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Supervisory Working Alliance and Job Satisfaction in Community Mental Health Settings

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Researchers have written extensively on many facets of supervision in the counseling profession, including the supervisee benefits associated with a strong supervisory working alliance. While the majority of studies have focused on the working alliance in academic settings with student trainees, there has been a lack of research exploring the role of the supervisory working alliance in workplace settings, where supervision can be different from supervision offered in a university clinic or counseling center. Employee job dissatisfaction has been a problem identified within the mental health workforce. Researchers have identified effective supervision as a mediating factor. The purpose of this study was to evaluate the relationship between the theoretical construct of the supervisory working alliance and job satisfaction. This multiple regression study included 250 workers who were providing direct services to persons with severe mental illness or severe emotional and behavioral disorders. Results yielded a significant relationship between the supervisees' perception of the supervisory working alliance, as measured by the Supervisory Working Alliance Inventory, and job satisfaction, as measured by the Job Satisfaction Survey. Specifically, participants who rated the supervisory working alliance higher were also more likely to report higher levels of job satisfaction. The implications for social change include knowledge useful for educators, trainers, supervisors, and supervisees seeking to promote positive outcomes of workers and clients in community mental health settings. Low job satisfaction leads to generally poorer client outcomes. The ability to understand the supervisory working alliance's influence on job satisfaction is beneficial to advancing the treatment for persons with chronic mental illness.

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Dedication

To my husband, Lucas. Thank you for your unrelenting support during this journey.

To my kids, Cullen and Peyton, I love you to the moon and back.

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I would have never been able to finish my dissertation without the guidance of my committee members and support from my family.

First, I would like to express my deepest appreciation to my committee chair, Dr. Susan Rarick, who has provided unrelenting guidance through my research project. She has provided me with the perfect mix of support and critique, ensuring that my work was elevated to the best that it could be.

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Finally, I owe a debt of gratitude to my family. I would like to thank my husband, Lucas. He has run by my side cheering me on the whole way. He has stood by me through all the good and bad of this process. I would also like to give a special thank you to my two wonderful kids, Cullen and Peyton, who have been so accepting and supportive of my educational journey.

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Chapter 1: Introduction to the Study

Background

Clinical supervision has been identified as an important component in training of new mental health professionals (Getz, 1999). Although the practice of supervision originated in the 1920s as a part of psychoanalytic training (Feltham, 2000), only in the past two decades has supervision emerged as a specialty in the field (Dye & Borders, 1990). A significant body of literature exists on many aspects of supervision in the mental health field, including the positive supervisee outcomes associated with a strong supervisory working alliance. Scholars have reached general consensus in the literature about the benefits associated with a strong working alliance in the therapeutic relationship, in particular its influences on successful outcomes of therapy (Horvath & Symonds, 1991). Only recently have investigators begun to evaluate the favorable outcomes associated with a successful supervisory working alliance. Several trainee studies demonstrated the application of the supervisor working alliance model (Bennett, Mohr, BrintzenhofeSzoc, & Saks, 2008; Bernard & Goodyear, 2009; Bhat & Davis, 2007; Bilideau & Lecomte, 2010; Cheon, Blumer, Shih, Murphy, & Sato, 2009; Cooper & Ng, 2009; Dickson, Moberly, Marshall, & Reilly, 2011; Gnilka, Chang & Dew, 2012; Gunn & Pistole, 2012; Hess, Hess, & Hess, 2008; Ladany, Brittan-Powell, & Pannu, 1997; Ladany, Ellis, & Friedlander, 1999; Ladany & Friedlander, 1995; Ladany, Hill, Corbett, & Nutt, 1996; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Mehr, Ladany, & Caskie, 2010; Patton & Kivlighan, 1997; Rarick & Ladany, 2013; Renfro-

Michel & Sheperis, 2009; Riggs & Bretz, 2006; White & Queener, 2003; Yourman & Farber, 1996).

Researchers found trainee perceptions of strong supervisory working alliances related to enhanced satisfaction with supervision (Cheon et al., 2009; Ladany et al., 1999), less role ambiguity and role conflict (Ladany & Friedlander, 1995), and greater emotional intelligence (Cooper & Ng, 2009). Strong ratings of the supervisory working alliance were related to perceptions of stronger supervisor ethical behaviors (Gnilka et al., 2012; Ladany et al., 1999), lower levels of perceived stress, and increased coping resources (Gnilka et al., 2012). Several researchers have also evaluated the supervisory working alliance in relationship to multicultural supervisory outcomes and found stronger ratings of supervisory working alliances related to stronger perceived multicultural competence of the supervisor (Bhat & Davis, 2007; Ladany et al., 1997). In addition, strong supervisory working alliances have been found to be related to a stronger therapeutic alliance between the supervisee and client (Bernard & Goodyear, 2009), as well as stronger trainee adherence to a treatment model (Bernard & Goodyear, 2009; Patton & Kivlighan, 1997).

The majority of studies conducted on the supervisory working alliance have taken place in university settings and settings where graduate students were being trained (Ronnestad & Skovholt, 1993; Schultz, Ososkie, Fried, Nelson, & Bardos, 2002; Spence, 2001; Watkins, 2012). Additionally, Ronnestad and Skovholt (1993) found that much of the research on clinical supervision had taken place with supervisors in training, who had limited field experience. Researchers have also suggested further research into how the

supervisory working alliance is affected in workplace environments, or where supervision settings can be quite different from supervision offered in a university clinic or counseling center (Culbreth & Borders, 1999; Mena, 2007; Schultz et al., 2002; Spence, 2001; Sterner, 2009; Watkins, 2012).

Researchers and practitioners have acknowledged that social service workers encounter many stressful experiences in their day-to-day work (Mor Barak, Travis, Pyun, & Xie, 2009). Workers in mental health, social work, and child welfare experience a variety of stressors including low pay, large workloads, excessive paperwork and more administrative work, inadequate training, and staff shortages (American Public Human Services Association [APHSA], 2005; Mor Barak el al., 2009; U.S. General Accounting Office [USGAO], 2003). There is significant turnover in the behavior health workforce, which stems from issues related to recruitment, retention, and performance. (Blankertz & Robinson, 1997; Paris & Hoge, 2009; Peterson & Lippincott, 1993). Community mental health services are labor intensive. The U.S. Department of Health and Human Services (1993) cited 80% to 85% of community mental health money being spent on labor alone. Employee retention and job dissatisfaction have been consistently identified as a problem within the mental health workforce (Mor Barak, Nissly, & Levin, 2001; Blankertz & Robinson, 1997; Dunn & Menz, 1992; Paris & Hoge, 2009; Peterson & Lippincott, 1993).

Mor Barak et al. (2001) found that reported rates of employee turnover in community mental health, social work, and child welfare services ranged from 30% to 60% annually. High rates of employee turnover require cases to be transferred to

remaining workers, which leads to high caseloads, fatigue, and a more reactive focus on crisis situations at the expense of responsive care planning. This leads to a disruption in continuity of care and impacts the workers' ability to develop and maintain strong working alliances with the clients, an essential component of effective outcomes. Finally, high rates of turnover were associated with poorer implementation of evidence-based practices (Ben-Dror, 1994), fewer services being offered, and financial difficulties associated with the elevated costs of recruitment and training of new hires (Blankertz & Robinson, 1997; Cyphers, et al., 2005; Mor Barak et al., 2001; Paris & Hoge, 2009).

Due the severity of the consequences associated with poor job satisfaction, it is a topic that has far-reaching interest to those who both work in as well as those who study organizations. Several researchers have identified effective supervision as a mediating factor that can offset the negative effects of working in social and human service agencies (Kadushin & Harkness, 2002; Mor Barak et al., 2001) and that it can contribute to positive worker outcomes, including job satisfaction (Abu-Bader, 2000; Annie E. Casey Foundation, 2003; Landsman, 2001; Mor Barak, Levin, Nissly, & Lane, 2006). In addition, quality supervision is a significant factor contributing to employee turnover and intent to leave (APHSA, 2005; Landsman, 2001; USGAO, 2003). Several researchers have also identified effective supervision to mediate or provide protection from the negative impact of stressful work demands by offering both emotional and social support (Kadushin & Harkness, 2002; Mor Barak et al., 2001; Sterner, 2009).

Problem Statement

A number of researchers have studied many aspects of supervision in the mental health field, including the positive supervisee outcomes associated with a strong supervisory working alliance. While the majority of studies have focused on the working alliance in academic settings (Bennett, et al., 2008; Bernard & Goodyear, 2009; Bhat & Davis, 2007; Bilideau & Lecomte, 2010; Cheon et al., 2008; Cooper & Ng, 2009; Dickson et al., 2011; Gnilka et al., 2012; Gunn & Pistole, 2012; Hess et al., 2008; Ladany et al., 1997; Ladany et al., 1999; Ladany & Friedlander, 1995; Ladany et al., 1996; Ladany et al., 1999; Mehr et al., 2010; Patton & Kivlighan, 1997; Rarick & Ladany, 2013; Renfro-Michel & Sheperis, 2009; Riggs & Bretz, 2006; White & Queener, 2003; Yourman & Farber, 1996), there has been a lack of research exploring the role of the supervisory working alliance in professional post educational workplace settings (Ronnestad & Skovholt, 1993; Schultz et al., 2002; Spence, 2001; Watkins, 2012). Researchers have also suggested further research in how the supervisory working alliance is affected in workplace environments, or where supervision settings can be quite different from supervision offered in a university clinic or counseling center (Culbreth & Borders, 1999; Mena, 2007; Schultz et al., 2002; Spence, 2001; Sterner, 2009; Watkins, 2012). Therefore, this research investigated the relationship between the supervisory working alliance and job satisfaction by utilizing professional workers in community mental health work settings.

Purpose Statement

The purpose of this quantitative study, which used a non-experimental survey design, was to examine the relationship between the constructs of supervisory working alliance and job satisfaction in community mental health settings.

Variables

Variables

For Research Question 1, to study the relationship between supervisory working alliance and job satisfaction, the variables used in the correlation analysis included the composite supervisory working alliance score and the composite job satisfaction score. The composite supervisory working alliance score is derived from subscales of client focus on rapport. The composite job satisfaction score is comprised of nine dimensions, (a) Pay, (b) Promotion, (c) Supervision, (d) Fringe benefits, (e) Contingent rewards, (f) Operating Procedures, (g) Coworkers, (h) Nature of Work, (i) Communication.

For Research Questions 2 through 4, to understand the predictive value of underlying aspects of the composite supervisory working alliance score on job satisfaction, the multiple regression incorporated the following variables:

- construct of job satisfaction (outcome variable),
- Supervisory working alliance: Total scale score
- Supervisory working alliance: client focus subscale,
- Supervisory working alliance: rapport subscale
- Demographic variables of age, educational attainment, workload, type of supervision and discipline.

The demographic variables were included because they may be confounding variables, and/or may help to explain some of the variance in the data.

Research Questions and Hypotheses

1. What is the relationship between the construct of the supervisory working alliance and the construct of job satisfaction in community mental health workers?

Null Hypothesis ($H_0$1): There will be no relationship between the construct of the supervisory working alliance, as measured by the overall score on the Supervisor Working Alliance Inventory- Trainee Version (SWAI-T) and the construct of job satisfaction, as measured by the total score on the Job Satisfaction Survey (JSS), in community mental health workers.

Alternate Hypothesis (H_a1): A significant positive correlation exists between the construct of the supervisory working alliance, as measured by the overall score on the SWAI-T and the construct of job satisfaction, as measured by the total score on the JSS, in community mental health workers.

2. To what extent do the dimensions of the supervisory working alliance of client focus and rapport predict the construct of job satisfaction in community mental health workers?

Null Hypothesis ($H_0$2): There will be no predictive relationship between the Rapport and Client Focus, as measured by the SWAI-T, and the construct of job satisfaction, as measured by the JSS composite score, in community mental health workers.

Alternative Hypothesis (H_a2): There will be a significant predictive relationship between one or both of the individual dimensions of the supervisory working alliance, *rapport* and *client focus,* as measured by the SWAI-T, and the construct of job satisfaction, as measured by the JSS composite, in community mental health workers.

3. To what extent do the demographic variables of age, educational attainment, workload, discipline and type of supervision predict the construct of job satisfaction in community mental health workers?

Null Hypothesis ($H_0$3): There will be no predictive relationship between the demographic variables of age, educational attainment, workload, discipline and type of supervision as measured by the demographic questionnaire and the construct of job satisfaction, as measured by the JSS composite score, in community mental health workers.

Alternative Hypothesis (H_a3): A significant predictive relationship exists between some or all of the demographic variables age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, and job satisfactions, as measured by the JSS, in community mental health workers.

4. What is the best model that predicts job satisfaction of workers in community mental health settings?

Null Hypothesis ($H_0$4): A model using the independent variables of the supervisory working alliance, as measured by the SWAI-T, and demographic

variables of age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, will not significantly predict job satisfaction in workers in community mental health settings.

Alternative Hypothesis (H_a4): A model containing certain independent variables, including the supervisory working alliance, as measured by the SWAI, and demographic variables of age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, will significantly predict job satisfaction in workers in community mental health settings.

Significance

With continued constraints placed on financial resources, the responsibility for serving persons with severe mental illness has been placed onto community mental health agencies (National Alliance, 2012). Consistent with the history in the field, community mental health has been plagued by low job satisfaction, turnover, and burnout (Ben-Dror, 1994; Blankertz & Robinson, 1997; Dunn & Menz, 1992; Mor Barak et al., 2001; Paris & Hoge, 2009; Peterson & Lippincott, 1993), which leads to lower levels of perceived therapeutic alliance, poorer implementation of evidence-based practice, and generally poorer client outcomes (Ben-Dror, 1994; Kadushin & Harkness, 2002; Poertner, 2006). Without adequate treatment, the consequences of severe mental illness for the individual and society are staggering: unemployment, substance abuse, homelessness, inappropriate incarceration, and suicide (National Institute of Mental Health [NIMH], n.d.b; Palmer, et al., 2005). However, supervision in settings serving such persons has been largely

neglected in the research (Schroffel, 2008; Tsui, 1997). The ability to understand supervision's, specifically the supervisory working alliance's, influence on job satisfaction is greatly beneficial to advancing the treatment for persons with chronic mental illness.

Theoretical Framework

The theoretical foundation for this study was based on Bordin's (1983) working alliance model of supervision, referred to as the supervisory working alliance. The construct of the working alliance is drawn from a psychoanalytic approach to therapy (Bordin, 1983). The working alliance model is a theory of counseling and psychotherapy initially developed by Bordin (1979). In a series of influential works, Bordin (1975, 1976, 1980) expanded the psychoanalytic conceptualization of the working alliance to include all relationships geared at producing change. According to Bordin (1976), the working alliance is the key ingredient that creates the ability for the client to follow through with and accept treatment. The working alliance is defined by three central components: tasks, goals, and bond (Bordin, 1979). Building a strong working alliance involves the collaborative approach to developing the goals desired in the change process and the subsequent tasks of each person in the relationship. In addition, the therapeutic working alliance requires a strong emotional bond between the clinician and client. Bordin (1979) asserted the degree of mutuality in the working alliance serves as the primary ingredient for change. He specifically noted that "the strength of the alliance between the person seeking change and the change agent, and the power of the task are incorporated, not the

alliance" (p. 35). Therefore, when the alliance is strong, the likelihood for change to occur is greater.

Bordin (1983) broadened the working alliance theory to include the supervisory relationship. Therefore, the working alliance model's three central components of goal, task, and bond also apply to the supervisory relationship. Similar to the working alliance in the therapeutic relationship, the supervisory working alliance has been perceived as fundamental in the supervisee's professional development and change process (Ladany et al., 1999).

The theory of the supervisory working alliance asserts that the supervisee and supervisor must have a mutually developed set of goals for supervision, and those goals must be negotiated early in the supervision process. Additionally, the tasks must align with the agreed upon goals and must be clearly defined and agreed upon. Finally, the supervisor and supervisee bond provides the support required to maintain the progress made in supervision (Bordin, 1983).

Definition of Key Terms

Supervision

Distinguishing between the roles of clinical supervision and administrative supervision has been difficult because there is not a uniform definition of clinician supervision and administrative supervision (Bernard & Goodyear, 2004). There were a number of definitions of supervision mentioned throughout the mental health literature. From the field of counseling, Bernard and Goodyear (2004) proposed a comprehensive definition of clinical supervision. They defined clinical supervision as follows:

> Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession. (p. 8)

Although the definition provided by Bernard and Goodyear (2004) could be applied to a variety of therapeutic disciplines, its primary focus is targeted toward the clinical oversight and development of the supervisee from the same therapeutic discipline of the supervisors. However, community mental health services are comprised of teams that focus on a wide range of skills and often include occupational therapists, counselors, psychologists, social workers, and substance abuse specialists. Thus, supervision must be considered in the broader context outside of a specific discipline to that of the agency and overall organizational purpose. For the purposes of the community mental health, such a definition lacks both the acknowledgement of the supervision taking place across disciplines, as well as the supervision in community mental health settings that consist of broader administrative functions.

McCarthy, Kulakowski, and Kenfield (1994) addressed the distinction between clinical and administrative supervision, defining administrative supervision as “the promotion of accountable programs and coordination of clinical services and evaluation mechanisms” (p. 177). McCarthy et al. further noted administrative supervision differs

from clinical supervision in that administrative supervision is not directly involved with the therapeutic process that exists between counselor and client.

Although McCarthy et al.'s (1994) definition acknowledged the distinction between clinical and administrative supervision, the authors assumed these functions are provided and maintained separately. However, data have indicated that a significant number of working counselors receive both clinical supervision and administrative supervision from the same person (Evans, 1993; Kenfeild, 1993). Supervision within community mental health organizations follow suit. Supervisors are often located in the mid-level of an organization, typically overseeing the direct line staff as they carry out requirements and purpose of the organization, in addition to overseeing the clinical work of the supervisee. Clinical supervision refers to supervision that promotes supervisee development, the maintenance of psychotherapy skills, or both. In the therapeutic relationships, it promotes clinical assessment and intervention approaches and clinical skills (Ladany & Bradley, 2011).

Administrative supervision is aimed at helping the supervisee function as an employee of an organization (Hart, 1982). Therefore, the general focus of administrative supervision is directly toward helping the organization run effectively and efficiently (Ladany & Bradley, 2011; Powell, 1993). Administrative supervision addresses managerial tasks such as (a) case assignment and assisting workers with implementing policies and procedures (Shulman, 1993; Tromski-Klingshirn & Davis, 2007), (b) overseeing case records, and (c) quality assurance and accountability (Tromski-Klingshirn & Davis, 2007). Further, the supervisor is charged with evaluating the

worker's performance, including hiring, firing, and reprimanding, as well as completing performance evaluations, participating in decisions regarding career advancements, and salary increases (Bogo & McNight, 2005; Gibelman & Schervish, 1998; Tromski-Klingshirn & Davis, 2007). Ladany and Inman (as cited in Ladany & Bradley, 2011) broadly defined supervision as a

> Didactic activity whereby the supervisor facilitates the provision of feedback to the supervisee, which is based on the interpersonal communication between both members of the dyad and can pertain to the work in supervision, the supervisee, the supervisee's clients, or the supervisor. (p. 3).

This definition of supervision was utilized in this study, as it can be expanded to include all types of supervision. Often neglected in previous definitions, Ladany's and Inman's current supervision definition (as cited in Ladany & Bradley, 2011) can be applied to the interrelated types of supervision often referred to as administrative supervision and clinical supervision, often found in community mental health.

Community Mental Health Services

Community mental health services support or treat adults with severe mental illness and/or children with severe emotional and/or behavioral disorders outside of a hospital or institutional setting.

Community Mental Health Worker

A community mental health worker is a staff person who provides direct services to adults with severe mental illness and/or children with severe emotional and behaviors disorders in a community mental health setting.

