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Supervision for treatment of depression:

An experimental study of the role of therapist gender and anxiety

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Abstract

Psychological treatments for depression are not always delivered effectively or consistently. Clinical supervision of therapists is often assumed to keep therapy on track, ensuring positive patient outcomes. However, there is a lack of empirical evidence supporting this assumption. This experimental study explored the focus of supervision of depression cases, comparing guidance given to supervisees of different genders and anxiety levels. Participants were clinical supervisors who supervised therapists working with patients with depression. Supervisors indicated their supervision focus for three supervision case vignettes. Supervisee anxiety and gender was varied across vignettes. Supervisors focused calm female supervisees more on therapeutic techniques than state anxious female supervisees. Males were supervised in the same way, regardless of their anxiety. Both male and female supervisors had this pattern of focus. Findings indicate that supervision is influenced by supervisors' own biases towards their supervisees. These factors may cause supervisors to drift from prompting their supervisees to deliver best practice. Suggestions are made for ways to improve the effectiveness of clinical supervision and how these results may inform future research practice.

Key words:

supervision; depression; cognitive behavioural therapy; gender; anxiety

Supervision for depression:

An experimental study of the role of therapist gender and anxiety

Depression is the leading cause of disability worldwide (World Health Organisation, 2012). Approximately 350 million suffer from the disorder at any one time (Marcus, Yasamy, van Ommeren, Chisholm, & Saxena, 2012), and depressive disorders have been implicated in approximately 59% of suicides (Henriksson et al., 1993). The way that this disorder diminishes quality of life combined with the high prevalence rate highlights the necessity for reliable treatments. The National Institute for Health and Care Excellence (NICE) recommends the use of CBT for all forms of depression (NICE, 2011), based on randomised controlled trials (RCT) (e.g., Butler, Chapman, Forman, & Beck, 2006; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). While these outcomes can be achieved in routine clinical settings (Persons, Bostrom, & Bertagnolli, 1999; Persons, Roberts, Zalecki, & Brechwald, 2006), they commonly are not. For example, Gibbons, Stirman, DeRubeis, Newman, and Beck (2013) found that patients with depression treated within an RCT setting experienced almost three times as much symptom improvement as those treated in a routine clinical setting.

While these differences in outcome of CBT for depression might be attributed to different patient samples (e.g., Kazdin, 2008; Westen & Morrison, 2001), the evidence is that most patients treated in naturalistic settings would meet the criteria for RCTs (Schindler, Hiller, & Witthoft, 2011; Stirman, DeRubeis, Crits-Christoph, & Brody, 2003; Stirman, DeRubeis, Crits-Christoph, & Rothman, 2005). Thus, patient complexity cannot fully explain differences in outcome of treatment for depression (Gibbons et al., 2013; Weisz, Jensen-Doss, & Hawley, 2006). An alternative is that the difference in outcomes might be due to clinicians in RCTs adhering more closely to evidence-based methods. Emotional, cognitive and behavioural factors can cause therapists to depart from evidence-based methods (Waller, 2009). Therefore, it is important not just that clinicians are competent to deliver a therapy, but that their actual delivery of the therapy is monitored so that such factors do not

impair the effectiveness of therapy. A commonly used mechanism for that monitoring is supervision.

There is an assumption that clinical supervision is a useful tool for ensuring that therapy is delivered accurately and constantly (Lambert & Ogles, 1997; Milne & James, 2000; Wampold & Holloway, 1997). However, there is very little research looking at the effect of clinical supervision upon therapy delivery or patient outcomes (Ellis & Ladany, 1997; Kilminster & Jolly, 2000; Milne & James, 2000; Watkins, 2011). Within such research, results are often mixed. While some studies indicate that supervision can have a positive impact on patient outcomes (Bambling, King, Raue, Schweitzer, & Lambert, 2006; Ost, Karlstedt, & Widen, 2012), other research finds no impact (White & Winstanley, 2010).

