Hunter, Q.**, Balkin, R., S., & Reiner, S. M. (2018). Addressing impact of counseling research: A comparative study of counseling and psychology journals. *Counseling Outcome Research and Evaluation*. doi: 10.1080/21501378.2017.1403848

### **Publications (Other)**

Kuo, N. C., Peters, S. & **Hunter, Q.** (2017) (Eds.). *Supporting Response to Intervention (RTI) through instructional leadership*. Champaign, IL: Stipes.

**Hunter, Q.**, & O'Hara, M., & Logan, C. (2017). Young LGBTQ adults: Family and social development. In C. B. Roland & L. D. Burlew (Eds.), *Counseling LGBTQ Adults Throughout the Lifespan* (pp. 16-19). Alexandria, VA: American Counseling Association.

Norman, D., **Hunter, Q.**, & O'Hara, M. (2017). Young LGBTQ adults: Career development. In C. B. Roland & L. D. Burlew (Eds.), *Counseling LGBTQ Adults Throughout the Lifespan* (pp. 6-9). Alexandria, VA: American Counseling Association.

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#### Presentations (Peer Reviewed)

##### International and National

**Hunter, Q.**, & Coma, M. (2018, June). Empathy, humanism, and mindfulness in multicultural counseling and social justice work. Presented at the annual conference of the Association for Humanistic Counseling in St. Petersburg, Florida.

**Hunter, Q.** (2017, October). Understanding confirmatory factor analysis in counseling. Presented at the biennial conference of the Association for Counselor Education and Supervision in Chicago, Illinois.

**Hunter, Q.**, & Washington, A. (2017, March). Leadership in school-based group counseling: What matters to students most? Presented at the annual conference of the American Counseling Association in San Francisco, California.

Lorenzi, T., **Hunter, Q.**, & Klipa, E. (2014 September). What's the 'T' - Promoting self-acceptance in Black adolescent gay males. Presented at the inaugural conference of the Association for LGBT Issues in Counseling in New Orleans, Louisiana.

##### Regional, State, and Local

Baxter, C., & **Hunter, Q.** (2018 February). Social emotional learning in schools: The role of the school counselor. Presented at the 2018 Impacting Student Learning conference in Augusta, Georgia.

May, R. K., & **Hunter, Q.** (2018 February). Coming out to help others understand the LGBT+ community. Presented at the annual Appalachian Counselors of Tomorrow Conference in Langley, Kentucky.

**Hunter, Q.** (2018 February) Whose Rights? The Men's Rights Movement and Implications for Counselors. Presented at the annual Cross-Cultural Counseling and Education Conference for Research, Action, and Change in Savannah, Georgia.

**Hunter, Q.**, Gosnell Richey, K., Sowell, S., & Balkin, R. (2017 November). Addressing

abuse with adolescents: Problems and processes. Presented at the annual Kentucky Counseling Association conference in Louisville, KY.

Richey, K., & **Hunter, Q.** (2017 May). Discussion of race in predominately White school settings: Implications for school counselors. Presented at the annual Indiana Counseling Association conference in Columbus, Indiana.

Sowell, S., Richey, K., & **Hunter, Q.** (2017 February). Road map: The roles and responsibilities of school counselors in the assessment and counseling of suicidal adolescents. Presented at the annual Kentucky School Counseling Association conference in Lexington, Kentucky.

Sowell, S., **Hunter, Q.**, & Richey, K. (2017 February). School counseling interns don't come with a manual? Tips & tools to enhance your comprehensive, data-driven school counseling program. Presented at the annual Kentucky School Counseling Association conference in Lexington, Kentucky.

**Hunter, Q.** (2016 November). Single out what works: Single case research design in counseling. Presented at the annual Kentucky Counseling Association conference in Louisville, KY

Balkin, R. S., Sowell, S., Richey, K., & **Hunter, Q.** (2016 November). Assessment and counseling of adolescent suicidality. Presented at the annual Kentucky Counseling Association conference in Louisville, Kentucky

**Hunter, Q.**, Richey, K., & Washington, A. (2016 October) "Are we doing this right?" Doctoral students discuss co-facilitating an experiential group. Roundtable session at the biennial Southern Association for Counselor Education and Supervision conference in New Orleans, Louisiana.

**Hunter, Q.**, & Baxter, C. (2016 April). "I don't know, go ask the counselor:" School counselor abilities and realities. Presented at the annual Indiana Counseling Association conference in Columbus, Indiana.

**Hunter, Q.**, & Lorenzi, T. (2016 February). Counselor and teacher contributions in helping black middle school boys succeed. Presented at the annual Cross-Cultural Counseling and Education Conference for Research, Action, and Change in Savannah, Georgia.

**Hunter, Q.**, & Baxter, C. (2015 November). "I don't know, go ask the counselor:" School counselor abilities and realities. Poster session at the annual Kentucky Counseling Association conference in Louisville, Kentucky.

Balkin, R.S., **Hunter, Q.**, & Gosnell, K. (2015 November). The counseling relationship in an era of accountability. Presented at the annual Kentucky Counseling Association conference in Louisville, Kentucky.

**Hunter, Q.** (2015 March). Helping students bounce back: Understanding adverse childhood experiences and promoting resilience. Presented at the 2015 Impacting Student Learning conference in Augusta, Georgia.

**Hunter, Q., & Baxter, C.** (2014 November). Fat caps and the mind: Graffiti art in child counseling. Poster session at the annual Kentucky Counseling Association conference in Louisville, Kentucky.

**Hunter, Q., & Yamaguchi, M.** (2014 March). Creating a safe space: LGBTQIQ individuals in the classroom, school, and community. Presented at the 2014 Impacting Student Learning conference in Augusta, Georgia.