Nature of Study

This quantitative study examined the relationship between the predictor variable, supervisory working alliance, and the criterion variable, job satisfaction, in community mental health workers. Supervisory working alliance was measured using the Supervisory Working Alliance Inventory-Trainee Version (SWAI-T; Efstation, 1990). Job satisfaction was measured by the Job Satisfaction Survey (JSS; Spector, 1985). Survey data were collected from self-report questionnaires completed by workers employed in community mental health agencies. All participants completed a demographic survey, the SWAI-T, and the JSS. A multiple regression analysis was used to analyze the data.

Participants varied in their levels of educational attainment, ranging from high school diplomas, bachelor's degrees, master's degrees, and/or doctorate degrees. Participants also varied in educational degree area, including counseling, psychology, marriage and family, addiction counseling, or social work. Participants were recruited through an online participant pool available from five community mental health agencies with total staff populations of over 1,000 workers. All community mental health agencies were located in Minnesota.

Assumptions

This study was based on the following assumptions.

- The SWAI-T is a psychometrically sound assessment tool for measuring the supervisory working alliance.

- The JSS is a psychometrically sound assessment to for measure job satisfaction in human service professionals.
- The assessment tools were appropriate for the identified sample.
- The workers were capable of understanding and completing the SWAI-T and JSS accurately.
- Participants would answer the questions honestly.
- The supervisory working alliance framework was the appropriate theoretical basis for the study.
- The impact of gender and race on job satisfaction were negligible.

Limitations

Limitations focus on the inherent problems in a given proposed research design. The following potential limitations were recognized for this study:

Issues of Internal Validity

- To participate in the study community mental health workers were required to complete and return the survey instruments independently. I had no control over the setting and completion of survey.
- The SWAI-T and JSS are self-report inventories. Therefore, some social desirability bias may have been present in the responses. It was difficult to discern whether participants completed the survey truthfully. Also, the surveys may have been influenced by the mood of the participants and other various conditions present during the time the survey was completed.

Limitations with Regard to External Validity

- The sample was drawn from a convenience sample and may not fully represent the entire community.
- The size of the population was limited to individuals working in one of five community mental health agencies. The sample size may have been limited by workers not choosing to respond to the survey.

Summary

An extensive body of research has been conducted on many facets of supervision in the counseling profession, including the supervisee benefits associated with a strong supervisory working alliance. While the majority of studies have focused on the working alliance in academic settings (Bennett et al., 2008; Bernard & Goodyear, 2009; Bhat & Davis, 2007; Bilideau & Lecomte, 2010; Cheon et al., 2008; Cooper & Ng, 2009; Dickson et al., 2011; Gnilka et al., 2012; Gunn & Pistole, 2012; Hess et al., 2008; Ladany et al., 1997; Ladany et al., 1999; Ladany & Friedlander, 1995; Ladany et al., 1996; Ladany et al., 1999; Mehr et al., 2010; Patton & Kivlighan, 1997; Rarick & Ladany, 2013; Renfro-Michel & Sheperis, 2009; Riggs & Bretz, 2006; White & Queener, 2003; Yourman & Farber, 1996), there is lack of research exploring the role of the supervisory working alliance in post educational settings (Ronnestad & Skovholt, 1993; Schultz et al., 2002; Spence, 2001; Watkins, 2012). Additionally, most of the supervision research has been conducted with trainees, not professional practitioners (Dye & Borders, 1990; Gray et al., 2001; Heppner & Hadley, 1982; Heppner & Roehlke, 1984; Kavanaugh et al., 2003; Ladany et al., 1999; Ladany & Friedlander, 1995; Ladany, Walker, & Melincoff,

2001; McCarthy et al., 1994; Mena & Baily, 2007; Ronnestad & Kovholt, 1993). Missing from the literature were empirical data regarding the supervisory working alliance in community mental settings.

Employee retention and job dissatisfaction have been a problem consistently identified within the mental health workforce (Blankertz & Robinson, 1997; Dunn & Menz, 1992; Mor Barak et al., 2001; Paris & Hoge, 2009; Peterson & Lippincott, 1993). Several researchers have identified effective supervision as a mediating factor that can offset the negative effects of working in social and human service agencies (Kadushin & Harkness, 2002; Mor Barak et al., 2001) that can contribute to positive worker outcomes including job satisfaction (Abu-Bader, 2000; Annie E. Casey Foundation, 2003; Landsman, 2001; Mor Barak et al., 2006). Therefore, expanding the understanding of the relationship between supervision and job satisfaction in community mental health is warranted.

Consistent with the history in the field, community mental health has been plagued by low job satisfaction, turnover, and burnout (Ben-Dror, 1994; Blankertz & Robinson, 1997; Dunn & Menz, 1992; Mor Barak et al., 2001; Paris & Hoge, 2009; Peterson & Lippincott, 1993), which leads to lower levels of perceived therapeutic alliance, poorer implementation of evidence-based practice, and generally poorer client outcomes (Ben-Dror, 1994; Kadushin & Harkness, 2002; Poertner, 2006). Therefore, understanding the relationship between the supervisory working alliance and job satisfaction lends itself to implication for positive social change.

Without adequate treatment the consequences of severe mental illness for the individual and society are staggering (NIMH, n.d.b; Palmer, et al., 2005), and yet there is a paucity of research in regarding supervision in such settings (Schroffel, 2008; Tsui, 1997). The ability to understand supervision's influence on job satisfaction is greatly beneficial to improving outcomes for persons with severe mental illness. .

Chapter 2 includes a review of the pertinent research and provides an in-depth discussion of the supervisory working alliance as it relates to job satisfaction. Chapter 3 presents the research methods used in this study, including the research design and approach, setting, sample, instrumentation, data collection and analysis, and a discussion of the protection of participants' rights.

Chapter 2: Literature Review

Introduction

The purpose of this quantitative, non-experimental research study was to explore the relationship between the supervisory working alliance and job satisfaction in community mental health settings. In order to understand the problem outlined in Chapter 1, a robust review of the literature for each construct will be presented.

The literature was identified in the following ways: (a) searching the databases PsychInfo, MedLine, Google Scholar, EbsoHost, and ProQuest using the following key words and phrases: *supervisory alliance, supervisory working alliance, supervisory relationship, supervision, clinical supervision, job satisfaction, job satisfaction, community mental health, turnover, working alliance,* (b) reference sections of identified studies were examined to further identify other appropriate articles for inclusion, and (c) recent supervision texts were also examined.

The first section will explore the theoretical construct of the supervisory working alliance and its application to a variety of research studies. The review focuses on research designed to evaluate the specific construct of the supervisory working alliance, as well as research that evaluated factors associated with the both positive and negative perceptions of the supervisory relationship that are similar to factors associated with the supervisory working alliance. The current limitations and gaps in the application of the supervisory working alliance are noted, with clear recommendations supporting future research. The first section will explore the development and research applications of the Supervisory Working Alliance Inventory-Trainee Version (SWAI-T). The second section

will explore the theoretical construct of job satisfaction, specifically focusing on its theoretical antecedents, theoretical models, significance in research, and application to supervision. It will provide an overview of specific issues related to job satisfaction in community mental health settings. In addition, I examine theories that influenced the development of the JSS, providing a critique of research studies using the JSS.

The chapter concludes with a summary of the literature review that indicates the need for future research designed to understand the relationship between supervision and job satisfaction in community mental health settings.

Supervisory Working Alliance Literature

Theoretical Foundation

The theoretical foundation for this study was based on Bordin's (1983) working alliance model of supervision, referred to as the supervisory working alliance. The construct of the working alliance is drawn from a psychoanalytic approach to therapy (Bordin, 1983). The working alliance model theory is a theory of counseling and psychotherapy initially developed by Bordin (1979). In a series of influential work Bordin (1975, 1976, & 1980) expanded the psychoanalytic conceptualization of the working alliance to include all relationships geared at producing change. According to Bordin (1976), the working alliance is the key ingredient that creates the ability for the client to follow through with and accept treatment. The working alliance is defined by three central components: tasks, goals, and bond (Bordin, 1979). Building a strong working alliance involves the collaborative approach to developing the goals desired in the change process and the subsequent tasks of each person in the relationship. In

addition, the therapeutic working alliance requires a strong emotional bond between the clinician and client. Bordin (1979) asserted the degree of mutuality in the working alliance serves as the primary ingredient for change. He specifically notes that "the strength of the alliance between the person seeking change and the change agent, and the power of the task are incorporated, not the alliance" (p. 35). Therefore, when the alliance is strong the likelihood for change to occur is greater.

Bordin (1983) broadened the working alliance theory to include the supervisory relationship. Therefore, the working alliance model's three central components of goal, task and bond, also apply to the supervisory relationship. Similar to the working alliance in the therapeutic relationship, the supervisory working alliance has been perceived as fundamental in the supervisee's professional development and change process (Ladany, et al., 1999).

The theory of the supervisory working alliance asserts that the supervisee and supervisor must have a mutually developed set of goals for supervision, and those goals must be negotiated early in the supervision process. Additionally, the tasks must align with the agreed upon goals, and must be clearly defined and agreed upon. Finally, the supervisor and supervisee bond provides the support required to maintain the progress made in supervision.

Goals. The goals of the supervisory working alliance are clearly articulated objectives or outcomes for change. They must be mutually agreed upon by both the supervisor and the supervisee. Formulating goals is a collaborative process between the supervisee and supervisor, in which the goals are negotiated until an agreement is

reached. This collaborative process takes into consideration the developmental level and individual needs of the supervisee. Bordin (1983) described the principal goals of the supervisee within the supervisory working alliance as follows:

> (a) mastering of specific skills; (b) enlarging one's understanding of clients; (c) enlarging one's awareness of process issues; (d) increasing awareness of self and impact on process; (e) overcoming personal and intellectual obstacles toward learning and mastery; (f) deepening one's understanding of concepts and theory; (g) providing a stimulus to research and (h) maintaining standards of service. (p. 37-38)

Bordin (1983) stressed the importance of the supervisor and supervisee in developing the goals prior to focusing on the tasks. If this order is not followed, there will be barriers to successful supervision.

Tasks. In similar fashion to goal setting, supervisors seek mutual agreement with the supervisee regarding the tasks that they will engage in to reach the established goals. The strength of the supervisory working alliance depends not only on the degree to which the tasks are agreed upon, but also on the degree to which the supervisor can connect the tasks to the attainment of their goals. Bordin (1983) identified several tasks that may be useful in supervision. One such task is to have the supervisee prepare a written report of the session he or she had with the client; the report would then be reviewed during the supervisory session. Then, taking into consideration the supervisee's goals, the supervisor may choose to provide feedback on specific skills or attend to the supervisee's feelings and self-awareness, expanding on or enhancing the supervisee's repertoire of client

responses (Bordin, 1983; Ladany & Bradley, 2011). The second supervisory task is to listen to or observe the session via audio recording, video recording, or direct observation. Without such observation, the supervisor has to rely on the selectivity of supervisee in regards to what he or she chooses to disclose or bring to the supervisory session. Bordin stated, "It is important that the supervisor not be a prisoner of that selectivity" (p. 38). The fact that there will be gaps in the supervisee's reporting is expected, thus the supervisor's inability to observe the session makes it difficult to create a learning opportunity for which the supervisee can become self-aware of such gaps. The third task of supervision is for the supervisee to select problems or concerns for supervision. In essence, the supervisor asks, "What would you like to work on in supervision today?"

Bond. The bond is known at the extent to which the supervisor and supervisee trust, respect, and care for one another (Bordin, 1983). The degree of agreement between the goals and task of supervision strengthen these feelings of caring, liking, and trusting (Bradley & Ladany, 2001). Bordin (1983) described the required bond in the supervisory relationship to "fall somewhere between those of teacher to class members and therapist to patient" (p. 38). The emotional bond is a fundamental aspect of both individual and group supervision modalities. Bordin acknowledged the problematic nature that the supervisor acting as an evaluator may play in disrupting the emotional bond. He suggested the focus on building a strong working alliance would mediate the tension associated with the power differential between the supervisor and supervisee (Ladany & Bradley, 2011). Although there are similarities between the counseling and supervisory

relationship, the two are not the same (Borders & Leddick, 1987; Dye & Borders, 1990; Leddick & Bernard, 1980; Ladany et al., 1999; Ladany & Bradley, 2011). The supervisory bond is different than the bond developed in the therapeutic relationship. Researchers observed that "evaluation is an important part of the supervisory process, perhaps making the bond a highly yet tenuous aspect of supervision" (Cheon et al., 2009, p. 62). Burke, Goodyear, and Guzzard (1998) explored the impact of weakening and repairs in the supervisory alliance. They found the nature of evaluation in the supervisory process can lead to weakening the supervisory relationship. Despite weakenings occurring in the supervisory relationship, supervisees who perceived the supervisory working alliance as strong were more likely to report positive outcomes of supervision (Burke et al, 1998). These findings further supported the notion that working alliance is an important factor in the supervisory experience.

In examining the construct of the supervisory working alliance, researchers have evaluated it form both a single factor (i.e. general alliance) and as a two-fact (i.e. bond and task/goals). Bother methods of measuring the alliance have been found equally valid (Efstation, Patton, & Kardash, 1990; Patton & Kivlighan, 1997). Research suggests that within the supervision process the bond alone can impact positive change. Bordin (1983) asserts "The amount of change is based on the building and repair of strong alliances" which may influence how the supervisee perceives the quality of the supervision (p. 36). How the supervisee perceives the strength of relationship may influence the level of satisfaction with his/her job.

Adaptability of the Supervisory Working Alliance Model

The supervisory working alliance model (Bordin, 1983) may be adaptable to the needs of community mental health supervisors because it has significant advantages. Two advantages are its trans-theoretical nature and its conduciveness to culturally competent supervision. According to Watkins (2012), "Across psychology competency frameworks, the formation of the supervisory alliance has been made a core competency" (p. 20).

Model's trans-theoretical nature. In the large number of supervision theoretical constructs, there is a general consensus that no single supervision theory or approach is more efficacious than another (Holloway, 1992). In a similar manner in which counselors pull from different approaches in their work with clients, most supervisors have a tendency to work from more than one model (Loganbill, Hardy, & Dellworth, 1982). The tendency to pull from a variety of approaches highlights the benefits of the working alliance model, which has been discussed as trans-theoretical in nature (Bordin, 1983; Horvath & Greenberg, 1994). In the therapeutic relationship, the formation of a strong working alliance has been identified as a common factor in counseling, as well the factor most strongly related to change (Grenevage & Norcoss, 1990). In evaluating the effectiveness of different therapeutic approaches, research has distinguished between specific and non-specific factors of the approach. Non-specific factors of the therapy refer to the relationship components, similar to those noted in the working alliance (i.e., rapport, installation, hope, trust and collaboration). Such factors have been identified as common within all psychotherapies and serve as the foundation to client improvement (Messer & Wampold, 2002). Specific factors of therapy are intervention techniques

unique to the type of therapy being provided. Studies show that a large percentage of change is associated with non-specific factors or the relationship aspects of the therapy. This may suggest that regardless of the different therapeutic approaches, it was the nature of the alliance that was positively associated with the outcome, not the specific form of therapy itself (Messer & Wampold, 2002). Similar to the therapeutic relationship, the trans-theoretical nature of the working alliance has also been discussed in the supervisory relationship (Bordin, 1983; Horvath & Greenberg, 1994). The model is trans-theoretical, in that it is common to different theoretical models of supervision. According to several theorists, the supervisory working alliance is a common factor to all supervision models, and is more important in facilitating the change process than the specific techniques of a supervisory model (Bordin, 1983; Efstation, et al., 1990; Holloway, 1987).

Model's conduciveness toward culturally competent supervision. Supervision can provide an influential opportunity for supervisees to develop both clinical and cultural competence. Specifically, a culturally competent supervisor has the ability to guide the supervisee towards the development of awareness and knowledge of multicultural factors with the intention of helping the supervisee translate such knowedge into practice skills (Ancis & Ladany, 2001; Ladany, et al., 1997). Ladany, Brittan-Powell, and Pannu (1997) investigated the relationship between the supervisory working alliance and multicultural supervision. Results of the study found that supervisors and supervisees who share racial identity attitudes and belief systems are more likely to agree on the goals and tasks of the supervision process. Suggesting the sharing of common beliefs influences the development of a strong emotional bond. Additionally, strong supervisory

working alliances were also associated with supervisors who had a more highly developed sense of racial identity than their supervisee. It could be the case that supervisors with a higher racial consciousness can provide empathy and acceptance to their supervisees at lower levels of racial consciousness, thus facilitating the development of a working alliance.

Inman (2006) examined cultural competency by surveying students about their perception of the supervisors' cultural competence, their reported supervisory working alliance, and supervisee satisfaction. Inman (2006) found that supervisors' multicultural competencies were positively correlated with the working alliance and satisfaction. Further, a study by Beaumont (2010) found as the perception of supervisor multicultural competence increased, the strength of the working alliance and the perception of growth as a culturally competent clinician increased. Both studies suggest strong working alliances are related to supervisees' perceptions of supervisor cultural competence and growth as a culturally competent clinician.

Although Bordin (1983) does not explicitly equate quality supervision to the supervisory working alliance, there is an assumption that a relationship exists (Sterner, 2009). If a bond does not develop and there is poor collaboration on goals and tasks, the supervisory working alliance will be weakened. On the other hand, a strong supervisory relationship is reflected in an agreement on goals, tasks, and the development of an emotional bond between the supervisory and supervisee. In this study, the quality of supervision is related to the strength of the supervisory working alliance. Therefore, a

strong supervisory working alliance equates to high quality supervision and a weak supervisory relationship equates to low quality supervision.

Application of the Supervisory Working Alliance

There is a general consensus in the literature of the benefits associated with a strong working alliance in the therapeutic relationship, in particular its influences on successful outcomes of therapy (Horvath & Symonds, 1991). Only recently have investigators begun to evaluate the favorable outcomes associated with the supervisory working alliance in successful supervisory outcomes. The application of the supervisory working alliance model is demonstrated in several trainee studies (Bennett, Mohr, BrintzenhofeSzoc, & Saks, 2008; Bernard & Goodyear, 2009; Bhat & Davis, 2007; Bilideau & Lecomte, 2010; Cheon, Blumer, Shih, Murphy, & Sato, 2009; Cooper & Ng, 2009; Dickson, Moberly, Marshall & Reilly, 2011; Gnilka, Chang, & Dew, 2012; Gunn & Pistole, 2012; Hess, Hess, & Hess, 2008; Ladany, Brittan-Powell & Pannu, 1997; Ladany, Ellis & Friedlander, 1999; Ladany & Friedlander, 1995; Ladany, Hill, Corbett, & Nutt, 1996; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Mehr, Ladany, & Caskie, 2010; Patton & Kivlighan, 1997; Rarick & Ladany, 2013; Renfro-Michel, & Sheperis, 2009; Riggs, & Bretz, 2006; White, & Queener, 2003; Yourman & Farber, 1996).

Researchers have studied the relationship between the supervisees' perception of the supervisory working alliance and trainee self-efficacy (Ladany, et al., 1999), satisfaction (Cheon, et al., 2009; Ladany, et al., 1999), role ambiguity and role conflict (Ladany & Friedlander, 1995), and emotional intelligence (Cooper & Ng, 2009). The

supervisory working alliance has been evaluated in regards to the supervisee's perception of the supervisor's ethical behaviors (Gnilka, et al., 2012; Ladany, Lehrman-Waterman, et al., 1999) as well as to perceived stress and coping resources (Gnilka, et al., 2012). Several researchers have also evaluated the supervisory working alliance in relationship to multicultural supervisory outcomes (Bhat & Davis, 2007; Ladany, et al., Brittan-Powell &Pannu, 1997), therapeutic alliance between the supervisee and client (Bernard & Goodyear, 2009), as well as trainee adherence to a treatment model (Bernard & Goodyear, 2009; Patton & Kivlighan, 1997). Researchers have studied the relationship between the supervisory working alliance and contextual variables including supervisor and supervisee matching in regards to gender (Cheon, et al., 2009; Rarick & Ladany, 2013), sexual orientation, religious preference, and ethnicity (Cheon et al., 2009). The supervisory working alliance has also been explored in terms of relationship attachment styles in both counseling (Dickson, et al., 2011; Gunn & Pistole, 2012; Moberly, Marshall & Reilly, 2011; Renfro-Michel & Sheperis, 2009; Riggs, & Bretz, 2006; White, & Queener, 2003) and social work trainees (Bennett, et al., 2008).