Supervisors might not be the objective third parties who they are assumed to be in the therapy process. They can be affected by their own biases (Dennhag, Gibbons, Barber, Gallop, & Crits-Christoph, 2012). While therapist characteristics can impact the therapy process (Lilenfeld, Ritschel, Lynn, Cautin, & Latzman, 2013; Waller, Stringer, & Meyer, 2012), it is not known whether and how those clinician characteristics affect the focus of supervision sessions (and ultimately the content of therapy sessions). Two factors that have been identified in the literature on clinicians' delivery of evidence-based treatments might be particularly pertinent to supervisory practice when working with depression – therapist anxiety and therapist gender.

It can be hypothesised that when faced with an anxious therapist who is avoiding evidence-based CBT techniques for depression, supervisors are reluctant to push the use of such techniques for fear of distressing the therapist. Such reluctance would parallel the reluctance of therapists themselves in delivering such techniques to anxious patients (e.g., Deacon et al., 2013). However, the impact of gender on supervision is a relative unknown. It has been shown that we have different expectations (either implicit or explicit) of the abilities of men and women (Heilman, 2012), and that men are often seen as more competent than women (Ridgeway & Correll, 2004). For example, supervisors treat male and female supervisees differently – assuming a more powerful role with female supervisees than with

males, and failing to reinforce females if they attempt to take a more powerful role themselves (Nelson & Holloway, 1990). Therefore, it can be hypothesised that supervisors will focus supervision differently for male and female supervisees, potentially focusing men more on the techniques of therapy because they see male therapists as more expert and competent than females.

Therefore, the aim of this study is to explore experimentally how supervisee anxiety and gender impact the advice that supervisors give in directing clinicians working with depression. The study focuses on supervision for CBT specifically, rather than other therapies. This is not only because it is the recommended treatment for depression (NICE, 2011), but also because it has a rigorous protocol (Beck, Rush, Shaw, & Emery, 1979). Therefore, departure from that protocol might, arguably, have a greater effect on this therapy than it would on others. It is hypothesised that supervisors who are working with a calm clinician will stress the need for their supervisee to focus on CBT techniques more than when the clinician is anxious. It is also hypothesised that supervisors will focus male supervisees more on CBT techniques than female supervisees.

Method

Participants

The participants were a sample of 89 clinical supervisors, supervising clinicians delivering CBT to patients with depression. Their names and email addresses were drawn from CBT clinician organisations from across Europe (members of the European Association for Behavioural and Cognitive Therapies). A snowball approach was used to recruit participants, and therefore the *N* approached is not known. The mean age of the group was 50.2 years (*SD* = 9.14, range = 27-68), and 55.1% were female. Participants were from eight different countries across Europe, the majority being from the UK (71.9%) and the second largest group being from the Netherlands (10.1%). The mean amount of time that the group had been using CBT was 13.8 years (*SD* = 7.43, range = 2-38). Participants came from a range of background professions, including clinical psychology (*N* = 27), nursing (*N* = 24), Improving Access to Psychological Therapies services (IAPT, *N* = 9), and counselling

psychology (*N* = 6).

Ethics

This research was approved by the University of Sheffield's Department of Psychology Research Ethics Committee.

Design

This was a survey-based, experimental design, using vignettes to present clinical material. The within-subjects independent variable was the level of supervisee anxiety in the vignettes, and the between-subject independent variable was supervisee gender. The dependent variable was supervisor reaction (guidance given to supervisees).