Given that self-disclosure is an important component to many supervision models, the supervisory working alliance has been evaluated in regards to its relationship to the supervisee's self-disclosure in both counseling (Hess, et al., 2008; Ladany, Hill, Corbett, & Nutt, 1996; Ladany, & Lehrman-Waterman, 1999; Mehr, et al., 2010; Webb & Wheeler, 1998; Yourman, & Farber, 1996) and social work trainees (Davidson, 2011). Results of the studies consistently support the relationship between a strong supervisory working alliance and the supervisee's willingness to self-disclose. Therefore,

supervisees who are most likely to keep secrets or fail to disclose pertinent aspects of their therapeutic relationships are also more likely to rate the supervisory working alliance less favorably. Bilideau and Lecomte (2010) investigated whether supervisee shame-proneness could be found to be significantly related to the supervisory working alliance. Results of the study demonstrated a significant relationship to the supervisee's experience of shame and perceptions of the supervisory working alliance. Therefore, supervisees who were more likely to experience shame were also more likely to rate the supervisory relationship less favorably. These results provide a potential explanation for previous research by Yourman and Farber (1996) and Ladany et al. (1996), who reported that shame frequently noted the rationale for why trainees chose not to self-disclose important issues to their supervisors.

Qualities of the Supervisory Relationship

The degree to which a collaborative relationship develops is related to the supervisee's perception of the quality of the supervisory alliance (Sterner, 2009). In a review of the literature, several studies evaluated positive or effective supervisory experience (Allen, Szollos, & Williams, 1986; Anderson, Schlossberg, & Rigazio-DiGilio, 2000; Henderson, Cawyer, & Watkins, 1999; Hess, 1987; Ladany, McCarthy, Mori, & Mehr, 2013; Shanfield, Matthews, & Hetherly, 1993; Worthen & McNeill, 1996; Worthington & Roehlke, 1979), while others evaluated negative or ineffective supervisory experiences (Gray, Ladany, Walker & Ancis, 2001; Magnuson, Wilcoxin, & Norem, 2000; Nelson & Friedlander, 2001; Ramos-Sanchez et al., 2002; Veach, 2001; Watkins, 1997).

Positive supervisory experiences. The attributes associated with positive supervision experiences are consistent across the literature. Positive supervisory relationships are characterized by attributes also associated with positive supervisory working alliances. These characteristics include an approach that is non-judgmental and provides validation and empathic attitude, which supports exploration and growth while normalizing anxiety (Worthen & McNeill, 1996).

Researchers also found positive supervisory relationships were related to the supervisor's perceived knowledge and clinical experience and ability to create a facilitative learning environment as characterized by openness, respect, support (Allen, et al., 1986; Anderson, et al., 2000; Henderson, et al., 1999; Ladany, et al., 2013), and appreciation for individual differences (Anderson, et al., 2000). Hess (1987) noted ideal supervisors were skillful at expressing "appropriate levels of empathy, respect, genuineness, concreteness and self-disclosure" (p. 248). Several researchers identified the ideal supervisor as having strong interpersonal and communication skills (Carifo & Hess, 1987), having clear well defined goals and expectations (Allen, et al., 1986; Anderson, et al., 2000; Carifo & Hess; McCarthy, et al., 1994), and constructive feedback as important elements contributing to positive supervisory relationships (Allen, et al., 1986; Anderson, et al., 2000; McCarthy, et al., 1994). Effective supervisory relationships are also characterized by respect for the trainee's personal integrity (Henderson, et al., 1999) and autonomy (Henderson, et al., 1999; Ladany, et al., 2013). In addition, positive relationships are reported when supervisors are affirming and reassuring (Black, 1988; Heppner & Roehlke, 1984; Worthen & McNeill, 1996; Wulf & Nelson, 2000), trusting,

warm, accepting and nonjudgmental (Hutt, et al., 1983; McCarthy, et al., 1994), as well approachable and attentive (Henderson, et al., 1999). In addition, several researchers reported that supervisees attributed positive supervisory experiences to their supervisor's ability to help conceptualize therapeutic issues (Ladany, et al., 2013; Shanfield, et al., 1993; Worthen & McNeill, 1996).

The approach that supervisors take toward their supervisees is a key factor in the development of the relationship. Hence, it makes sense that supervisory style is related to the supervisory working alliance. Several researchers identified positive supervisory relationships with supervisors who demonstrated ability and willingness to be flexible and adaptable in their approach (Carifio & Hess, 1987; Cherniss & Egnotios, 1977; Ladany et al., 2001; Worthington & Roehlke, 1979).

Cherniss and Egnotios (1977) investigated five clinical supervision styles in their application to clinical staff working in community mental health programs. The five supervision styles were labeled: (a) didactic-consultative, (b) insight-oriented, (c) feelings-oriented, (d) authoritative, and (e) laissez faire. Results of the study indicated stronger alliances formed when the supervisor was able to use all five styles, adjusting their style to meet the individual needs of the supervisee.

Friedlander and Ward (1984) identified three different types of supervisor styles: Attractive, Interpersonally Sensitive, and Task-Oriented. The Attractive style is typically described as friendly and supportive, reflecting a collegial approach to supervision. The Interpersonally Sensitive style is described as therapeutic and invested, and reflects counselor approach to supervision. The Task-Oriented Style is described as goal oriented

and structured, reflecting a focus on content in supervision. Ladany et al. (2001) examined the relationship between the supervisory styles identified by Friedlander and Ward (1984) in relationship to supervisory working alliance and self-disclosure. The results of the study found significant relationships between supervisory style and the supervisory working alliance. Thus, the supervisor's perception of the relationship with their supervisee was related to the manner in which the supervisor approached their work. Specifically, supervisors who perceived themselves as more supportive and warm were also more likely to report having supervisory relationships that were trusting and highly collaborative in regards to goals and tasks of supervision. Furthermore, the task-oriented supervisors perceived themselves as achieving higher agreement on the task of supervision. Additionally, supervisors who perceived themselves as having a warm, friendly, and invested relationship were more likely to use self-disclosure, suggesting the use of self-disclosure can facilitate a strengthened emotional bond in the supervisory working alliance. Similar to Cherniss and Egnotios (1977), the results of Ladany et al. (2001) found that working alliances were greater when supervisors were able to utilize a variety of supervisory styles, demonstrating the ability to adjust their supervisory approach to meet the individual needs of the supervisee.

Worthington and Roehlke (1979) investigated the relationship between specific supervisor behaviors and supervisor effectiveness. Results indicated positive supervisory experiences were associated with supervisors who provided a structured and instructional approach in the early parts of the supervisee's training, targeted toward helping the

supervisee develop and implement counseling skills while also providing a relaxed and supportive environment.

Negative supervisory experiences. Similar to the attributes associated with positive supervisory experiences, the attributes associated with negative supervisory experiences are also consistent across the literature. Several research studies have identified characteristics associated with negative supervision experiences which include: inflexibility in the supervision approach, lack of understanding of individual differences, lack of empathic response, lack of respect, lack of trustworthiness, being overly critical, lack of openness, providing little support, inattentiveness, ineffective feedback, and being demeaning (Gray et al., 2001; Magnuson, Wilcoxin, & Norem, 2000; McCarthy et al., 1994; Nelson & Friedlander, 2001; Ramos-Sanchez et al., 2002; Veach, 2001). Trainees identified negative supervisory relationships as lacked respect, openness, trust (Allen, et al., 1996; Huss et al., 1983; Kennard, et al., 1987) support, and instruction (Allen, et al., 1996; Huss et al., 1983). Watkins (1997) identified qualities of ineffective supervision in the context of his supervisor complexity model. Watkins (1997) suggested that ineffective supervisors are characterized as being non empathetic, discouraging, defensive, and uninterested in enhancing their own supervisory skills. Poor supervisory alliances and relationships can hinder or be unhelpful in the trainee's growth and development. Nelson and Friedlander (2001) suggested that discord in the supervisory relationship may negatively influence the supervisee's job satisfaction, performance, and work-related stress. Similarly, Kadushin and Harkness (2002) found that a lack of perceived support in supervision, can lead to low morale, job dissatisfaction, and high

turnover. Each of these can negatively impact the quality of service provided to clients. These findings highlight the influence of the supervisory relationship on the outcomes of supervision.

Ramos-Sanchez et al. (2002) found negative events in supervision were related to incongruent goals and tasks and an absence of respect, trust and collaboration in the supervisory relationship. Therefore, discord in the relationship leads supervisees to report negative experiences in supervision, specifically interpersonal relationship and supervision tasks. In addition to lower ratings of the supervisory working alliance, participants who reported negative supervisory events were more likely to report lower levels of satisfaction with their supervisor when compared to participants who did not experience negative events (Ramos-Sanchez et al., 2002). Implications of the study suggest a strong supervisory working alliance can mediate the harmful outcomes associated with negative supervisory events.

Limitations of the Supervisory Working Alliance Research

The majority of studies conducted on the supervisory working alliance have taken place in university settings and settings where graduate students are being trained (Ronnestad & Skovholt, 1993; Schultz et al., 2002; Spence, 2001; Watkins, 2012). Typical trainee participants are students in the master's or doctoral programs in psychology, counseling, or social work programs (Watkins, 2012). Schultz et. al. (2002) argue, “Clinical supervision has been largely ignored in post-educational settings” (p. 213). Additionally, Ronnestad and Skovholt (1993) noted clinical supervision research has predominately been conducted on supervisors in training who have limited

experience in the field. Researchers have also suggested further research to investigate how the supervisory working alliance is affected in workplace environments, or where supervision settings can be quite different from supervision offered in a university clinic or counseling center (Culbreth & Borders, 1999; Mena, 2007; Schultz et al., 2002; Spence, 2001; Sterner, 2009; Watkins, 2012). Watkins (2012) notes, "the evaluation of the supervision and alliance impact in work sites outside of the university setting is quite limited" (p. 47).

Researchers have begun to expand investigation of the supervisory working alliance outside of student trainee studies into the professional workplace. Culbreth and Borders (1999) examined the supervisory alliance in the context of the substance abuse field. Specifically, researchers evaluated the difference in perceptions of the supervisory alliance based on the match or mismatch between the counselor and supervisor's recovery status. Participants included 547 substance abuse counselors who were working in a public mental health system. Results of the study found that that the strength of the supervisory relationship is not related to the recovery status of the counselor and supervisor. Consistent with student trainee studies, the supervisory relationship is a key factor of successful supervision.

Mena (2007) explored the effects of the supervisory relationship on worker outcomes regarding work satisfaction and burnout in a specific social service agency. Results concluded that supervisees who evaluated the supervisory working alliance higher also reported greater work satisfaction. Likewise, Sterner (2009) expanded the research of the supervisory working alliance in the counseling field into the professional

work setting. Specifically, he evaluated the relationship between the following variables: (a) the supervisee's perception of the supervisory working alliance, (b) work satisfaction, (c) work-related stress for supervisees working in mental health agencies, (d) counseling setting, and (e) number of clients per week. Participants of the study included professional counselors who held a master's degree in counseling and had been working in mental health or drug and alcohol settings for a least one year, and who were also receiving clinical supervision. Both Sterner (2009) and Mena (2007) found supervisees who rated the supervisory relationship more favorably were also more satisfied with their work.

Schultz et al. (2002) conducted a study designed to find further empirical support of the supervisory relationship in Holloway's (1995) systems approach with post-academic, rehabilitation work settings, and to assess current practices in clinical supervision in work place environments. Participants of the study included 111 rehabilitation counselors employed by the Division of Vocational Rehabilitation in two western states. The study revealed that a significant number participants did not receive supervision on a regular basis; rather, supervision was typically only provided when a situation arose which warranted it (e.g., crisis). Despite the lack of consistent supervision, the results found the frequency of supervision to be related to the perceived quality of supervisory alliance. When supervision was provided less often or inconsistently, supervisory alliances were perceived less favorably. Consistent with trainee studies, Ladany et al. (2001) and Schultz et al. (2002) found counselors rated the supervisory alliance more favorably when supervisees perceived the supervisory style of the

supervisor as attractive or expert. Finally, counselors perceived legitimate power and reward to have little impact on the supervisory alliance, as these variables were considered outside of the supervisors' expected duties.

Herbert and Trusty (2006) investigated 145 rehabilitation counselors' and supervisees' assessments of the supervisory working alliance and satisfaction with both administrative and clinical supervision. The results of the study found that rehabilitation counselors were satisfied with the supervision they were receiving and likewise, supervisors were satisfied with the supervision they were providing. When comparing administrative and clinical supervision, administrative supervision appeared to be more satisfying than clinical supervision, potentially due to the lower level of counselor experience. Herbert and Trusy's (2006) findings were similar to Schultz et al.'s (2002) in that supervision was not regularly scheduled and instead was provided on an as needed basis. Herbert and Trusty (2006) also found that males were more satisfied than females with supervision. Additionally, rehabilitation counselors were more satisfied with supervision when the amount of time spent on supervision decreased.

Both Schultz et al. (2002) and Herbert and Trusty (2006) identified that participants had been receiving different types of clinical or administrative supervision, and/or both. Neither study separated the different functions, nor explored differences in alliance ratings that resulted from different supervisory functions. It remains unknown whether alliance can be measured in the same manner for administrative versus clinical supervision. However, a benefit of the working alliance model is its adaptability to diverse models (Bordin, 1983; Efstation et al., 1990; Holloway, 1987; Loganbill et al.,

1982), and therefore it may be reasonable to expect the alliance to play an important role in the administrative supervision as well.

Despite some recent research efforts to evaluate the role of the supervisory working alliance in the workplace, the evaluation of the supervisory alliance outside of the university setting remains quite limited. Watkins (2012) stated "Work place investigations are sorely needed for our understanding of alliance to advance" (p. 47). Further, Livni, Crowe, and Gonsalvez, (2012) recommended further research in comparing the impact of supervision across different therapeutic disciplines.

Community Mental Health and Supervision

For centuries, institutions were the most prevalent form of treatment for severe mental illness. The direction of care for those with mental illness has always been shaped by the economic, social, and religious tempo at the time. The movement toward institutionalization began with the growth of the secularism in the 17th and 18th centuries. As the power of the church decreased, so did the perception that disturbed behavior was a result of demon possession to be taken care of by exorcism or death. However, in its place grew the belief that disturbed behavior was a problem with one's morality and therefore should be managed by discipline and segregation from society. Although institutions replaced witch-hunting, "the basic objective remained the same, to protect society rather than to care for the individual" (Bassuk & Gerson, 1978, p. 46). It was not until the introduction of moral treatment by Philippe Pinel, in the early 19th century, that the concern for the welfare of the institutionalized person was considered in addition to the concerns for society (Bassuk & Gerson, 1978; Isaac & Armat, 1990; Richard, 1984).

As inhumane and harsh treatment began to raise concern for a more humane approach, there was also growing desire to understand the etiology and nature of disturbed behavior from more of a medical perspective. Therefore, the focus shifted away from that of disturbed behavior and social deviance to a focus on mental illness. As the medical model of care took front stage in the treatment of mental illness, so did the growth of new state institutions. Although these institutions were developed in sight of a new reform for persons with mental illness, they had largely turned into a large bureaucratic morass where patients endured poor sanitation conditions along with the continuation of maltreatment, neglect, and abuse (Isaac & Armat, 1990; Richard, 1984). Such conditions persisted until after World War II when a significant number of potential soldiers were rejected as a result of a diagnosis of mental illness. The high prevalence of mental illness among soldiers brought into light the stark awareness of the lack of adequate and effective treatment and prevention (Richard, 1984). At the same time soldiers were returning, antipsychotic drug treatments were widely introduced. Many hoped that access to innovative drug treatments, made available in outpatient settings, would provide adequate symptom reduction that would eliminate the need for 24-hour institutional care. (Isaac & Armat, 1990; Johnson, 1990). The possibility of outpatient treatment, in combination with an increased emphasis of human rights and financial burdens of large state hospitals, fueled the development of adequate community-based treatment. These pressures influenced the development of the 1955 Joint Commission on Mental Illness and Health, which was charged with formulating a new national mental health program (Grob, 2005). In 1960, the commission made an influential recommendation which laid

the fundamental ground work of the Community Mental Health Centers Construction Act of 1963 (Bassuk & Gerson, 1978; Grob, 2005; Isaac & Armat, 1990; Richard, 1984). Many of the patients were moved into general hospitals, outpatient medical clinics, or halfway houses. No longer segregated from the general population, persons with severe mental illness quickly rejoined it (Johnson, 1990; Richard, 1984).

The general aims of community mental health services were to prevent unnecessary hospital admissions by providing community based alternatives for treatment, to reduce the number of patients in the state hospitals, and to develop community-based supports for people receiving mental health services (Bachrach, 1977; Johnson, 1990; Richard, 1984).

For years, the prevalent perception around severe mental illness was solely a biomedical model, suggesting mental illness would be managed and stabilized solely with pharmacological treatments. The concept of community mental health implied an expanded view of treatment to include both pharmacological and psychosocial rehabilitation for persons with severe mental illness.

As community mental health services developed, the perception of those with severe mental illness has moved beyond a narrow model of maintenance to one that includes rehabilitation and recovery. People with mental illness are more often perceived in a context that includes a family, leisurely pursuits, and a contribution to a larger community (Multidisciplinary, 2014). Consistent with such changes in perception, services for mental illness that were once thought to be dedicated to psychiatrists now pull from a wide range of therapeutic skills which are provided by multidisciplinary

teams. Such community mental health teams often consist of occupational therapists, counselors, psychologists, social workers, and others who join with psychiatrists and psychiatric nurses. Hope began to form that while living in a community based setting, people with severe mental illness could live happy, healthy lives with a combination of medication and therapy (Isaac & Armat, 1990; Johnson, 1990).

Despite the significant rise of community based treatment services for persons with severe mental illness, little data exists on the supervision in such settings (Schroffel, 2008; Tsui, 1997). This is of concern for both clinical and fiscal reasons. The cost of treating schizophrenia alone is over $63 billion annually for direct treatment and societal costs (NIMH, 2013). The NIMH (n.d.b) estimated that 30% of the costs are associated with the direct care. Other indirect costs are comprised of the expenses associated with time lost from work, care givers, social supports, and criminal justice resources. In addition to the costs associated with schizophrenia alone, the fiscal costs associated with all mental health diagnoses in the United States, which include treatment, social services, and disability payments to clients, loss productivity, and premature mortality, total over $150 billion each year (NIMH, 2014). In regards to clinical concerns, persons with severe mental illness are 50 times more likely than the general public to attempt suicide, with the lack of adequate treatment being a likely factor in the high prevalence (Palmer, Pankratz, & Bostwick, 2005).

In the 1990s, with the expansion of managed care and increased focus agencies placed on becoming efficient and profitable, the function of the supervisor has transformed from a clinical form toward a more administrative one (Borenzwieg, 1981;

Munson, 1993; Ross, 1992). There is less agency support for consistent and ongoing individual clinical supervision. Additionally, “there has been a shift from a mentoring and professional development model, to administrative management of productivity. The shift has taken a toll on the job satisfaction of the workers, as the priority on productivity may be at the expense of the professional value system" (Schroffel, 2008, p. 93).

Community mental health agencies have often reduced or eliminated clinical supervision during times of o structural reorganization. The focus on productivity and billable units has resulted in organizations eliminating expenses that are not directly reimbursable. Because clinical supervision is an expense associated with providing the service and not one which is incorporated into reimbursement, it has been subjected to consistent reductions in the service provision (Schroffel, 2008). Despite the changes in perceptions of those with severe mental illness, Schroffel (2008) suggests another reason for the reduction in clinical supervision in community mental health services is a result of the continued overemphasis on the medical model perspective of mental illness. With the assumption that mental illness is solely a biomedical issue, agencies will see little need to invest in supervision aimed at developing high quality, well trained workers to provide therapeutic and other psychosocial treatment services for such populations. If one assumes that the only way to treat mental illness is through pharmacological interventions then there is little need to involve anyone beyond a medication prescriber. As Schroffel (2008) notes, the flaw in such a simplistic perception of mental illness is that very few people respond effectively to such a narrow scope of intervention. Leung (1994) suggests

that the optimal treatment for persons with severe mental illness includes at the minimum psychological, environmental and social in addition to biological interventions.

The provision and supervision of optimal treatment for persons with mental illness can have positive influences both fiscally and clinically. The data suggest adequate treatment for severe mental illness would reduce the costs of providing the actual treatment significantly (National Alliance on Mental Illness, 2011). Further, research shows that supervised therapy leads to improved client outcomes, including higher alliance ratings, larger symptom reduction (Bambling, King, Raue, Schweitzer, & Lambert, 2006) and greater adherence to effective treatment models (Ladany et al., 1999). Supervisors can offer valuable education and social support that can make significant contributions to worker effectiveness, which in turn can translate into quality service delivery (Kadushin & Harkness, 2002; Poertner, 2006). Therefore, the importance given to supervision in the community mental health treatment for persons with severe mental illness is warranted.

Research Applications of the SWAI

The SWAI was developed by Efstation, Patton, and Kardash (1990) as a self-report instrument to measure the perceived strengths of the supervisory relationship from the perspective of the supervisee and supervisor.

Several researchers have applied the SWAI to measure the supervisory working alliance construct in a variety of settings and populations including graduate level student trainees (Bilodeu & Lecomte, 2010; Bilodeu & Lecomte, 2012; Chen & Bertstein, 2000; Gunn & Pistole, 2012; Murray, Portman, & Maki, 2003; Patton & Kivilighan, 1997;

Renfro-Michel & Sheperis, 2009; Webb & Wheeler, 1998; Wester, Vogel & Archer, 2004; White & Queener, 2003; Williams, Helm, & Clemons, 2012), probation officers (Norrie, Eggleston, & Ringer, 2003), and post-educational work place settings (Herbert & Trusty, 2006; Mena & Baily, 2007; Schulz, et al., 2002; Sterner, 2009). In addition, researchers have utilized to SWAI to measure the supervisory working alliance across clinical and administrative supervision (Herbert & Trusty, 2006; Mena, 2007; Schutlz et al., 2002). The SWAI is designed to measure the supervisory relationship in clinical settings, and results of such studies have not been explicitly clear how the responses apply to administrative supervision (i.e. is the alliance measure the same for administrative versus clinical supervision?). Because the working alliance construct is a common factor across supervision, it may be reasonable to suggest the SWAI would effectively measure the supervisory relationships in both clinical and administrative supervision settings.

The SWAI was initially applied mainly to investigations on trainees in academic settings. More recently, however, the application of the SWAI has expanded to post education work place settings, suggesting a growing importance of understanding the perceptions of supervision in professional workplace environments.

Job Satisfaction

Introduction

Job satisfaction is a topic that has wide reaching interest to both people who work in as well as study organizations. It is one of the most frequently studied variables in organizational behavior research. Job satisfaction has been a variable central to research

and theory of organizational phenomena, including supervision (Spector, 1997). In a review of the literature, Locke (1976) found over 3,000 articles or dissertations dedicated to the topic. It is estimated that to date there are well over 5,000 published articles focused on job satisfaction. The Hawthorne Studies (1924-1933) was one of the first and most significant set of studies investigating job satisfaction. The focus of the study was to determine if changes in environmental work conditions in turn changed worked productivity. Specifically, the study investigated whether decreasing the amount of light workers received would have an effect on their productivity. The results of the study found that, in fact, productivity did increase. However, after the study was over productivity decreased. Researchers suggested the increase in productivity was due to the attention or observation of the research team, and not the independent variable itself. This short-term performance effect that results from employee observation is referred to as the Hawthorne Effect.

Several theories have evolved to provide a foundation for the construct of job satisfaction, as it pertains to this study. Hoppock (1935) published the first intensive study of job satisfaction. Hoppock did not focus on any one particular philosophical approach; rather his studies emphasized the multiplicity of factors related to job satisfaction. Hoppock (1935) viewed "work satisfaction from a global perspective as a composite satisfaction with the job as a whole" (p. 48). The composite satisfaction was made up of several factors such as fatigue, working conditions, supervision, and achievement. Weiss, Dawis, England, and Lofquist (1967) disagreed with solely assessing job satisfaction from a global perspective, and instead suggested that looking at

specific components of one's job offered greater insight into understanding what drove work satisfaction.

Maslow (1954) identified five basic human needs and arranged them in hierarchical order in regards to level of importance. Needs ranged from physiological, safety, belonging, self-esteem to self-actualization. Some researchers have based models of job satisfaction on Maslow's hierarchy of needs (Rogers & Porto, 2006; Worf, 1970). Such models suggest that job satisfaction is the product of an evaluation between the person's needs and the job's ability to meet those needs (Huber, 2006; Lu et al., 2005).

Herzberg and Mausner (1959) built upon Maslow's theory. They identified two different types of need factors: intrinsic and extrinsic. Intrinsic factors are also referred to as 'motivators.' They are the factors associated with the job that are inherently motivating, and tend to be related to the satisfying aspects of a job. Examples of intrinsic factors may be the work itself, appreciation, achievement, and recognition. Extrinsic factors are also referred to as 'hygiene' factors, and tend to be related to dissatisfying factors of a job. Examples of extrinsic need factors may be policies, supervision, salary, and administration. Herzberg and Mausner (1959) suggested job satisfaction results from the interplay between the two needs systems. Hertzberg and Mausner's Motivation-Hygiene (1959) model founded the basis for job satisfaction theory and pioneered future studies. Needs-based theories have become less popular, as more recent theories have begun to emphasize the role cognitive processes have in job satisfaction.

Locke (1976) identified three approaches that determine the attitudes associated with job satisfaction. Attitudes can arise from the degree to which the job offers what the

person expects, meets the employee's needs, or from the degree to which the employee's needs and wants are fulfilled. Therefore, the construct of job satisfaction moves beyond an affective response to the job to incorporate cognitive processes, including appraisal of expectations, desires, values, and goals (Cranny et al., 1992; Smith et al., 1969). The focus on cognitive processes suggests that what makes a job satisfying or dissatisfying is not only the job itself, but the person's expectation about what the job should provide. Therefore, job satisfaction can be conceptualized as global feelings about the job itself, or constellation attitudes about different facets of the job (Lu et al., 2005). The global approach to job satisfaction can be used when the overall attitude is the variable of interest, while the facet approach may be utilized when the researcher is interested in studying aspects of the job that produce satisfaction or dissatisfaction.

Effects of Job Satisfaction

Spector (1997) identified a number of reasons why job satisfaction is an important construct that should concern members across all levels of the organization. He noted that employees who are more satisfied with their jobs are more likely to go beyond the formal requirements of their job to help out colleagues and see to the success of the organization. Job satisfaction is also linked to the employees' physical health and psychological well-being. Individuals who are dissatisfied with their job are more likely to experience adverse health outcomes and psychosomatic symptoms (Spector, 1997). In addition, research has found job dissatisfaction to be related to negative emotional responses associated with anxiety and depression (Jex & Gudanowski, 1992; Jex, & Bliese, 1999; Spector, 1997). According to Spector (1997), studies have been consistent in

demonstrating a correlation between job dissatisfaction and employee turnover and burnout. The research on burnout originally came out of direct care fields such as nursing, social work, and counseling. It was hypothesized that those servicing individuals with high needs were more vulnerable to the emotional experiences of burnout (Prosser et al., 1996).

Job Satisfaction in Community Mental Health

Researchers and practitioners acknowledge that social service workers encounter many stressful experiences in their day-to-day work (Mor Barak et al., 2009). Workers in mental health, social work, and child welfare experience a variety of stressors including low pay, large workloads, excessive paperwork, more administrative work than client work, inadequate training, and staff shortages (APHSA, 2005; Mor Barak el al., 2009; USGAO, 2003). As a result, behavioral health has been plagued by concerns with recruitment, retention, and turnover (Blankertz & Robinson, 1997; Paris & Hoge, 2009; Peterson & Lippincott, 1993). Community mental health services are labor intensive. The U.S. Department of Health and Human Services (1993) reports that 80% to 85% of community mental health money is spent on labor. Employee retention has been a problem consistently identified within the mental health workforce (Blankertz & Robinson, 1997; Dunn & Menz, 1992; Mor Barak et al., 2001; Paris & Hoge, 2009; Peterson & Lippincott, 1993). Blankertz and Robinson (1997) noted a 20% yearly turnover rate for community mental health workers. In two separate studies, Blankertz and Robinson (1997) surveyed 848 psychosocial rehabilitation direct service workers and found that 50% indicated they were likely to leave the psychosocial rehabilitation field

within two years. Ben-Dror (1994) concluded that the turnover rate of employees in the mental health field exceeded 60% each year. Similarly, a meta-analysis by Mor Barak et al. (2001) found that reported rates of employee turnover in community mental health, social work, and child welfare services ranged from 30%-60% annually. High rates of employee turnover requires cases to be frequently reassigned to current workers, resulting in high caseloads, emotional exhaustion, and a focus on more immediate issues such as crisis situations at the expense of adequate care planning. Instability in the community mental health workforce leads to a disruption in continuity of care. This impacts the worker's ability to develop and maintain strong working alliances with the clients, an essential component of effective outcomes. Finally, high rates of turnover are associated with poorer implementation of evidence based practices (Ben-Dror, 1994), fewer services being offered, financial difficulties associated with the elevated costs of recruitment, and training of new hires (Mor Barek et al., 2001; Blankertz & Robinson, 1997; Cyphers et al., 2005; Paris & Hoge, 2009).

Antecedents of Job Satisfaction

Spector (1997) identified antecedents of job satisfaction and classified them into two categories. First is the job environment itself, which includes the nature of the job tasks, relationships with colleagues, and rewards of the job. Second are the characteristics that the individual employee brings into the job. Examples of individual factors may include personality and prior experiences. Researchers have found several individual and job environment factors that are related to job satisfaction including, age, educational attainment, workload, and supervision.

Age. Researchers have examined how age and job experience relate to burnout and job satisfaction (Blankertz & Robinson, 1997; Jinnett & Alexander, 1999; Kiyak et al., 1997; Lantham, Rye, Rimsky, & Weill, 2012; Manlove & Guzell, 1997; Mor Borak et al., 2001; Rupert & Morgan, 2005). It is generally accepted that younger employees are more likely to leave than are their older counterparts. These results have been observed across therapeutic disciplines, including counseling (Lantham et al., 2012), psychology (Rupert & Morgan, 2005), psychosocial rehabilitation (Blankertz & Robinson, 1997a; 1997b), and substance abuse service workers (Knudsen, Ducharme, & Roman, 2006, 2007, 2009). Similarity, Schroffel (1999) examined supervision and job satisfaction of clinicians who work with persons with serious mental illness and also found age to be significantly related to the job satisfaction of the worker.

However, the findings are not fully consistent as some studies found more experienced (often older) mental health workers were more likely to report symptoms of burnout than their less experienced (often younger) counterparts (Lasalvia et al., 2009; Linely & Joseph, 2007). In studies examining nurses in the mental health field, weak relationships were observed between age and job satisfaction (Hyraks, 2005; Hyrkas, 2006; Lu, While, & Barriball, 2004). Given a significant number of findings indicated that age is a significant factor in job satisfaction, it is important to consider age as a potential covariate in the relationship between supervision and job satisfaction in mental health settings.

Educational level. Regardless of educational attainment, researchers have found individuals who hold higher level jobs within an organization are less likely to intend to

leave (Tai, Bame, & Robinson, 1998). These findings are further supported by studies that have found employees who currently act as supervisors or managers' report higher levels of job satisfaction in both nursing (Hykras, 2005, 2006) and child welfare agencies (Strand et al., 2010).

Level of educational attainment is related to turnover for employees holding midlevel jobs (Todd, Deery, & Schmitt, 1996). This suggests that those who have less education tend to remain in the job longer than those who have a moderate level of degree attainment. Researchers have found, when compared to persons with a bachelor's degree, workers with a master's degree were more likely to experience symptoms of burnout and have intention to the leave the agency (Abu-Bader, 2000; Blankertz & Robinson, 1997a; 1997b). Similar findings have been observed in substance abuse treatment settings (Knudsen et al., 2009), as well as child welfare settings (Chou et al., 2010).

Despite some inconsistencies in the literature, there is sufficient data to suggest educational attainment may play a role in job satisfaction. Therefore, education is an important variable to consider.

Perceived workload. Workers in mental health, social work, and child welfare services experience a variety of stressors including large workloads (APHSA, 2005; Mor Barak et al., 2009; USGAO, 2003). Workload is defined by the demands placed on the worker by the job (Spector, 1997). Perceived workload has also been identified as a correlate of job satisfaction. Specifically, persons who report higher or more demanding workloads are more likely to report lower levels of job satisfaction (Cole et al., 2004;

Jayaratne et al., 1991; Kadushin & Kulysis, 1995; Um & Harrison, 1998). Cole et al. (2004) examined job satisfaction in licensed social workers. The survey was designed to measure job satisfaction, perceived workload, efficacy, and quality of supervision. Data on workload was collected utilizing the following question: Do you think your workload is (1) too light, (2) manageable, or (3) too heavy. Results found that perceived workload was predictive of job satisfaction (Cole, et al., 2004). According to Spector (1997), the relationship between workload and job satisfaction has been inconsistent and is therefore is not well understood. Large workloads have been identified as a characteristic of human service work, and therefore should be considered as a possible variable.

Discipline. Kavanagh et al. (2003) explored the relationship between characteristics of supervision and job satisfaction across a variety of therapeutic disciplines. The study utilized 272 allied mental health professionals including social workers, occupational therapists, and speech therapists. The results found no statistically significant differences in job satisfaction between respondents in regards to their therapeutic disciplines. However, no studies have explored whether there is a relationship between therapeutic disciplines and job satisfaction in community mental health settings. Therefore, it would be reasonable to evaluate discipline as a possible variable.

Supervision. Research suggests that supervision can contribute to positive worker outcomes, including job satisfaction (Abu-Bader, 2000; Annie E. Casey Foundation, 2003; Landsman, 2001; Mor Barak et al., 2006) and employee retention (APHSA, 2005; Landsman, 2001; USGAO, 2003). Several researchers have suggested that effective supervision, that offers both emotional and social support, may be a mediating factor

which can offset the negative effects of working in social and human service agencies (Kadushin & Harkness, 2002; Mor Barak et al., 2001). According to Tsui and Ho (1997), supervision "has been identified as one of the most important factors in determining job satisfaction levels of social workers" (p.181).

Job Satisfaction and Supervision

Several studies investigated work satisfaction and supervision in the allied health fields. Hyrkäs (2005) explored the relationship between work satisfaction, burnout and clinical supervision, with 569 Finnish mental health and psychiatric nurses. Results of the study indicated that nearly 50% of the supervisees reported high levels of intrinsic and overall work satisfaction, yet only moderate levels of extrinsic work satisfaction. Overall, supervisees who found clinical supervision valuable viewed it as a positive factor, as well as factor that contributed to greater work satisfaction (Hyrkäs, 2005). One concern with this study was at least half of the participants were not satisfied with their job, yet the potential factors contributing to the job dissatisfaction where not explored.

Begat, Ellefsen, and Severinsson (2005) examined differences in satisfaction and well-being between supervised and unsupervised nurses. Participants of the study included 71 nurses, selected from two community hospitals in Norway. Begat et al. (2005) concluded that ethical conflicts in nursing can lead to a poorer sense of well-being and satisfaction. However, the results suggest that clinical supervision may have a positive influence on the nurses' perception of their well-being. In comparison to unsupervised nurses, nurses who received clinical supervision reported less somatic symptoms and anxiety. Supervised nurses were also more likely to report a sense of being

in control than their unsupervised counterparts. A limitation of the study was the low number of participants. A larger sample size would have provided a more effective sample for which to compare supervised versus non-supervised nurses.

Hyrkäs et al. (2006) evaluated the relationships between job satisfaction, burnout, and the evaluation of clinical supervision. The study included 799 licensed health care staff (e.g. registered nurse, mental health nurse, midwife, nursing auxiliary, physiotherapist). Results of the study found that supervisees who perceived their supervisors as having high levels of trust and rapport were also more likely to evaluate their job satisfaction more favorably. Further, the study concluded that evaluations of the supervision were predictors of job satisfaction, burnout, and assessments of care. Specifically, participants who evaluated supervision more favorably were likely to be more satisfied in their job and less prone to burnout.

Koivu et al. (2012) conducted a study to explore whether nurses receiving supervision were healthier and more satisfied than peers not receiving supervision. The results of the study found nurses who received clinical supervision were more motivated and committed to doing their jobs and reported having greater access to both job and personal resources. These findings suggest that clinical supervision may be a job resource, which serves to support and enhance the worker's well-being. Well-being and satisfaction may be considered reciprocal factors, in that supervisees who reported greater well-being may be more likely to be satisfied with their job. One limitation of the study was it took place in a large teaching hospital, and thus results may not necessarily generalize to community health care institutions.

Eklund and Hallberg (2000) conducted a study of 334 occupational therapists working in a psychiatric care setting to determine how clinical supervision and other work-related factors influenced work satisfaction. In this study, supervisors were either occupational-therapy specific supervisors or psychologist supervisors. Therefore, this study was unique in that it also focused on multidisciplinary supervision. Occupational-therapy specific supervisors typically limited their supervision to occupational therapists. Psychologist supervisors frequently provided team supervision of a treatment team that consisted of staff from a variety of therapeutic disciplines. Results of the study found when compared to participants receiving individual supervision, participants receiving team-oriented supervision were more satisfied in work situations which required interpersonal communication and cooperation (Eklund & Hallberg, 2000). This study supports the need to further evaluate the role of supervision and job satisfaction in settings utilizing a multidisciplinary approach.

Supervision and Job Satisfaction in Counseling and Helping Professions

Several studies have evaluated supervision and job satisfaction within the context of social service workers (Abu-Bader, 2000; APHSA, 2005; Kadushin & Harkness, 2002; Landsman, 2001; Mor Barak et al., 2006; Mor Barak et al., 2009; USGAO, 2003), as well as other helping professions (Cole, 2008; Crutchfeild & Borders, 1997; Himle, Jayaratne, & Thyness, 1989; Ladany et al., 1999; Olk & Friedlander; 1992; Schroffel; 1999; Staudt, 1997; Sterner, 2009; Swartz; 2007).

Olk and Friedlander (1992) found that supervisee dissatisfaction with clinical work and supervision was related to role conflict and role ambiguity. Similarly, Ladany

et al. (1999) evaluated the relationship between the supervisory working alliance and trainee satisfaction and found a positive correlation between the bond in the supervisory alliance and both comfort and satisfaction with supervision. The results showed that when supervisees perceived the emotional bond as increasing in strength over time, they also perceived and evaluated their supervisor's qualities and performance more positively. Furthermore, supervisees had a tendency to be more comfortable in supervision. On the other hand, when supervisees rated the supervisory bond as weaker, they judged both their supervisors and their performance more negatively and were less comfortable in supervision. These results highlight the important role a strong supervisory bond plays in enhancing the satisfaction and comfort of the supervisee. Both studies were restricted to participants in academic settings. However, evidence indicates job satisfaction and supervision may be related to mental health professionals beyond the academic setting. Sterner (2009) found similar results when he evaluated the relationship between the supervisory working alliance and work-related stress and satisfaction for counselors in professional work environments. Results of the study concluded supervisees who rated their supervisory relationship more favorably were also more satisfied with their work.

Newsome and Pillari (1992) examined social workers and the relationship between their satisfaction with supervision and the impact on their work with clients. Results from this study yielded a number of findings. First, although supervisors were not viewed positively across all professional social work groups, those who rated supervision more favorably were also more satisfied with their job. Further, Newsome and Pillari

(1992) found a significant relationship between the supervisory working alliance and general work satisfaction. The facets of job satisfaction rated most favorably were personal autonomy and job security. A high degree of personal autonomy may explain the general negative view of supervisors, yet general satisfaction with supervision.