Measures and Procedure

Participants were either sent an email containing a link to the online questionnaire, hosted by the website Qualtrics (*N* = 73), or given a paper copy of the questionnaire at a workshop (*N* = 16). Participants read through the instruction sheet and indicated consent before beginning the questionnaire. After collecting demographic information, three case vignettes were presented, relating to patients with depression that their supervisees were working with. Participants were randomly assigned to either a female or male supervisee condition. Within each condition, the vignettes varied in terms of the supervisee's level of anxiety – one high trait anxiety, one high state anxiety and one calm (see Appendix 1 for full vignettes). These were presented in random order. After each vignette, the participant was asked: 'To what extent would you focus on the following techniques when giving the clinician advice during supervision?'. The techniques were: 'Focus on evidence-based therapeutic techniques'; 'Focus on the development of the therapeutic alliance with the patient'; and 'Focus on other issues in supervision'. Focus was measured using five-point Likert scales, ranging from 1 'I would not focus on this' to 5 'I would focus entirely on this'. Further detail was requested if participants indicated that they would focus on other issues. 'Other issues' are henceforth referred to as 'Case-Management issues'. These areas of focus (therapeutic techniques, alliance, and case-management) were based on the three main functions of

supervision often described in the literature - formative, restorative, and normative (Proctor, 1988), or educational, supportive, and managerial (Kadushin, 1976).

Data analysis

A repeated measures analysis of variance (ANOVA) was used to assess the reactions of the supervisors to each vignette. The within-subject factor was supervisee anxiety (three levels), the between-subject factor was supervisee gender, and the dependent variables were the rated levels of focus on different topics in supervision.

Results

Supervision focus for different supervisees

Overall patterns of supervision focus (alliance, therapeutic technique and case management issues) for each vignette were assessed across genders, using repeated measure ANOVAs (Table 1).

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Insert Table 1 about here

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Alliance focus. There was an overall effect of supervisee anxiety (F(1.75,143.5) = 13.0, P < .001, partial η^2 = 0.14) on alliance focus. Post-hoc multiple comparisons showed that supervisors focused on the alliance most when the supervisee was state anxious (M = 3.21, SD = 1.20), less when they were trait anxious (M = 3.00, SD = 1.17), and least for calm supervisees (M = 2.67, SD = 1.11), all differences – P < .05. There was an overall effect of supervisee gender (F(1,82) = 4.31, P = .041, partial η^2 = 0.04) on alliance focus, indicating that supervisors focused more on the alliance when advising female (M = 3.17, SD = 0.99) than male clinicians (M = 2.72, SD = 1.00). There was no significant interaction of the two factors.

Case management focus. There was an overall effect of supervisee anxiety (F(2,162) = 4.81, P = .009, partial η^2 = 0.06). Post-hoc multiple comparisons indicated that supervisors focused more on case management issues with trait anxious supervisees (M =

3.11, *SD* = 1.31) than with calm supervisees (*M* = 2.64, *SD* = 1.35), *P* = .005, but there were no differences between these and the state anxious supervisees. There were no main or interaction effects involving supervisee gender.

Technique focus. There were no main effects of supervisee anxiety or gender on technique focus. However, there was an interaction effect of supervisee anxiety x gender ($F(2,172) = 5.45$, $P = .005$). Post hoc *t*-tests were used to investigate this effect. Supervisors focused more on technique for trait anxious than for state anxious female supervisees ($t(45) = 2.21$, $P = .032$, Cohen's $d = 0.33$), and more on technique for calm female supervisees than state anxious females ($t(45) = 3.23$, $P = .002$, Cohen's $d = 0.26$). The trait anxious female supervisees were not treated significantly differently to the calm female supervisees ($t(45) = 1.75$, $P = .086$), though the direction of differences is in keeping with the hypothesis that anxious supervisees are not directed towards therapeutic techniques when treating depression. There were no such differences in supervisor focus for male supervisees with different anxiety levels. In addition, focus on technique was higher for calm female supervisees than for calm males ($t(87) = 2.01$, $P = .047$, Cohen's $d = 0.46$), but not under other supervisee anxiety conditions.