Kavanagh et al. (2003) explored the relationship between characteristics of supervision and job satisfaction across a variety of therapeutic disciplines. The study utilized 272 allied mental health professionals including social workers, occupational therapists, and speech therapists. The results found no statistical differences in job satisfaction between respondents in therapeutic disciplines. In addition, across all disciplines, there was no relationship between the frequency of supervision and job satisfaction. These results were similar to Newsome and Pillari (1992) who also found no difference in job satisfaction between groups of social workers working in different settings. The results did suggest that a different type of supervision may be required depending on the discipline. One limitation of the study is that data were averaged across all the disciplines; therefore, it would be difficult to truly compare job satisfaction across different professional groups.

Davis-Sacks et al. (1985) evaluated the effects of social support from supervisors, co-workers, and spouses on burnout and other mental health related variables among child welfare workers. The researchers hypothesized that the support from all three facets would be negatively related to burnout and mental health factors. The researchers hypothesized that the satisfaction and pleasure received from these relationships would offset the stressful nature of the job that leads to burnout and mental health symptoms.

However, because supervisors and co-workers may be more equipped to provide the support needed, Davis-Sacks et al. (1985) predicted supervisor and co-worker support would more strongly correlate to burnout than spousal support. Results of the study found all three facets of support lead to lower reports of stress, burnout, and other mental health symptoms (e.g., depression, anxiety). Supervisor support was significantly related to lower levels of burnout, depression, anxiety, irritation and higher ratings of self-esteem. However, unexpected similar results were noted with spousal support. Likewise, unexpected was a lack of relationship between co-worker support and burnout. These results are interesting, in that the majority of respondents stated they would prefer to talk with their spouse or a co-worker following a work-related stressful event, yet there is no relationship between co-worker support and burnout. Perhaps, although the workers would prefer to talk to a co-worker, the nature of the work does not allow that interaction to take place. For example, a co-worker may be out on calls or inaccessible for other reasons. The results of the study highlight the importance of supervisor support in reducing burnout and other negative symptoms associated with poor job satisfaction.

Staudt (1997) investigated job satisfaction in school settings. The study surveyed 78 school social workers for the purpose of gathering information about the nature of school social work, including the nature of job satisfaction of school social workers in Iowa. A multiple regression analysis was used to evaluate the impact of six factors on job satisfaction, one of which was supervision. Results of the study found that satisfaction with supervision accounted for a significant portion of the variance. Hence, respondents who were more satisfied with the supervision they received were also more likely to be

satisfied with their jobs. One limitation of the study was its broad scope. It served to collect data on the nature of school social work and therefore was not solely focused on job satisfaction. As a result, in addition to the factors identified in the study, there were several variables that may have been unaccounted for which may have also influenced job satisfaction.

Similarly, Schroffel (1999) examined the impact supervisory experiences have on clinicians who work with person with serious mental illness. Several findings were noted, including a positive relationship between job satisfaction and length of time the person held a license and a positive relationship between the quality of supervision and Job Description Index (JDI) subscales. Additionally, higher ratings of job satisfaction were reported when the supervisor's style of supervision matched the preferences of the supervisee. A potential limitation of the study is the participants were made up of mental health workers who had different years of experience, training credentials, and were from different therapeutic disciplines. It is uncertain to what extent such factors influenced the findings. However, the variety within participants of this study may represent the workforce in community mental health. Thus, suggesting that supervision may also be related to job satisfaction in settings with similar staffing, including community mental health.

Several studies have examined the relationship between supervisory style and job satisfaction in social workers (Himle et al., 1989; Swartz, 2007). Himle et al. (1989) examined the impact of four different supervisory support styles (instrumental, informational, approval, and emotional) on social workers' job satisfaction. The results of

the study found that both informational and instructional support reduced the psychological symptoms associated with stress (i.e. anxiety and somatic complaints), thus reducing the job dissatisfaction and burnout.

The match between expectations of both the supervisor and supervisee has also been of interest to researchers. Swartz (2007) conducted a theoretical exploration to better understand the relationship between the degree of supervisor and supervisee goal orientation matching and job satisfaction. He suggested that when the supervisee and supervisor have higher agreement on the goal orientations of supervision than greater job satisfaction will exist. Swartz (2007) suggests that supervisors who can demonstrate an understanding of the supervisees' goal orientation are also better able to individualize their approach to meet the needs of the supervisee. Swartz's (2007) findings suggest a more individualized approach to supervision will lead to more enhanced job satisfaction.

Cole (2008) examined job satisfaction in licensed social workers. The survey was designed to measure job satisfaction, perceived workload, efficacy, and quality of supervision. Results from a multiple regression analysis found that perceived quality of supervision and perceived workload were predictive of job satisfaction (Cole, 2008). The results further support supervision as an important factor in job satisfaction for individuals working in helping professions.

All of the above noted studies found an important relationship between supervision and job satisfaction (Cole, 2008; Crutchfeild & Borders, 1997; Davis-Sacks et al., 1985; Himle et al., 1989; Ladany et al., 1999; Olk & Friedlander; 1992; Schroffel; 1999; Staudt, 1997; Sterner, 2009; Swartz; 2007). Therefore, it may be reasonable to

expect that the supervisory relationship to be related to job satisfaction in community mental health settings.

Summary

Researchers have evaluated the benefits associated with a strong supervisory working alliance, yet the majority of studies have focused on the working alliance in academic settings (Bennett et al., 2008; Bernard & Goodyear, 2009; Bhat & Davis, 2007; Bilideau & Lecomte, 2010; Cheon et al., 2008; Cooper & Ng, 2009; Dickson et al., 2011; Gnilka et al., 2012; Gunn & Pistole, 2012; Hess et al., 2008; Ladany et al., 1996, 1997, 1999; Ladany & Friedlander, 1995; Mehr et al., 2010; Patton & Kivlighan, 1997; Rarick & Ladany, 2013; Renfro-Michel & Sheperis, 2009; Riggs & Bretz, 2006; White & Queener, 2003; Yourman & Farber, 1996). The research has largely ignored the supervision in professional work environments (Ronnestad & Skovholt, 1993; Schultz et al., 2002; Spence, 2001; Watkins, 2012).

As financial resources dedicated for mental health services remain low, the responsibility for serving persons with severe mental illness has been placed on community mental health agencies (National Alliance, 2012). Community mental health organizations have long suffered with employee turnover, burnout, and low job satisfaction (Ben-Dror, 1994; Blankertz & Robinson, 1997; Dunn & Menz, 1992; Mor Barak et al., 2001; Paris & Hoge, 2009; Peterson & Lippincott, 1993), which leads to lower levels of perceived therapeutic alliance, poorer implementation of evidence-based practice and generally poorer client outcomes (Ben-Dror, 1994; Kadushin & Harkness, 2002; Poertner, 2006). Without adequate treatment, the consequences of severe mental

illness for the individual and society are staggering: unemployment, substance abuse, homelessness, inappropriate incarceration, and suicide (NIMH, n.d.b; Palmer, et al., 2005). Researchers have identified several factors that influence job satisfaction including age, workload, educational attainment, and supervision. Yet research on such factors in settings serving persons with severe mental illness has been largely neglected in the literature (Schroffel, 2008; Tsui, 1997). The ability to understand the role of supervision, specifically the supervisory working alliance, in relationship to job satisfaction is greatly beneficial to advancing the treatment for persons with chronic mental illness. Chapter 3 will provide an overview of the research design and methods for the study.

Chapter 3: Research Method

Introduction

The purpose of this non-experimental quantitative study was to examine the relationship between the perceived supervisory working alliance and the job satisfaction of workers in community mental health settings.

The construct of the supervisory working alliance is the degree of collaboration and agreement on the goals and tasks of supervision, as well as the degree of rapport and trust. The perception of the supervisory working alliance was measured using the SWAI-T (Efstation et al., 1990). The total construct of job satisfaction was assessed using the JSS (Spector, 1985).

This chapter describes the methods used to test the research hypotheses presented in Chapter 1. Specifically, this chapter addresses the research design, setting and sample, instrumentation, procedures, and protection of participants. The literature review provided the basis for the research questions, which investigated the relationship between the supervisory working alliance and job satisfaction in community mental health workers.

Research Design

Employing a non-experimental, quantitative method utilizing a survey research design was appropriate for this study because it sought to examine the relationship between a predictor variable and outcome variable.

The goal of this correlational non-experimental quantitative survey design was to collect numerical data, using psychometrically sound instruments, to evaluate the

perceived strength of the supervisory working alliance and job satisfaction of workers in community mental health settings. The perceived strength of the supervisory working alliance was based on the total and subscale scores using the SWAI-T, developed by Efstation et al. (1990). The level of job satisfaction was based on the total score measure by the JSS developed by Spector (1985).

The advantages of survey research include the following: (a) several variables can be studied, (b) data can be collected from several participants with relative ease, and (c) it does not require the use of an interviewer, making respondents more likely to respond honestly. There are also disadvantages, which include an inability to draw casual conclusions, poor response rate, and potential weak validity resulting from sampling constraints.

Other research methods were considered and rejected. Experimental design was not an appropriate option as variables could not be manipulated. A qualitative research design was not considered because the focus of this study was to investigate the statistical relationship between two constructs, rather than examine trends based on interviews or group discussions.

Setting and Sample

The population consisted of workers from five community-based mental health agencies located in Minnesota. Participants were providing direct services to adults with severe mental illness and/or children with severe emotional/behavioral disturbance. Participants varied in age, total experience, and experience at their particular agency. The type of supervision they received, including administrative supervision, clinical

supervision, or both clinical and administrative supervision, also varied. Participants varied in their educational levels including high school, bachelor's degrees, master's degree, and/or doctorate and in educational degree area including counseling, psychology, marriage and family, addiction counseling, or social work. Participants were recruited through an online participant pool available from five community mental health agencies with staff populations of over 1,000 workers.

Availability and convenience sampling were utilized for several reasons. First, it allowed for greater participant accessibility. Second, convenience sampling helped to provide a sufficient sample size (Creswell, 2009). The G-Power software program (version 3.1.9.2) was used to calculate the minimum sample size required, using a standard alpha of .05 and power of .80. In addition, because there was no a priori knowledge of effect size, the conventional intermediate effect size ($f^2 = .15$) was used. A minimum estimated number of participants needed to achieve statistical power with a moderate effect size was 98. As a safeguard against potential data quality issues, between 98 and 110 participants were sought for this study.

Researchers have evaluated the response rate associated with electronic or web-based survey designs. Kaplowitz, Hadlock, and Levine (2004) found a response rate of approximately 20% while Cook, Heath, and Thompson (2000) found slightly higher response rates of 25% to 30%. For this study, I anticipated the response rate would be lower because the study targeted busy workers who would be limited in the time they could commit to completing the survey. Due the lower expected response rate, I

estimated that 15% to 20% of those invited to participate would respond. Based on this response rate, a minimum of 560 workers were invited to ensure a sample size of 110.

Instrumentation

Demographic Questionnaire

Participants completed a brief questionnaire to gather data on both demographic and work-related variables. The purpose of the demographic questionnaire was twofold: (a) to describe the participants, and (b) to screen out participants who did not meet the criteria to participate. Data collected included (a) age, (b) gender, (c) highest level of education, (d) work load, (e) discipline, (f) type of supervision, and (g) whether or not the respondent worked with clients who had one or both of the following: severe mental illness and/or severe emotional and behavioral disturbances. Participants who were not currently working in community-based mental health programs and serving clients with mental illness and/or severe emotional and behavioral disturbances were excluded from the study. Respondents who did not complete one or more of the demographic questions were excluded. In addition, the survey design was anonymous and therefore would allow the participant to take the survey more than once. To guard against this problem, the survey included a question that asked if the participant had previously taken the survey. If a participant indicated that he or she had already taken the survey, his or her subsequent survey was excluded from data collection.

SWAI-T

The purpose of the SWAI-T is to measure the relationship in the counseling supervision, as rated by supervisee or trainee. The SWAI-T form was utilized in this

study to measure workers' perceptions of their supervisory working alliance. To assess what influence supervision has on mental health worker job satisfaction, it was essential to understand how mental health workers perceived the supervisory relationship.

The SWAI-T form is made up of 19 items, which are divided into two subscales, Rapport and Client Focus. The Rapport subscale consists of 13 items (e.g., I feel comfortable working with my supervisor) and Client Focus consists of six items (e.g., my supervisor welcomes my explanations about the client's behavior). The items are measured on a 7-point Likert scale, with responses that range from (1) *never* to (7) *almost always* (Efstation et al., 1990). The SWAI-T can yield scores that range from 19 to 133. The SWAI-T score is calculated by adding the Client Focus subscale score, which ranges from 6 to 42, and the Rapport subscale score, which ranges from 13 to 91.

The SWAI-T does not have cut off scores that indicate high or low perception of the SWA. Therefore, lower overall and subscales score are interpreted as the supervisee's perception of a weak supervisory alliance, where higher overall and subscales score are interpreted as supervisee's perceptions of strong supervisory alliances. (Efstation et al., 1990).

Efstation et al. (1990) conducted an exploratory factor analysis that gave rise to the two subscales noted above, Rapport and Client Focus. Factor 1, Rapport, on the SWAI-T accounted for 30% of the variance that loaded highly (< .40), which represents the perception of supervisory support (Efstation et al., 1990). Factor 2, Client Focus, on the SWAI-T accounted for about 8% of the variance with 7 items loaded highly (> .50).

Efstation et al. (1990) measured internal consistency reliability of the instrument using Cronbach's alpha. Alpha coefficients for the SWAI-T scales were .90 for rapport and .77 for client focus ($N = 178$). Item-scale correlations were also obtained for the two SWAI-T subscales. The item-scale correlations ranged from .44 to .77 for the rapport scale, and .37 to .53 for the client focus scale (Efstation et al., 1990).

Efstation et al., (1990) assessed convergent and divergent validity against the Supervisory Styles Inventory (SSI) (Friedlander & Ward, 1984). Validity results found a statistically significant correlation between the SWAI-T and the scales of the SSI.

Patton et al., (1992) conducted a study of validity between the SWAI and Halloway and Wampold's Personal Reaction Scale-Revised (1984). Consistent with Efstation et al. (1990), results of Patton et al.'s (1992) validity study found the cross factor analysis yielded a two factor solution for the SWAI-T. In addition, internal reliability for the SWAI-T subscales were .82 for client focus and .91 for rapport, similar alphas to those reported by Efstation et al. (1990).

Several researchers have applied the SWAI-T to measure the supervision working alliance construct. Researchers have used the SWAI-T in a variety of settings and populations including graduate level student trainees (Bilodeu & Lecomte, 2010; Bilodeu & Lecomte, 2012; Chen & Bertstein, 2000; Gunn & Pistole, 2012; Murray, Portman, & Maki, 2003; Patton & Kivilighan, 1997; Renfro-Michel & Sheperis, 2009; Webb & Wheeler, 1998; Wester, Vogel, & Archer, 2004; White & Queener, 2003; Williams, Helm, & Clemons, 2012), probation officers (Norrie, Eggleston, & Ringer, 2003), and post-educational

work place settings (Herbert & Trusty, 2006; Livini, Crowe, & Gonsalvez, 2012; Mena & Baily, 2007; Schulz, Ososkie, Fried, Nelson & Bardos, 2002; Sterner, 2009).

The SWAI-T has been used to measure the supervisory working alliance in regards to its relationship to worker outcomes, including job satisfaction (Mena, 2007; Sterner, 2009). Schultz et al. (2002) utilized the SWAI-T to measure the perception of the supervisory working alliance with vocational rehabilitation workers. Herbert and Trusty (2006) utilized the SWAI-T in a study investigating rehabilitation counselors' and supervisees' assessments of the supervisory working alliance and satisfaction with both administrative and clinical supervision. Patton and Kivlighan (1997) conducted a study with 75 graduate-level pre-practicum counseling students to evaluate the relationship between the supervisees' ratings of the supervisory working alliance, as measured by the SWAI-T, and their clients' ratings of the therapeutic alliance, as well as the supervisees' adherence to a specific model of counseling. The SWAI-T was utilized to measure the supervisory working alliance in relationship to self-disclosure critical issues in supervision (Webb & Wheeler, 1998), attachment styles (Renfro-Michel & Sheperis, 2009; White & Queener, 2003), and gender differences in regards to satisfaction with supervision (Wester et al., 2004).

JSS

The JSS was developed to measure job satisfaction in human services (Spector, 1984). The JSS measures both the individual facets associated with job satisfaction and overall satisfaction. The JSS is a 36 item, 9-facet scale including (a) Pay, Promotion, (b)

supervision, (c) Fringe Benefits, (d) Contingent Rewards (performance-based rewards), (e) Operating Procedures (required rules and procedures), (f) Coworkers, (g) Nature of Work, and (h) Communication, to assess employee attitudes about the job and aspects of the job. Four items were used to measure each facet, and a total score is computed from all items. A rating scale format is used, ranging from, 1, *strongly disagree*, to, 7, *strongly agree*. Items are written in both directions, so approximately half must be scored in reverse. Although the JSS was developed originally for use in human service organizations, it is applicable to all organizations (Spector, 2004).

Data aiding the development of the JSS were collected from 2,870 participants who made up 19 different samples. The samples were varied in size and organization. Participants were all from human service, public, and non-profit sector organizations, which included community mental health centers, psychiatric hospitals, state social service departments, and nursing homes (Spector, 1985). In addition, the sample consisted of a variety of different types of workers, including administrators, managers, line workers, clerks, administrative assistants, and maintenance workers.

In efforts to define the total domain of interest (job satisfaction), researchers conducted a thorough review of the literature, including studies of the dimensions of job satisfaction. The literature review yielded studies on several existing instruments used to measure job satisfaction. Several of these instruments were examined, using factor analysis, to identify common dimensions of job satisfaction. In addition, researchers conducted a qualitative analysis in efforts to identify the underlying dimensions of satisfaction. Researchers identified a list of nine dimensions, and the most common and

meaningful were chosen for the scale. The researchers asserted that the sum of the nine scales adequately represented total job satisfaction.

The total scale, as well as each subscale was tested for internal consistency reliability, using coefficient alpha. Coefficient alpha for all the subscales scores, with the exception of two, were over .70, and the total scale was .91. These results are sufficiently high enough to suggest adequate reliability of the measure.

To determine test-retest reliability, the researchers administered the JSS to a small sample (n = 43) and two occasions 18 months apart. Despite the significant length of time between the two test administrations, the correlation between the two scores was high. The coefficient alpha's ranged from .37 to .74 for the subscales and .71 for the total scale. The alpha score is strong enough to support the reliability of the instrument further (Spector, 1985).

Discriminate and convergent validity were demonstrated by a multi trait-multi-method analysis of the JSS and the Job Description Index (JDI). The results of the validity study yielded several findings. First, the validity correlations between equivalent subscales were of a sufficient amount, .61 to .80 (Spector, 1985). Second, the correlations for equivalent subscales were higher than correlations resulting from comparisons with non-equivalent subscales. Third, the pattern of association between the various subscales for both instruments was reasonably consistent, with all but one from each instrument ranging from .20 to .37. These findings suggest the JSS has sufficient validity (Spector, 1985).

Several studies have used the JSS to measure job satisfaction. Although the literature review related to this instrument yielded no specific studies measuring job satisfaction in community mental health, there were several studies in similar settings, , including child welfare services (Auerbach, McGowan, Ausberger, Strolin-Goltzman, & Schudrich, 2010; Augsberger, Schudrich, McGowan, & Auerbach, 2012; Strand, Spath, & Bosco-Ruggiero, 2010) and developmental disabilities services (Chou, 2010; Chou, 2011).

Data Collection and Data Analysis

This study examined the relationship between the supervisory working alliance and job satisfaction as perceived by community mental health workers. The research questions were answered using several statistical analyses. In addition, descriptive statistics of demographics were also evaluated for relationships to the criterion variable. The research questions and hypothesis were developed to examine the potential relationships between the supervisory working alliance and job satisfaction.

Restatement of Research Questions and Hypothesis

1. What is the relationship between the construct of the supervisory working alliance and the construct of job satisfaction in community mental health workers?

   Null hypothesis ($H_0 1$). There will be no relationship between the construct of the supervisory working alliance, as measured by the overall score on the SWAI and the construct of job satisfaction, as measured by the total score on the JSS, in community mental health workers.

Alternate hypothesis (H_a1). A significant positive correlation exists between the construct of the supervisory working alliance, as measured by the overall score on the SWAI-T and the construct of job satisfaction, as measured by the total score on the JSS, in community mental health workers.

2. To what extent do the dimensions of the supervisory working alliance of client focus and rapport predict the construct of job satisfaction in community mental health workers?

   Null hypothesis ($H_0$2). There will be no predictive relationship between the *rapport* and *client focus,* as measured by the SWAI-T and the construct of job satisfaction, as measured by the JSS composite score, in community mental health workers.

   Alternative Hypothesis (H_a2). There will be a significant predictive relationship between one or both of the individual dimensions of the supervisory working alliance, *rapport* and *client focus,* as measured by the SWAI-T, and the construct of job satisfaction, as measured by the JSS composite, in community mental health workers.

3. To what extent do the demographic variables of age, educational attainment, workload, discipline and type of supervision predict the construct of job satisfaction in community mental health workers?

   Null hypothesis ($H_0$3). There will be no predictive relationship between the demographic variables of age, educational attainment, workload, discipline and type of supervision as measured by the demographic questionnaire and the

construct of job satisfaction, as measured by the JSS composite score, in community mental health workers.

Alternative Hypothesis (H_a3). A significant predictive relationship exists between some or all of the demographic variables age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, and job satisfactions, as measured by the JSS, in community mental health workers.

4. What is the best model that predicts job satisfaction of workers in community mental health settings?

   Null hypothesis (H_04). A model using the independent variables of the supervisory working alliance, as measured by the SWAI, and demographic variables of age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, will not significantly predict job satisfaction in workers in community mental health settings.

   Alternative Hypothesis (H_a4). A model containing certain independent variables, including the supervisory working alliance, as measured by the SWAI-T, and demographic variables of age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, will significantly predict job satisfaction in workers in community mental health settings.

Procedures

Data Collection

Two self-administered psychometric surveys (SWAI-T and JSS) and self-administered demographic questionnaire surveys were made available via Survey Monkey to workers at organizations that provide community mental health services.

Participants were invited to participate voluntarily in the research study through an e-mail notification announcing the study. An e-mail distribution list was developed through collaboration with community organizations. Community organizations may have directly provided e-mail addresses of their workers. An organization may also have chosen to provide an e-mail address for a centralized contact, in which the e-mail invitation was sent, and forwarded to potential participants. In addition, a community agency may have chosen to do a combination of the two methods.

The e-mail announcement included an invitation to potential participants, informed consent and link to the survey. Vaux (1996) outlined several important considerations for a participant invitation letter which will be considered for this study. The e-mail announcement included a brief introduction of the researcher and a clear statement distinguishing the role of research as separate from the agency or organization. The e-mail announcement also provided an overview of the purpose of the study, its importance in the field, and the anticipated length of time required to complete the survey. In addition, it included a statement regarding the voluntary and anonymous nature of the study. This invitation directed prospective participants to read the informed consent that follows.

The informed consent provided a brief introduction of the researcher, background of the study and procedures for completing the survey. In situations in which the researcher may have also be perceived as representing the organization, the informed consent clearly asserted that the role of the researcher was separate from the work role in the organization. The informed consent included participant eligibility requirements and brief description of the procedures. In addition, the informed consent included a description of the voluntary and anonymous nature other of the study. The informed consent outlined risks and benefits of participation in the study, as well as procedures for discontinuing or managing distress as needed. Finally, it concluded with a statement of consent and a link to the survey.

After sending the initial e-mail announcement, I followed-up with reminder e-mails. The anonymous nature the study made it impossible for the researcher to know who had already completed the study, therefore, all potential participants received a reminder e-mail. Therefore, the follow-up e-mail invitation was amended from the initial format to include a thank you statement to those who have already completed the survey.

Data collection continued for approximately three weeks. Upon completion of the data collection, all data were downloaded and maintained in a secure file. Data were available to the researcher and to qualified professionals upon request.

Data Analysis

All data were collected, analyzed for accuracy, completeness, and scoring. Data were analyzed using IBM SPSS software application. The research questions proposed in this study were answered utilizing a correlational analysis and multiple regression

analyses. A correlation is a single number that describes the degree of relationship between two variables. The correlational analysis was utilized to investigate the relationship between the SWA and job satisfaction. In a multiple regression analysis, two or more known variables are used to predict the value of a dependent variable (Field, 2013). For the purpose of this study, multiple regression analysis was utilized to investigate the predictive relationship between the following known variables: (a) client focus (SWAI-T subscale), (b) rapport (SWAI-T subscale), (c) age of the worker, (d) educational attainment of the worker, (e) therapeutic discipline of the worker, and (f) job satisfaction (Gravetter & Wallnau, 2009).

Composite supervisory working alliance scores were calculated from the SWAI-T. The composite job satisfaction score was calculated from the JSS. Individual scores for each dimension of the supervisory working alliance were calculated utilizing the corresponding subscale of the SWAI-T.

Data analysis also included descriptive analysis and tests of normality. Collinearity is an undesirable situation that occurs when the independent variables are highly correlated. When this occurs, the standard error increases. To avoid such error, a test of collinearity between six predictor variables (rapport, client focus, age, educational attainment, workload, and discipline) and the criterion of job satisfaction were determined.

Threats to Validity

Self-administered survey instruments have several advantages. First, surveys are delivered wherever e-mail or mail goes (i.e. home, office), and respondents can answer at

their convenience. Second, an interviewer is not present to inject bias in the way questions are asked (Duffy, Smith, Terhanian, & Bremer, 2005). Additional advantages over structured interviews include (a) cost efficiency, (b) no need to set up interview appointments, and (c) ease of reaching large numbers of people. However, self-administered surveys also have their drawbacks. They lack the presence of a researcher to clarify questions and to ensure all surveys are completed in totality (Duffy et al., 2005). In addition, there may be repeat and non-serious respondents and respondents who may not accurately report their demographic information (Gosling, Vazire, Srivastava, & John, 2004). Finally, self-administered surveys may lead to self-selection bias that occurs when some individuals can self-select to opt-in or out of the research (Thompson, Surface, Martin, & Sanders, 2003). Self-selection can create a biased sample which limits the generalizability of the findings. However, the benefits of using a self-administered survey design, in terms of convenience, costs efficiency, and resource allocation, outweighed the potential drawbacks.

The study utilized a correlational and multiple regression statistical test to answer the research questions. Correlation and multiple regression analysis require several common assumptions were met including: (a) variables are normally distributed, (b) variables are measured in a reliable manner, and (c) there is a linear relationship between independent and dependent variables (Osborne & Waters, 2002). As stated above, the data analysis included a test for normality and collinearity to ensure the data met the required assumptions to draw statistical conclusions.

The probability of errors increases if the sample size is too small. An insufficient sample size cannot provide sufficient data to achieve true statistical significance (Kalla, 2009). As stated above, to mediate this threat, a G-power analysis was conducted to determine the minimum number of participants required to achieve a moderate effect size. The study invited significantly more than the minimum required respondents to participate to compensate for the lower expected response rate.

Protection of Participants' Rights

Ethical considerations were important to this study. Efforts were made to adhere to ethical standards and provide protection for all participants.

This research has meaning to supervisors and leadership in community mental health settings who seek a better understanding of their employees' job satisfaction. The supervisee's perception of the strength of the supervisory relationship can impact his/her overall sense of satisfaction (Abu-Bader, 2000; Annie E. Casey Foundation, 2003; Landsman, 2001; Mor Barak et al., 2006). This research also has meaning to supervisees seeking to understand factors that can counterbalance the negative effects of the demanding work associated with community mental health (Kadushin & Harkness, 2002; Mor Barak et al., 2001). The results can be used to help supervisors and professional leaders recognize the importance of quality supervision. In turn, supervisee's who receive quality supervision will have improved job satisfaction and client outcomes.

Although the risks are minimal when filling out the questionnaire, employees may have had concerns that negative ratings of the supervisory relationship or job satisfaction may negatively impact their employment. To guard against such concern, the participants

were made aware that the surveys are anonymous and confidential, and all data will only be available to the researcher.

All participants provided informed consent indicating his/her agreement to participate in the research. Each participant were provided with a brief introduction of the researcher, background of the study and procedures for completing the survey. In situations in which the researcher may also be perceived as representing the organization, the informed consent clearly asserted that the role of the researcher as being separate from the work role in the organization. Participants were not deceived in any way and were informed that his/her participation in the study is confidential and voluntary. In addition, participants were informed that they can withdraw from the study at any time without negative consequences.

The researcher sought approval from the Walden University Institutional Review Board (IRB) prior to data collection. Participant confidentiality was ensured by collecting data anonymously. The survey tool did not collect IP address information from participants. It had no individually identifying information (i.e. name, date of birth, identification numbers, mailing addresses, e-mail address). No combination of indirect identifiers collected would reasonably allow the researcher or anyone else to identify the participants. Upon completion of data collection, the data were downloaded and stored on a password protected external hard drive, only available to the researcher. Data collected directly to Survey Monkey will be maintained for one year, upon which time it will be deleted. Data downloaded and maintained on an external hard drive will be maintained

for five years, at which time the data will be permanently deleted. All data analysis and interpretation was conducted accurately and honestly.

Summary

This chapter presented the research methods for this non-experimental quantitative study, which seeks to explore the relationship between the constructs of the supervisory working alliance and job satisfaction in community mental health settings. The research design, setting and sample, instrumentation, as well as procedures, have been described. Data were collected utilizing a brief demographic survey and two self-report surveys, the SWAI-T and the JSS. The reliability and validity of the instrumentation has been discussed, as well as threats to statistical validity of the study. Attention was given to the ethical issues related to the study and the protection of the participants' rights.

Chapter 4: Results

Introduction

The purpose of this non-experimental quantitative study was to examine the relationship between the constructs of the supervisory working alliance and job satisfaction in community mental health workers. Specifically, the study was conducted to answer four research questions.

Research Questions

1. What is the relationship between the construct of the supervisory working alliance and the construct of job satisfaction in community mental health workers?

   Null hypothesis ($H_0$1). There will be no relationship between the construct of the supervisory working alliance, as measured by the overall score on the SWAI-T and the construct of job satisfaction, as measured by the total score on the JSS, in community mental health workers.

   Alternate hypothesis (H_a1). A significant positive correlation exists between the construct of the supervisory working alliance, as measured by the overall score on the SWAI and the construct of job satisfaction, as measured by the total score on the JSS, in community mental health workers.

2. To what extent do the dimensions of the supervisory working alliance of client focus and rapport predict the construct of job satisfaction in community mental health workers?

   Null hypothesis ($H_0$2). There will be no predictive relationship between the *rapport* and *client focus,* as measured by the SWAI-T, and the construct of job

satisfaction, as measured by the JSS composite score, in community mental health workers.

Alternative Hypothesis (H_a2). There will be a significant predictive relationship between one or both of the individual dimensions of the supervisory working alliance, *rapport* and *client focus,* as measured by the SWAI-T, and the construct of job satisfaction, as measured by the JSS composite, in community mental health workers.

3. To what extent do the demographic variables of age, educational attainment, workload, discipline and type of supervision predict the construct of job satisfaction in community mental health workers?

   Null hypothesis ($H_0$3). There will be no predictive relationship between the demographic variables of age, educational attainment, workload, discipline and type of supervision as measured by the demographic questionnaire and the construct of job satisfaction, as measured by the JSS composite score, in community mental health workers.

   Alternative Hypothesis (H_a3). A significant predictive relationship exists between some or all of the demographic variables age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, and job satisfactions, as measured by the JSS, in community mental health workers.

4. What is the best model that predicts job satisfaction of workers in community mental health settings?

Null hypothesis ($H_0$4). A model using the independent variables of the supervisory working alliance, as measured by the SWAI-T, and demographic variables of age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, will not significantly predict job satisfaction in workers in community mental health settings.

Alternative Hypothesis (H_a4). A model containing certain independent variables, including the supervisory working alliance, as measured by the SWAI-T, and demographic variables of age, educational attainment, workload, discipline and type of supervision, as measured by the demographic questionnaire, will significantly predict job satisfaction in workers in community mental health settings.

The hypotheses were tested using correlational and multivariate regression analyses. This chapter describes the participant sample, provides an overview of the design procedure, and summarizes the results of the analyses.

Data Collection

The participants of this study were selected using a convenience sampling strategy from a population of community mental health agency employees. All data were collected with an online survey instrument. I used Survey Monkey to distribute two self-report instruments and the demographic questionnaire to staff at five community mental health organizations. From the first invitation e-mail, data collection was completed within a 3-week timeframe. Data collection procedures varied slightly with Organization A, as it was my workplace. To begin data collection at Organization A, I utilized the

agency's e-mail distribution list to send the invitation e-mail to all staff, excluding my direct reports. The invitation e-mail contained the Informed Consent and survey link. One week later, I sent the same staff a reminder e-mail. The reminder e-mail also contained Informed Consent and the survey link. Two-weeks from the initial e-mail invitation, I sent the staff a final thank you and reminder e-mail. The final reminder e-mail also contained the Informed Consent and the survey link. Data collection ended 1 week from the final reminder e-mail.

Data collection at Organizations B, C, D, and E began when I sent the invitation e-mail to a central contact within the organization. The central contact then forwarded the invitation to their staff. The invitation e-mail contained the Informed Consent and survey link. One week later, I sent the reminder e-mail to the central contact within the organization. Again, the central contacts then forwarded the reminder e-mail invitation to their staff. Data collection for Organizations B, C, D, and E ended 2 weeks from the final reminder e-mail. Data collection for all organizations began and ended on the same day. All e-mail invitations were sent via a "no reply" e-mail address created within Organization A's e-mail system.

Recruitment and Response Rates

Recruitment was conducted through online surveys at five community mental health organizations that employed community mental health workers. A total of 291 respondents clicked on the survey link in the e-mail invitation. Records were collected between March 23, 2015 and April 13, 2015. Thirty cases were deleted as both the SWAI-T and the JSS were blank (10% of the items). Ten cases were deleted because the

JSS was left blank (4% of the items). Further examination revealed that one case reported not working with clients with severe mental illness or severe emotional behavioral disturbances, and it was deleted. This resulted in a final working sample of 250 respondents.

Characteristics of the Sample

Table 1 summarizes the demographic characteristics of the sample. The largest number of respondents was between the ages of 31 to 40 years old (37.6%). The second largest number of respondents was between the ages of 25 and 30 years old (25.6%).

The majority of survey respondents had completed their master's degree (47.2%) or bachelor's degree (37.6%). The majority of respondents reported they were trained in psychology as their therapeutic discipline (36%). Twenty-four percent of respondents indicated they were trained in social work. Nineteen percent of respondents indicated that they were trained in a field other than psychology, social work, marriage and family therapy, substance abuse counseling and nursing.

The majority of respondents reported that their workload was manageable (78.4%). In looking at the type of supervision that respondents received, the majority reported receiving both clinical and administrative supervision (47.6%).

No comparative data were available to describe how representative the sample was of the population of interest.

Table 1

Descriptive Statistics of Demographic Variables

Variable	*n*	Category	Frequency	Percent
Age	250	18 to 24	21	8.4
		25 to 30	64	25.6
		31 to 40	94	37.6
		41 to 50	32	12.8
		50 to 60	28	11.2
		60 or older	11	4.4
Education	250	High school degree	13	5.2
		Associate degree	24	9.6
		Bachelor degree	94	37.6
		Master's degree	118	47.2
		Doctorate degree	1	0.4
Discipline	250	Psychology	91	36.4
		Social work	60	24
		Marriage and Family	16	6.4
		Substance abuse	17	6.8
		Nursing	18	7.2
		Other	48	19.2
Workload	250	To light	6	2.4
		Manageable	196	78.4
		Two heavy	48	19.2
Type of supervision	250	Clinical	78	31.2
		Administrative	53	21.2
		Both clinical and administrative	119	47.6

Responses to the SWAI – T and JSS

The SWAI-T form is made up of 19 items. It can be scored in two ways. First, the SWAI-T can be scored as a total score. Second, it can also divided into two subscales, *rapport* and *client focus*. The total score is calculated by the sum of all 19 items. The *rapport* subscale consists of 13 items (e.g., I feel comfortable working with my supervisor). The *client focus* subscale consists of six items (e.g., my supervisor welcomes my explanations about the client's behavior). The items are measured on a 7-point Likert scale, with responses that range from (1) never to (7) almost always (Efstation et al., 1990). The SWAI-T can yield scores that range from 19 to 133. The SWAI-T score is calculated by adding the *client focus* subscale score, which ranges from 6-42, and the rapport subscale score, which ranges from 13 to 91.

The SWAI-T does not have cut off scores that indicate high or low perception of the SWA. Therefore, lower overall and subscales score are interpreted as the supervisee's perception of a weak supervisory alliance, where higher overall and subscales score are interpreted as supervisee's perceptions of strong supervisory alliances. (Efstation et al., 1990). The SWAI–T total scale mean was 104.46 (*SD* = 24.82). The *rapport* subscale mean was 72.43 (*SD* = 17.51). The C*lient focus* subscale mean was 32.03 (*SD* = 8.05). The range of scores for the total supervisory working alliance and subscales were as follows: total scores ranged from 26 to 133, 13 to 91 for rapport, 7 to 42 for client focus. Reliability of the SWAI-T was confirmed by calculating a coefficient alpha for the composite score (.98), for the *rapport* subscale (.97) and for the *client focus* subscale (.92).

Table 2

Descriptive Statistics for the Total and Subscales of SWAI-T

Statistic	Total Score	Rapport	Client Focus
Valid N	250	250	250
Missing	0	0	0
Mean	104.46	72.43	32.03
SD	24.82	17.52	8.05
Minimum	26	13	7
Maximum	133	91	42
Coef. α	0.98	0.97	0.92

The second survey instrument was the JSS. The JSS was measured using a composite job satisfaction score. The mean for the composite score of job satisfaction was 149.10 (*SD* = 26.51). The scores ranged from 73 to 216. Reliability of the JSS was confirmed by calculating the coefficient alpha (.93) for the composite score.

Table 3

Descriptive Statistics for the JSS

Statistic	Total Score
Valid N	250
Missing	0
Mean	149.10
SD	1.68
Minimum	73
Maximum	216
Coef. α	0.93

The JSS assesses job satisfaction on a continuum from low to high. There are no specific cutoff scores that determine whether an individual is satisfied or dissatisfied. Therefore it cannot be confidently determined that there is a particular score that is the dividing line between satisfaction and dissatisfaction. Spector (1994) suggests two

approaches for drawing conclusions about satisfaction and dissatisfaction. The first approach is a normative approach that will compare the sample to the norm sample. This approach is limited in that the norms are not from representative samples, but rather are an accumulation of mostly convenient samples.

The second approach to drawing conclusions about satisfaction versus dissatisfaction utilizes "logical, if arbitrary cutoff scores to represent dissatisfaction versus satisfaction" (Spector, 1994, p. 2). The JSS utilizes a six point *agree* to *disagree* response choice. It can then be assumed that satisfaction is represented by agreement with positively worded items and disagreement with negatively worded items. On the other hand, dissatisfaction is represented by disagreement with positive worded items and agreement with negative worded items (Spector, 1994). Therefore, scores with a mean response of four or more represent satisfaction. Mean responses of three or less represent dissatisfaction. Subsequently, mean scores between three and four represent ambivalence. For the 36-item total, where possible scores range from 36 to 216, the ranges are 36 to 208 for dissatisfaction, 144 to 216 for satisfaction and between 108 and 144 for ambivalent (Spector, 1994). Utilizing this approach, 17 of the respondents were dissatisfied (6.8%); 86 were ambivalent (12.8%), and 147 were satisfied (80.4%).