Supplementary analyses. To ensure that these findings were not a product of differences in participant characteristics, further ANOVAs were conducted with supervisor age as a covariate and supervisor gender as independent variable. With these variables factored in, the only significant result remaining was the supervisee anxiety by gender interaction effect for technique focus ($F(2,164) = 5.40$, $P = .005$, partial $\eta^2 = 0.06$). This result suggests that this interaction is a robust one. The age and gender of supervisors did not affect how they proposed delivering supervision to different subsets of therapists.

Discussion

This experimental study has explored the focus of clinical supervision for therapists treating cases of depression. The study aimed to explore how supervisee anxiety and gender impact the advice that supervisors give in supervision. It was hypothesised that supervisors would focus 'calm' supervisees more on CBT techniques than 'anxious'

supervisees. This hypothesis was supported, but only when the supervisors were working with female supervisees who were state anxious. Male supervisees were supervised in the same way, regardless of their anxiety. These findings imply that, in the supervisors' eyes, supervisee anxiety has an influence on guidance only if that supervisee is female. It was also hypothesised that supervisors would focus male supervisees more on CBT techniques than female supervisees. Overall, supervisors focused both male and female supervisees on CBT techniques to the same extent. However, supervisors focused female supervisees more on alliance work than males. To summarise, both supervisee anxiety and gender had an impact on supervisor focus in supervision.

This finding supports the conclusion that supervisors have biases (whether implicit or explicit) in how they support the work of different clinicians treating depression. Dennhag et al. (2012) showed that bias came from the supervisor having a prior working relationship with the therapist, but here it is based purely on therapist characteristics. There are a number of possible explanations for this finding. Perhaps supervisors are aware that anxious therapists tend to focus on immediate patient comfort to the exclusion of more change-oriented methods (Deacon et al., 2013). Therefore, supervisors might be particularly reluctant to push anxious therapists towards more anxiety-evoking aspects of therapy (e.g., behavioural techniques). Alternatively, supervisors might feel that supervisee anxiety is preventing the establishment of a good therapeutic alliance with the patient (Hardy, Cahill, & Barkham, 2009). A third possible explanation is that supervisors might be reluctant to challenge their supervisee because they do not want to disrupt the supervisory relationship, as it has been suggested that poor supervisory relationships can be harmful to supervisee growth (Gray, Ladany, Walker, & Ancis, 2001).

However, none of these possibilities account for the fact that this pattern of focus exists only when supervisors are directing female supervisees in treating depression. Perhaps male and female supervisors assume that female therapists are likely to have a more anxious disposition, by virtue of their gender (e.g., Leahy, Holland, & McGinn, 2012). Therefore, any display of anxiety might lead supervisors to assume that female clinicians are

more vulnerable than males. However, any such assumption would be ill- founded, as therapist gender has little consistent impact on therapy performance and patient outcome, with females sometimes performing better than males (Branson, & Shafran, 2015; Huppert, Bufka, Barlow, Gorman, Shear, & Woods, 2001). An alternative explanation is that supervisors might feel that females are more likely to pick up on cues that there are alliance problems, which might stall therapy progression. Supervisors might therefore take female supervisees' anxiety more seriously than that of male supervisees and hold off focusing on CBT techniques accordingly. The finding that supervisors are more likely to focus females on alliance work than males would support this explanation.

It is worthy of note that supervisor gender was unrelated to this different treatment of male and female supervisees. Nelson and Holloway (1990) found a similar pattern in their study of power balance in supervision, where both male and female supervisors assumed more power in supervision with female supervisees than with male supervisees. There is similar evidence of gender relevance in other domains. For example, Steinpreis, Anders, and Ritzke (1999) discovered that regardless of their own gender, employers were more likely to offer positions and higher starting salaries to men than women with identical curricula vitae.

Although supervision is commonly represented as necessary to keep therapists on track (Bernard & Goodyear, 2004; Care Quality Commission, 2013; van Ooijen, 2000), the present study suggests that this assumption is not straightforward. Supervisors themselves are influenced by similar factors to therapists, causing them to drift away from encouraging their supervisees to deliver best practice. Indeed, supervisory drift might even contribute to or exacerbate therapist drift, influencing differences in patient outcome across settings (Gibbons et al., 2013).

These findings are informative to both clinical and research practice. With regards to clinical practice, greater regulation of supervision might make a difference to patient outcomes. Such regulation might take the form of more stringent protocols for supervision in clinical settings, similar to those used in many RCTs (Gibbons et al., 2013; Roth, Pilling, & Turner, 2010). In particular, protocols should address clinician characteristics and how they

might influence supervision (and, ultimately, therapy outcome). The tendency to supervise anxious female clinicians differently to all others is a particular concern, and more gender-neutral supervisory practice might be a specific part of supervisor training. This study can also inform future research. Within research protocols, supervision is often used to ensure therapist adherence. Results of this study indicate that supervision by itself might not be enough to ensure adherence, as supervisors themselves may drift. This supervisory drift should be acknowledged within future study designs, possibly requiring researchers to monitor adherence to expected supervisory practice as well as monitoring therapists' adherence.

Further research is clearly needed to elaborate on these early findings. Such research will need to examine the effects of therapist characteristics on supervision focus for disorders other than depression, as well as within that domain. The therapy process is an active, triadic relationship between the supervisor, therapist and patient (Tracey, Bludworth, & Glidden-Tracey, 2012), and that three-way interaction should be further analysed. Combining and manipulating both therapist and patient variables will paint a more realistic picture of the supervision process. How supervisors deal with therapy-interfering behaviours from therapists or patients will provide further insight into this complex relationship. For example, will supervisors accept non-compliance from anxious female but not calm male clinicians? Will they allow non-compliance from an inexperienced therapist, or a patient with a more complex condition? And will supervisor's own anxieties affect how they deal with refusal from therapists and patients? These are questions that can be addressed using experimental studies, similar to the present one. As participant representativeness was unclear in our study due to the sampling method used, further research should improve on this. Finally, further investigation would benefit from naturalistic studies of real-life clinical and supervisory practice and its relation to patient outcome.

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Table 1

ANOVAs showing differences in overall supervision focus by supervisee gender and anxiety.

	Clinician Vignettes						3x2 ANOVA						
Supervisee anxiety	Trait		State		Calm		Anxiety			Supervisee gender		Anxiety x Supervisee gender	
Supervisee gender	Male	Female	Male	Female	Male	Female	*F*	*P*	MC	*F*	*P*	*F*	*P*
Focus of supervision													
Alliance	2.79 (1.22)	3.18 (1.11)	2.92 (1.26)	3.47 (1.10)	2.44 (1.10)	2.87 (1.10)	13.0	<.001	2>1>3	4.31	.041	0.29	*NS*
Technique	3.71 (1.09)	3.78 (0.92)	3.81 (1.02)	3.52 (1.01)	3.60 (0.96)	4.00 (0.76)	0.81	*NS*	-	.139	*NS*	5.45	.005
Case management	3.03 (1.23)	3.19 (1.38)	2.88 (1.22)	2.81 (1.44)	2.90 (1.34)	2.40 (1.33)	4.81	.009	1>3	.326	*NS*	2.62	*NS*

Appendix A – Case vignettes used in the questionnaire.