Table 4

Job Satisfaction by Category

	Frequency	Percent
Dissatisfied	17	6.8
Ambivalent	86	19.6
Satisfied	147	80.4
Total	250	80.4

To determine the extent to which the distributions are normally distributed, skewness and kurtosis were calculated. In a normal distribution, skewness and kurtosis are equal to zero. The further these values are from zero, the more likely it is that the distribution is not normal. By convention, skewness statistics with values greater than the absolute value of 1.96 deviate beyond acceptable limits of normality. Kurtosis values greater than the absolute value of 3.29 deviate beyond acceptable limits of normality (Randolph & Myers. 2013). The distribution of scores for the JSS was within the acceptable limits to be considered normal with a skewness value of -.155 (*SE* = .154) and a kurtosis value of -.468 (*SE* = .307). In addition, the distribution of scores for the SWAI–T were also within the acceptable limits to be considered normal with a skewness value of-1.091(*SE* = .154) and a kurtosis value of .813 (*SE* = .307).

Data Analysis Results

Research Question 1

The first question examined the relationship between the supervisory working alliance and job satisfaction. The hypothesis was initially tested using a simple bivariate correlation, using Pearson's *r*. As shown in table 5, the supervisory working alliance was strongly, positively associated with job satisfaction, ($r = .589$, $p < .001$).

Table 5

Correlation between Supervisory Working Alliance and Job Satisfaction (n = 250)

Variables	1
1. Supervisory Working Alliance	-
2. Job Satisfaction	0.589*

* Correlation is significant at the 0.01 level (1-tailed).

There was a significant correlation between the supervisory working alliance and job satisfaction, r (248) = .59, $p < .001$. The analyses suggest that greater job satisfaction was related to strong perceptions of the supervisory working alliance. R-squared was .35, implying that 35% of variance for job satisfaction is associated with the variance in the supervisory working alliance.

Based on the findings of the correlational analysis, the null hypothesis for the first research question," There will be no relationship between the construct of the supervisory working alliance, as measured by the overall score on the SWAI and the construct of job satisfaction, as measured by the total score on the JSS, in community mental health workers," was rejected. The alternative hypothesis was supported indicating a significant positive relationship between the construct of the supervisory working alliance and the construct of job satisfaction.

Research Question 2

The second question examined the extent to which job satisfaction could be predicted from the individual dimensions of the supervisory working alliance, *rapport* and *client focus.* The hypothesis was tested using a standard regression procedure.

Bivariate correlations between the two subscales of *rapport* and *client focus* and the dependent variable, job satisfaction, were computed to examine relationships of the predictors and outcome variables.

Table 6

Correlations for the Regression for Individual Supervisory Working Alliance Subscale Variables, Rapport and Client Focus and Job Satisfaction (n = 250)

	1	2
1. Job Satisfaction		
2. Rapport	0.577*	
3. Client Focus	0.562*	.868*

* Correlation is significant at the .001 level (2-tailed).

Both subscales *rapport* and *client focus* were moderately correlated to job satisfaction (rapport, r = .577, p < .001 and client focus, r = .562, p < .001). Although, the bivariate correlations between the two predictor variables was moderately high (*r* = .868), the tolerance (.247) and variance inflation factor (4.046) were within acceptable limits, suggesting that multicollinearity is not an issue.

The two subscales of the supervisory working alliance, *rapport* and *client focus*, were entered into the multiple regression. Table 8 shows that the results of the regression analysis revealed that with an alpha level of .05, the regression equation was statistically significant for the prediction of job satisfaction ($F(2,247) = 65.86$, $p < .001$).

Table 7

ANOVA Table for Regression Analysis with Individual Supervisory Working Alliance Subscale Variables, Rapport and Client Focus predicting Job Satisfaction (n = 250)

Model	Sum of Squares	df	Mean Square	*F*	Sig.
Regression	60865.002	2	30432.501	65.86	< .001
Residual	114134.694	247	462.084		
Total	17499.696	249			

Regression weights were examined and are shown in Table 10. Both predictor variables had a positive relationship to job satisfaction. The strongest predictor was *rapport* (β = .361), followed by *client focus* (β = .248. The analysis indicated that approximately 34% of variance in job satisfaction was accounted for by the individual subscales of *rapport* and *client focus.*

The residuals of this model were examined to determine if the assumptions of the multiple regression were met. The result indicates that the residuals are fairly normally distributed, and there is no evidence of heteroscedasticity.

Based on the findings of the correlational analysis, the null hypothesis for the second research question, "There will be no predictive relationship between the *rapport* and *client focus,* as measured by the SWAI, and the construct of job satisfaction, as measured by the JSS composite score, in community mental health workers," was rejected. The alternate hypothesis was supported indicating a significant predictive relationship between individual dimensions of the supervisory working alliance, *rapport* and *client focus,* and the construct of job satisfaction, in community mental health workers.

Table 8

Summary of Regression Analysis for Individual Supervisory Working Alliance Subscale Variables, Rapport and Client Focus Predicting Job Satisfaction (n = 250)

Model		Unstandardized Coefficients		Standardized Coefficients	*t*	Sig.
		B	*SE B*	*B*		
1	(Constant	83.290	5.894		14.131	< .001
	Rapport	0.547	0.156	0.361	3.497	< .001
	Client Focus	0.817	0.341	0.248	2.400	< .05

Research Question 3

The third question examined the extent to which job satisfaction could be predicted from the demographic variables of age, educational attainment, discipline, workload and type of supervision. The hypothesis was tested using a stepwise regression procedure.

To examine relationships of the predictors and outcome variables, bivariate correlations between the five demographic variables and the dependent variable of job satisfaction, were computed.

Table 9

Correlations for the Regression of Demographic Variables and Job Satisfaction (n = 250)

	1	2	3	4	5	6
1.Job Satisfaction						
2.Age	-0.065					
3.Education	0.04	0.99				
4.Discipline	-0.068	0.208*	-0.422*			
5.Workload	-0.295*	0.077	0.057	-0.035		
6.Type of Supervision	-0.075	0.105	0.046	0.01	0.022	

*Correlation is significant at the .01 level (2-tailed).

Only one of the predictors (workload) was significantly correlated with job satisfaction (r = -.295, p < .01). Among the predictor variables there was no evidence of multicollinearity. The most highly correlated variables were discipline and education (r = -.422). Discipline and age were also moderately correlated (r = .208, p < .01).

All the demographic variables were entered into the regression model using the stepwise method. The stepwise method combines both forward and backward procedures taking into consideration the influence of variables on the variances of other variables entered into the equation. This process removes variables in which the predictive value has been weakened or has been accounted for by the remaining variable in the equation (George & Mallory, 2006). Only one of the six variables was entered into the analysis: workload. The other variables (age, education, discipline and type of supervision) were

removed from the equation. Table 12 shows the results of the regression analysis revealed that with an alpha level of .05, the regression equation was statistically significant for the prediction of job satisfaction ($F(1,248) = 23.609$ $p < .001$).

Table 10

ANOVA Table for Regression Analysis for Workload Predicting Job Satisfaction (n = 250)

Model		Sum of Squares	df	Mean Sqaure	*F*	Sig.
1	Regression	15211.296	1	15211.296	23.609	< .001
	Residual	159788.4	248	644.308		
	Total	174999.696	249			

Regression weights were examined and are shown in Table 13. The predictor variable (workload) had a significant relationship to job satisfaction ($\beta = .295$, $p < .001$). The analysis indicates that approximately 9% of the variance in job satisfaction could be accounted for by perceived workload.

The residuals of this model were examined to determine if the assumptions of the multiple regression were met. The result indicates that the residuals are fairly normally distributed, and there is no evidence of heteroscedasticity.

Based on the findings of the analysis, the null hypothesis for the third research question, “will be no predictive relationship between the demographic variables of age, educational attainment, workload, discipline and type of supervision and the construct of job satisfaction, composite score, in community mental health workers” was rejected. The alternative hypothesis stating that a significant predictive relationship exists between some or all of the demographic variables and job satisfactions, was supported.

Table 11

Summary of Regression Analysis for the Demographic Variable of Workload Predicting Job Satisfaction (n = 250)

Model		*B*	*SE B*	*B*	*t*	*p*
1	Constant	188.122	8.191		22.968	< .001
	Workload	-18.001	3.705	0.295	4.859	< .001

Research Question 4

The fourth question examined the extent to which job satisfaction could be predicted from the supervisory working alliance, age, educational attainment, discipline, workload and type of supervision. The hypothesis was tested using a stepwise procedure.

To examine relationships of the predictors and outcome variables, bivariate correlations between the five demographic variables and the dependent variable of job satisfaction were computed.

Table 12

Correlations for the Regression of the Supervisory Working Alliance, Demographic Variables and Job Satisfaction (n = 250)

	1	2	3	4	5	6	7
Job Satisfaction							
Supervisory Working Alliance	0.589*						
Age	-0.065	0.152**					
Education	0.040	0.174**	-0.001				
Discipline	-0.068	0.044	0.208*	-0.422*			
Workload	-0.295*	-0.129***	0.077	0.057	-0.035		
Type of Supervision	-0.075	0.045	0.105	0.046	0.010	0.022	

***p < .05, **p < .01, *p < .001

Two of the predictor variables (supervisory working alliance and workload) were significantly correlated with job satisfaction. Among the predictors there was no evidence of multicollinearity. The most highly correlated variables were discipline and education (r = -.442, p < .001). The other correlations were weak to moderate (*r* = .129-.174).

Table 15 presents the summary of the change in R^2. The first variable to enter into the analysis was supervisory working alliance, which produced an R^2 of .344. This variable also had the largest bivariate correlation with job satisfaction (*r* = .589). In Model 2, workload (*r* = -.295) was included, incrementing R^2 to .391. Model 3. Finally, age (*r* = -.065) was entered into the analysis, minimally increasing R^2 to .407. The three variables of education, discipline and type of supervision were not included in the model.

Table 13

Summary of Change in R Square of Variables Predicting Job Satisfaction (n = 250)

Model	R	R^2	R^2 Change
1[a]	0.589	0.344	0.347
2[b]	0.629	0.391	0.049
3[c]	0.643	0.407	0.018

a. Predictors: (Constant), SWAITOTAL
b. Predictors: (Constant), SWAITOTAL, Workload
c. Prectictors: (Constant), SWAITOTAL, Workload, Age

Across all three models, the ANOVA for the regression remained statistically significant. As expected, the F ratio was reduced at each step. Table 16 shows the results of the regression indicated the three predictor variables supervisory working alliance, age and workload explained 41% of the variance ($R^2 = .407$, $F(3,246) = 57.913$, $p < .001$).

Table 14

ANOVA Table for Regression Analysis for Variables Predicting Job Satisfaction (n = 250)

Model		Sum of Squares	df	Mean Sqaure	*F*	Sig.
1[a]	Regression	60720.03	1	60720.03	131.769	< .001
	Residual	114279.666	248	460.805		
	Total	174999.696	249			
2[b]	Regression	69256.659	2	34628.329	80.887	< .001
	Residual	105743.037	247	428.109		
	Total	174999.696	249			
3[c]	Regression	72436.254	3	24145.418	57.913	< .001
	Residual	102563.442	246	416.925		
	Total	174999.696	249			

a. Predictors: (Constant), SWAITOTAL,
b. Predictors: (Constant), SWAITOTAL,Workload
c. Predictors: (Constant), SWAITOTAL,Workload, Age

Regression weights were examined and are shown in Table 17. According to the findings, job satisfaction was related to overall supervisory working alliance, perceived workload and age. Standardized coefficients (Beta) were used to determine the significance of predictors. The coefficients in the final model indicate that the supervisory working alliance was the strongest predictor (β = .583), followed by workload (β = -.209) and then age (β = -.137). The negative signs indicate an inverse relationship to the dependent variable. Therefore, as job satisfaction increases, age and workload decrease.

The residuals of this model were examined to determine if the assumptions of multiple regression were met. The results indicated that the residuals are fairly normally distributed, and there was no evidence of heteroscedasticity.

Based on the findings of the analysis, the null hypothesis for the fourth research question was rejected. The findings supported the alternative hypothesis that some combination of factors, including the supervisory working alliance and demographic characteristics would account for a significant amount of the variance in job satisfaction. .

Table 15

Summary of Regression Analysis for Supervisory Working Alliance, Workload and Age Predicting Job Satisfaction (n = 250)

Model		Unstandardized Coefficients		Standardized Coefficients	*t*	Sig.
		B	*SE B*	*B*		
1	(Constant)	83.377	5.884		14.170	< .000
	SWAI Total	0.629	0.055	0.589	11.479	< .000
2	(Constant)	116.5055	9.258		12.535	< .000
	SWAI Total	0.599	0.053	0.56	11.236	< .000
	Workload	-13.598	3.045	-0.223	-4.465	< .000
3	(Constant)	120.638	9.286		12.991	< .000
	SWAI Total	0.623	0.53	0.583	11.684	< .000
	Workload	-12.773	3.02	-0.209	-4.230	< .000
	Age	-2.903	1.051	-0.137	-2.762	< .000

a. Dependent Variable: Job Satisfaction

Summary

Based on the findings of the correlation and regression analysis the null hypothesis regarding the relationship between the overall perceived supervisory working alliance and job satisfaction was rejected. The alternative hypothesis was accepted. The overall results support the premise that community mental health workers who perceive the supervisory relationship more favorably were also more likely to report higher levels of job satisfaction. Based on additional analysis, job satisfaction could also be predicted

by perceived workload. Specifically, as workload increases, job satisfaction declines. Chapter 5 will provide discussion and conclusions for the study. Recommendations will be offered for future action and further research.

Chapter 5: Discussion, Conclusions, and Recommendations

Purpose

The purpose of this study was to examine the influence of the supervisory working alliance and demographic characteristics of job satisfaction and community mental health workers. Some researchers have identified that turnover rates for community mental health workers have been as high as 30% to 60% annually (Mor Barak et al., 2001). Instability in the community mental health workforce leads to a disruption in continuity of care. This impacts the worker's ability to develop and maintain strong working alliances with the clients and results in poor implementation of evidence-based practices (Ben-Dror, 1994). Researchers have identified several factors that influence job satisfaction including supervision. Yet research on supervision in settings serving persons with severe mental illness has been largely neglected in the literature (Schroffel, 2008; Tsui, 1997). Therefore, the intent of this study was to expand the understanding of the role supervisory working alliance in relationship to job satisfaction in community mental health settings.

Interpretation of the Findings

Supervisory Working Alliance

As described in Chapter 2, a considerable amount of study has been invested in the examination of supervision and outcomes for clinical trainees in educational settings. However, there has been little attention paid to the role of supervision in professional work environments, which provided justification for the research questions. Consistent with previous research (Gibbs, 2001; Mena, 2007; Newsom & Pillari, 1992, Schroffel,

1999; Sterner, 2009), the overall results of this study indicated that when community mental health workers were satisfied with the supervisory relationship, they were satisfied with their job.

The results from this study were particularly important as it added to the empirical exploration of supervision in post-educational settings. Participants' responses suggested that supervision is a valuable component to job satisfaction. Although significant, the perception of the supervisory working alliance only accounted for 34% of the variance in job satisfaction. Therefore, other factors had an obvious influence of the workers' job satisfaction.

Demographic Factors

Given the amount of unexplained variance between the supervisory working alliance and job satisfaction, demographic variables (age, education, discipline, workload and type of supervision) were analyzed to determine if they had any predictive relationship to job satisfaction. The results of the study found that secondary to the supervisory working alliance, workload accounted for a significant portion of the variance in job satisfaction. Although age significantly predicted job satisfaction, it only accounted for a minimal amount of the variance.

As noted above, therapeutic discipline and educational attainment did not predict job satisfaction. The findings in regards to therapeutic discipline were congruent with previous research (Kavanagh et al., 2003; Newsom & Pillari, 1992). Similar to this study, Kavanagh et al., (2003) explored the relationship between factors related to job satisfaction across a variety of therapeutic disciplines, including social workers,

occupational therapists, and speech therapists. The results found no statistical differences in job satisfaction between respondents in therapeutic disciplines.

The findings in regards to educational attainment were inconsistent with previous research studies (Abu-Bader, 2000; Blankertz & Robinson, 1997a, 1997b; Knudsen et al., 2009), which found that when compared to persons with a bachelor's degree, workers with a master's degree were more likely to experience symptoms of burnout and have intention to the leave the agency. The discrepancy in the findings of this study from previous studies may be attributed to a couple of factors. First, previous studies evaluated factors that may be attributed to job satisfaction such as turnover and burnout, not job satisfaction itself. Second, previous research has not evaluated education attainment in relationship to job satisfaction in community mental health settings. The results may suggest that community mental settings have unique characteristics that interact with educational attainment in regards to its relationship to job satisfaction.

Sterner (2009) evaluated the relationship between supervisory working alliance and work satisfaction in professional counselors. The results of the study indicated that a portion of workers reported not receiving clinical supervision. For this reason, Sterner (2009) recommended further research to evaluate the role of administrative supervision in job satisfaction. This study responded to Sterner's (2009) recommendation by evaluating the relationship between the type of supervision (administration, clinical, or both clinical and administrative) and job satisfaction. The results suggested that the type of supervision did not significantly predict job satisfaction in community mental health workers. These results may further support that rapport within the supervisory

relationship is more important that the tasks and focus of supervision in predicting worker outcomes.

Supervisory Working Alliance Theory

The supervisory working alliance theory was the theoretical foundation for this study (Bordin, 1983). The supervisory working alliance theory suggests the supervisor and supervisee must have a common articulation of goals of supervision. These goals must be established through negotiation during supervision sessions. The tasks of supervision must also be in line with those goals. Further, there must be a common definition and agreements on those tasks. Finally, supervisory working alliance theory suggests that there must be an emotional bond between the supervisor and supervisee that provides the support necessary to sustain the work done in supervision. The connection between supervisory working alliance theory and job satisfaction has been documented in several research studies of child welfare and social service workers (Dickinson & Perry, 2012; Kadushin & Harkness, 2002; Mor Barak et al., 2001) When people reported having higher perceived supervisory working alliances, they tended to have a strong sense of security and emotional closeness with their supervisor (Dickinson & Perry, 2012; Yankeelov et al., 2009), which offers both emotional and social support mediating the negative effects of working in social and human service agencies (Kadushin & Harkness, 2002; Mor Barak et al., 2001).

Research Question 2 evaluated the relationship between the individual subscales of the SWAI-T (Rapport and Client Focus) and job satisfaction. Rapport is a measure of the supervisor's effort to build a bond or relationship with the supervisee. Client Focus is

a measure of the degree to which the supervisee believes his or her supervisor encouraged focused efforts towards specific goals and tasks that would benefit the client (Harrocks & Smaby, 2012). The results of this study found that both rapport and client focus were strongly related to job satisfaction. However, rapport accounted for more of the variance in job satisfaction. These results were consistent with previous research (Koeske & Kelly; Mena, 2007), which found higher levels of perceived rapport within the supervisory working relationship as related higher levels of job satisfaction. In addition, the findings drew some parallels to the Greenson's (1967) theory of working alliance. Counselors may not bring about change in the clients when they rely only on the use of techniques or counseling skills. Similarly, supervisors may not optimize supervisee development or satisfaction when the relationship or rapport is not considered in the supervision process. These results further strengthen the connection between the supervisory working alliances and job satisfaction. Specifically, supervisees who perceive higher levels of supervisory support are more likely to feel more satisfied with their jobs. These findings further strengthen the arguments that perceived emotional and social supports in supervision can potentially offset the challenges of working in social service settings. As Robinson (1950) indicated in his research on therapeutic alliance, rapport is a critical component in the development of the supervisory working alliance.

Limitations

While the results of the study identified significant findings, these must be interpreted with caution. To recruit mental health workers, I utilized a non-random convenience sampling strategy. All participants were recruited from five mental health

organizations in one north-central United States geographical area. Utilizing a convenience sample can limit the ability to generalize and make inference about the entire population. Because the external validity for the accessible population is limited, it is unknown if the results of the study speak for the entire population. This can result in low external validity of the study. Therefore, it is unknown how generalizable these findings are to the population of mental health workers in other settings.