Clinician type	Vignette
Male trait	'Your supervisee, James, is 40 and has been a qualified therapist for 15 years. He is quite an anxious individual, and seems to worry about his patients a lot of the time. When discussing his cases, a particular issue comes up about a depressed patient called Lauren, who he has been seeing for eight sessions. Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk. James has reservations about pushing Lauren to change behaviourally. He is particularly concerned that Lauren will not cope well with the demands of behavioural activation, and that, if this aspect of therapy is pushed, she might get worse or stop coming to sessions.'
Male state	'Your supervisee, William, is 42 and has been a qualified therapist for 16 years. He is usually quite confident in his abilities as a therapist but he is noticeably anxious in your supervision session today. During your session, it transpires that he is concerned about a depressed patient, Mary, who is halfway through her course of treatment. Mary is 36 and lives with her two children. She got divorced from her husband two years ago, and currently has a partner of about four months. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still doing her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood. William explains that he is struggling to push Mary towards behavioural activation. He is concerned that if he pushes Mary to engage in behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. William is deeply worried about Mary's welfare if she does decide to end her treatment.'
Male calm	'Your supervisee, Richard, is 45 and has been a qualified therapist for 19 years. He is very relaxed when discussing his cases in supervision and is rarely worried about carrying out therapy. During your supervision session he discusses one of his patients, Emma, who has depression and has just had her ninth treatment session. Emma is 35 and lives with her daughter and long-term boyfriend of seven years. In recent years she has started feeling that life is pointless and she is unhappy. Over the past five months she has started showing signs of depression, including poor self-esteem, low mood and self-blame. She is still managing to attend her job as a cashier but has stopped seeing people socially. She currently has no biological signs of depression and has given no indication of suicide. Richard is about to commence behavioural activation with Emma, and says he is quite comfortable in doing so. He is currently feeling satisfied with Emma's progress and has no immediate concerns.'

Female trait	'Your supervisee, Jane, is 40 and has been a qualified therapist for 15 years. She is quite an anxious individual, and seems to worry about her patients a lot of the time. When discussing her cases, a particular issue comes up about a depressed patient called Lauren, who she has been seeing for eight sessions. Lauren is 32 and lives with her husband and son. In the past few years she has been getting increasingly unhappy with life and has started showing signs of depression. She has no biological signs but has a low mood and poor self-esteem. Although she is managing to keep attending her job at a supermarket, she vary rarely sees anyone outside of work and is feeling unhappy in her marriage. She has showed no signs of self-harm or indication that she is a suicide risk. Jane has reservations about pushing Lauren to change behaviourally. She is particularly concerned that Lauren will not cope well with the demands of behavioural activation, and that, if this aspect of therapy is pushed, she might get worse or stop coming to sessions.'
Female state	'Your supervisee, Wendy, is 42 and has been a qualified therapist for 16 years. She is usually quite confident in her abilities as a therapist but she is noticeably anxious in your supervision session today. During your session, it transpires that she is concerned about a depressed patient, Mary, who is halfway through her course of treatment. Mary is 36 and lives with her two children. She got divorced from her husband two years ago, and currently has a partner of about four months. She has been unhappy with life for approximately four years. In recent months, she has shown more and more signs of depression, including a low mood and poor self-esteem, though there are no biological signs. Although she is still doing her job in a bakery, she is becoming increasingly socially isolated. She has given no indication that she is suicidal. She was referred because of her low mood. Wendy explains that she is struggling to push Mary towards behavioural activation. She is concerned that if she pushes Mary to engage in behavioural aspects of therapy, she will be reluctant to come to sessions and may drop out of therapy altogether. Wendy is deeply worried for Mary's welfare if she does decide to end her treatment.'
Female calm	'Your supervisee, Rebecca, is 45 and has been a qualified therapist for 19 years. She is very relaxed when discussing her cases in supervision and is rarely worried about carrying out therapy. During your supervision session she discusses one of her patients, Emma, who has depression and has just had her ninth treatment session. Emma is 35 and lives with her daughter and long-term boyfriend of seven years. In recent years she has started feeling that life is pointless and she is unhappy. Over the past five months she has started showing signs of depression, including poor self-esteem, low mood and self-blame. She is still managing to attend her job as a cashier but has stopped seeing people socially. She currently has no biological signs of depression and has given no indication of suicide. Rebecca is about to commence behavioural activation with Emma, and says she is quite comfortable in doing so. She is currently feeling satisfied with Emma's progress and has no immediate concerns.'