The data were collected using a web-based survey instrument with a link that was sent to employees' e-mail addresses. Employees may receive many e-mails a day and as a result may have missed or discarded the e-mail invitation. A low response rate of 25% and partially completed surveys may suggest a concern of self-selection bias. Further, busy workers may have been discouraged by the length of time needed to complete the two surveys in the demographic questionnaire.

The study relied on participant self-reports. There are several disadvantages to self-report data, including the degree of bias that enters into the participant responses (Heppner et al., 1999). Social desirability bias may have played a role in reporting the level of strength between supervisory working alliance and job satisfaction. Expressing negative feelings towards a supervisor and negative feelings towards one's job may be seen as professionally unacceptable. In addition, this study took place at a single point in time. As a result, the participants' responses may have been influenced by their state of mind at the time they completed the survey. A recent positive or negative event related to supervision or their job may have influenced their responses. The results of the study should be understood within the context of these limitations in the study design.

Suggestions for Future Research

Future research should investigate what additional factors contribute to the variance in job satisfaction in community mental health settings. This research study found that workers' perception of the supervisory working alliance and workload accounted for 41% of the variance in job satisfaction. It is unclear what accounted for the remaining variance. Future research should attempt to identify those factors.

This study did not look at the influence of mutual agreement on tasks and goals as a part of workers' perception of the supervisory working alliance. The supervisory working alliance theory suggests the supervisor and supervisee must have a common articulation of goals of supervision. These goals must be established through negotiation during supervision sessions. The tasks of supervision must also be in line with those goals. Further, there must be a common definition and agreement on those tasks. Understanding how community mental health workers perceive these components will provide a more robust picture of the supervisory working alliance in community mental health settings.

This study highlights the importance of the supervisory working alliance in community mental health settings. It may be important to understand what factors influence the development of a strong supervisory alliance in such settings. Several studies have explored the supervisor attributes that influence the supervisee's perception of the supervisory working alliance in educational and academic settings. However, it is unknown how generalizable those findings are to professional work settings. Therefore,

future research should explore how such attributes are associated with participants' perception of the supervisory working alliance in community mental health settings.

Future research should consider changes to the demographic questionnaire, including adding a number of years the participants have been working in community mental health settings. This data can provide the researcher with the opportunity to look for an association between years of experience in the field as contributing to the variance in job satisfaction.

It is recommended that future studies utilize a longitudinal research design to evaluate job satisfaction over time so the research is applicable to a larger population. As stated above, the participants' responses may have been influenced by their state of mind at the time of the study. Future research could have participants take the SWAI-T and the JSS at different times to establish an average rating of the supervisory working alliance and job satisfaction. This process may reduce the impact that a single recent event may have on the overall ratings of supervision and job satisfaction.

Implications

Practice

The outcomes from this study can be beneficial to supervisors in community mental health settings to better understand their role and the importance of the relationship they establish with their supervisees. Supervisors need to be aware that they can have significant influence on their supervisees' perceptions of their job satisfaction. Therefore, supervisors must realize that how they approach supervision can have significant implications on whether or not supervisees stay in the profession. Further,

when supervisors focus on developing a strong supervisory working alliance, supervisees are more likely to perceive the supervisory relationship as helpful. Previous research studies have found that supervisees that perceive the supervisory relationship favorably also experience secondary benefits such as emotional balance and a sense of well-being (McMahon & Patton, 2000; Mor Barak et al, 2006). In this scenario, supervisees are better equipped to offset the negative aspects of their job, including high workloads.

Training

Providing supervision in community mental health settings has unique challenges. Community mental health services are often provided by multidisciplinary teams (Multidisciplinary, 2014). Therefore, mental health workers come from a variety of disciplines and levels of education, which makes supervision challenging and multifaceted. Lack of time and resources also pose challenges for supervisors in such settings. In addition, many supervisors in professional work settings have received limited or no formal training in providing clinical supervision (Sterner, 2009). This lack of training may affect the quality of the supervisory working alliance. The findings from this study may give supervisors a better understanding of the role of the supervisory working alliance in community mental health settings, especially since the majority of the literature has focused only on academic settings. The findings will also help supervisees to gain a better understanding of the benefits of developing strong supervisory working alliances. Finally, the study suggests that supervisees can use administrative supervision more effectively by incorporating components of the supervisory working alliance in those relationships.

Social Justice

Mental illness is a national health concern. According to the NIMH (n.d.a), in a given year, approximately one in twenty-five adults in the U.S (13.6 million) experiences a serious mental illness that substantially interferes with or limits one or more major life activities. Further, approximately one in five youth between the ages of thirteen and eighteen experiences a severe mental disorder (NIMH, n.d.a). Mental illnesses are the leading cause of disability in North America (National Alliance on Mental Illness, 2015).

Financial resources for mental health services remain low, while the responsibility for serving persons with severe mental illness has been placed on community mental health agencies (National Alliance, 2012). Community mental health organizations have long suffered with employee turnover, burnout and low job satisfaction (Ben-Dror, 1994; Blankertz & Robinson, 1997; Dunn & Menz, 1992; Mor Barak et al., 2001), which leads to generally poorer client outcomes (Ben-Dror, 1994; Kadushin & Harkness, 2002). The consequences for inadequate treatment of severe mental illness for individuals and society include unemployment, homelessness, inappropriate incarceration and suicide (NIMH, n.d.b; Palmer, et al., 2005). For these reasons, the treatment of mental illness is a social justice issue.

There is overwhelming support in the literature for the positive outcomes associated with strong therapeutic alliances. According to their meta-analysis based on the results of 24 studies, Horvath and Symonds (1991) demonstrate the existence of a moderate but reliable association between good therapeutic alliance and positive therapeutic outcome. These findings are consistent across both adult and youth

psychotherapy (Karver et al., 2006, Martin et al., 2000; Shirk & Karver, 2003). Several meta-analysis studies have indicated that the quality of the alliance was more predictive of positive outcome than the type of intervention (Karver et al., 2006, Martin et al., 2000; Shirk & Karver, 2003). Research has also shown that perceived strong supervisory working alliances are related to stronger therapeutic alliance between the supervisee and client (Bernard & Goodyear, 2009). The outcome of the study supports the idea that supervisors may be able to improve the outcomes for persons with severe mental illness by focusing on developing strong supervisory alliances with their supervisees. Therefore, understanding the role of the supervisory working alliance, in relationship to job satisfaction, may be greatly beneficial to advancing the treatment for persons with severe mental illness.

Conclusion

The results of this study demonstrate a relationship between the supervisee perception of the quality of the supervisory working alliance and job satisfaction. Consistent with previous studies in other disciplines exploring the relationship between these constructs, the current study demonstrated that supervision plays an important role in how supervisees perceive their job. There has been a lack of research that explores the quality of the supervisory working alliance in professional work settings. This study responded to the recommendations of previous researchers, who have suggested further research to investigate how the supervisory working alliance is affected in workplace environments, or where supervision settings can be quite different from supervision offered in a university clinic or counseling center (Culbreth & Borders, 1999; Mena,

2007; Schultz et al., 2002; Spence, 2001; Sterner, 2009; Watkins, 2012). This study broadens our understanding of supervision in community mental health settings.

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Appendix A: Demographic Questionnaire

Please complete this demographic section of the survey. It is important that you answer each question carefully and accurately. No personal information will be revealed in the study results. Data collected will include: (a) age, (b) gender, (c) highest level of education, (d) work load, (e) discipline and (f) type of supervision received.

1. I have previously taken the survey.
   - ☐ Yes
   - ☐ No

2. I currently work with clients who have severe mental illness and/or severe emotional and behavioral disturbances.

   - ☐ Yes
   - ☐ No

3. Highest degree earned.
   - ☐ High School Diploma
   - ☐ Associates Degree
   - ☐ Bachelors Degree
   - ☐ Master's Degree
   - ☐ Doctorate Degree

4. Age
   - ☐ 18-24
   - ☐ 25-30
   - ☐ 31-40
   - ☐ 41- 50
   - ☐ 50-60
   - ☐ 60+

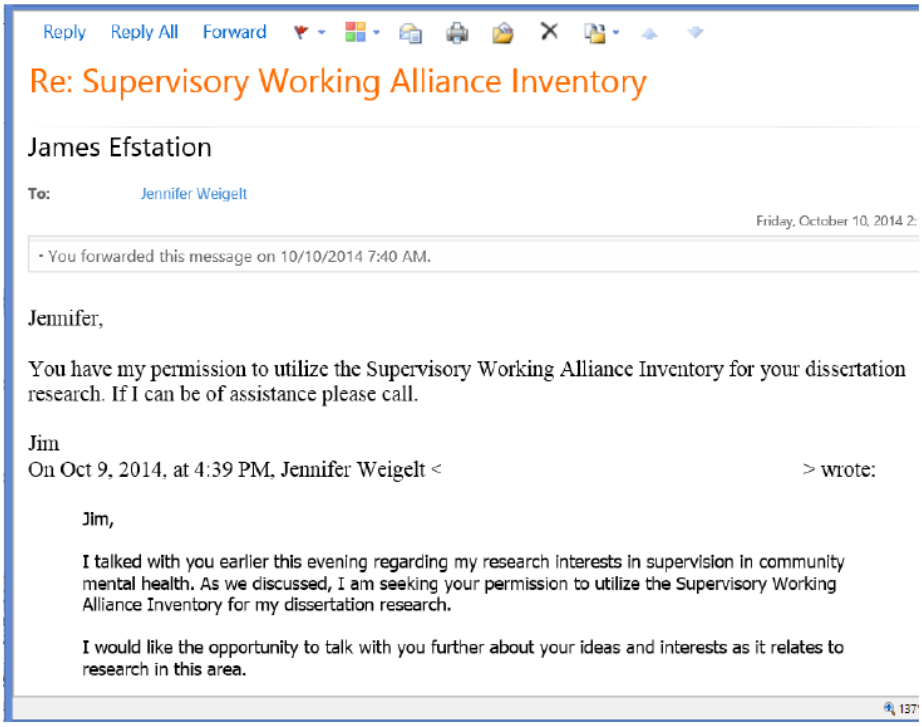
5. Discipline
   - ☐ Psychology
   - ☐ Social Work
   - ☐ Marriage and Family
   - ☐ Substance Abuse/ Drug and Alcohol
   - ☐ Nursing
   - ☐ N/A

6. Do you think your workload is
   - ☐ Too light
   - ☐ Manageable
   - ☐ Too heavy

7. What type of supervision are your receiving?

☐ Clinical
☐ Administrative
☐ Both Administrative/Clinical

Appendix B: SWAI Permission



Reply Reply All Forward

Re: Supervisory Working Alliance Inventory

James Efstation

To: Jennifer Weigelt

Friday, October 10, 2014 2:

You forwarded this message on 10/10/2014 7:40 AM.

Jennifer,

You have my permission to utilize the Supervisory Working Alliance Inventory for your dissertation research. If I can be of assistance please call.

Jim
On Oct 9, 2014, at 4:39 PM, Jennifer Weigelt < > wrote:

Jim,

I talked with you earlier this evening regarding my research interests in supervision in community mental health. As we discussed, I am seeking your permission to utilize the Supervisory Working Alliance Inventory for my dissertation research.

I would like the opportunity to talk with you further about your ideas and interests as it relates to research in this area.

Appendix C: SWAI-T Form

Instructions: Please indicate the frequency with which the behavior described in each of the following items seems characteristic of your work with your supervisor. After each item, check (X) the space over the number corresponding to the appropriate point of the following seven-point scale.

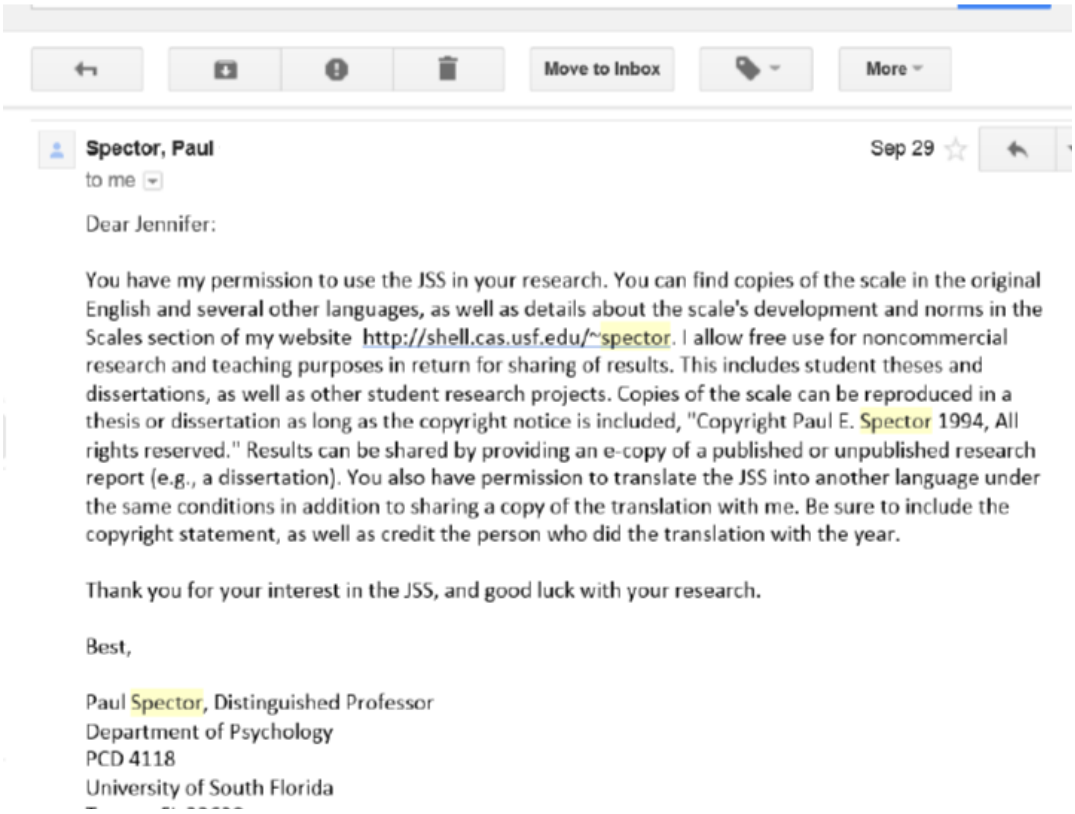
1	2	3	4	5	6	7
Almost Never						Almost Always

I feel comfortable working with my supervisor	1	2	3	4	5	6	7
My supervisor welcomes my explanations about the client's behavior	1	2	3	4	5	6	7
My supervisor makes the effort to understand me.	1	2	3	4	5	6	7
My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.	1	2	3	4	5	6	7
My supervisor is tactful when communicating about my performance.	1	2	3	4	5	6	7
My supervisor encourages me to formulate my own interventions with the client.	1	2	3	4	5	6	7
My supervisor helps me talk freely in our sessions.	1	2	3	4	5	6	7
My supervisor stays in tune with me during supervision.	1	2	3	4	5	6	7
I understand client behavior and treatment technique similar to the way my supervisor does.	1	2	3	4	5	6	7
I feel free to mention to my supervisor troublesome feelings I might have about him/her	1	2	3	4	5	6	7
My supervisor treats me like a colleague in our supervisory sessions.	1	2	3	4	5	6	7

In supervision, I am more curious than anxious when discussing my difficulty with clients.	1	2	3	4	5	6	7
In supervision, my supervisor places a high priority on our understanding the client's perspective.	1	2	3	4	5	6	7
My supervisor encourages me to take time to understand what the client is saying and doing.	1	2	3	4	5	6	7
My supervisor's style is to carefully and systematically consider the material I bring to supervision.	1	2	3	4	5	6	7
When correctly my errors with a client, my supervisor offers alternative ways of intervening with that client.	1	2	3	4	5	6	7
My supervisor helps me work within a specific treatment plan with my clients.	1	2	3	4	5	6	7
My supervisor helps me stay on track during our supervision meetings.	1	2	3	4	5	6	7
I work with my supervisor on specific goals in the supervisory session.	1	2	3	4	5	6	7

Supervisory Working Alliance from: Efstation, J.E, Patton, M. J., & Kardash, C.M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counselling Psychology*, 37, 322-329.

Appendix D: JSS Permission



Move to Inbox More

Spector, Paul Sep 29

to me

Dear Jennifer:

You have my permission to use the JSS in your research. You can find copies of the scale in the original English and several other languages, as well as details about the scale's development and norms in the Scales section of my website http://shell.cas.usf.edu/~spector. I allow free use for noncommercial research and teaching purposes in return for sharing of results. This includes student theses and dissertations, as well as other student research projects. Copies of the scale can be reproduced in a thesis or dissertation as long as the copyright notice is included, "Copyright Paul E. Spector 1994, All rights reserved." Results can be shared by providing an e-copy of a published or unpublished research report (e.g., a dissertation). You also have permission to translate the JSS into another language under the same conditions in addition to sharing a copy of the translation with me. Be sure to include the copyright statement, as well as credit the person who did the translation with the year.

Thank you for your interest in the JSS, and good luck with your research.

Best,

Paul Spector, Distinguished Professor
Department of Psychology
PCD 4118
University of South Florida

Appendix E: JSS English Version

	JOB SATISFACTION SURVEY Paul E. Spector Department of Psychology University of South Florida 	
	PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT.	Disagree very much Disagree moderately Disagree slightly Agree slightly Agree moderately Agree very much
1	I feel I am being paid a fair amount for the work I do.	1 2 3 4 5 6
2	There is really too little chance for promotion on my job.	1 2 3 4 5 6
3	My supervisor is quite competent in doing his/her job.	1 2 3 4 5 6
4	I am not satisfied with the benefits I receive.	1 2 3 4 5 6
5	When I do a good job, I receive the recognition for it that I should receive.	1 2 3 4 5 6
6	Many of our rules and procedures make doing a good job difficult.	1 2 3 4 5 6
7	I like the people I work with.	1 2 3 4 5 6
8	I sometimes feel my job is meaningless.	1 2 3 4 5 6
9	Communications seem good within this organization.	1 2 3 4 5 6
10	Raises are too few and far between.	1 2 3 4 5 6
11	Those who do well on the job stand a fair chance of being promoted.	1 2 3 4 5 6
12	My supervisor is unfair to me.	1 2 3 4 5 6
13	The benefits we receive are as good as most other organizations offer.	1 2 3 4 5 6
14	I do not feel that the work I do is appreciated.	1 2 3 4 5 6
15	My efforts to do a good job are seldom blocked by red tape.	1 2 3 4 5 6
16	I find I have to work harder at my job because of the incompetence of people I work with.	1 2 3 4 5 6

	PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT. Copyright Paul E. Spector 1994, All rights reserved.	Disagree very much	Disagree moderately	Disagree slightly	Agree slightly	Agree moderately	Agree very much
17	I like doing the things I do at work.	1	2	3	4	5	6
18	The goals of this organization are not clear to me.	1	2	3	4	5	6
19	I feel unappreciated by the organization when I think about what they pay me.	1	2	3	4	5	6
20	People get ahead as fast here as they do in other places.	1	2	3	4	5	6
21	My supervisor shows too little interest in the feelings of subordinates.	1	2	3	4	5	6
22	The benefit package we have is equitable.	1	2	3	4	5	6
23	There are few rewards for those who work here.	1	2	3	4	5	6
24	I have too much to do at work.	1	2	3	4	5	6
25	I enjoy my coworkers.	1	2	3	4	5	6
26	I often feel that I do not know what is going on with the organization.	1	2	3	4	5	6
27	I feel a sense of pride in doing my job.	1	2	3	4	5	6
28	I feel satisfied with my chances for salary increases.	1	2	3	4	5	6
29	There are benefits we do not have which we should have.	1	2	3	4	5	6
30	I like my supervisor.	1	2	3	4	5	6
31	I have too much paperwork.	1	2	3	4	5	6
32	I don't feel my efforts are rewarded the way they should be.	1	2	3	4	5	6
33	I am satisfied with my chances for promotion.	1	2	3	4	5	6
34	There is too much bickering and fighting at work.	1	2	3	4	5	6
35	My job is enjoyable.	1	2	3	4	5	6
36	Work assignments are not fully explained.	1	2	3	4	5	6