TRAINING AND SUPERVISION IN MARRIAGE AND FAMILY THERAPY: A NATIONAL SURVEY

PAUL N. McKENZIE
Texas Tech University

BRENT J. ATKINSON
Northern Illinois University

WILLIAM H. QUINN
University of Georgia

ANTHONY W. HEATH
Northern Illinois University

This article reports on the results of a national survey of AAMFT Approved Supervisors. The respondents (N = 550) answered questions regarding areas of concentration during supervision, specific techniques employed, professional goals and priorities, and theoretical models used in supervision. Results are compared with a previous survey conducted in 1976 (Everett, 1980). Although audiotapes of trainees' sessions were the most frequently utilized method of supervision, the most effective method was thought to be live supervision with immediate feedback. The most frequently used theoretical models were structural, strategic, and communications/humanistic; and the most frequent concentrations of supervision were focused on identifying family structures, interrupting attempted solutions, and alleviating the presenting problem.

The authors wish to gratefully acknowledge Harvey Joanning, Stephen Jorgensen, Sven Daelemans, Glen Carter, and Frank Thomas for their valuable comments on an early draft of this paper. Additional thanks to LeAnn Atkinson for computer assistance, and to Laurel McKenzie, Larry Smith, and Marea Smith for clerical help.

Paul N. McKenzie, M.S., is Mental Health Coordinator and Family Therapy Supervisor at the Plainview Counseling Center, 2700 Yonkers, Plainview, TX 79072, and Ph.D. candidate in Family Therapy, Department of Human Development and Family Studies, Texas Tech University, Lubbock, TX 79409. Brent J. Atkinson, Ph.D.; is Assistant Professor and Coordinator of the Family Center, Specialization in Marital and Family Therapy, Department of Human and Family Resources, Northern Illinois University, DeKalb, IL 60115-2854. William H. Quinn, Ph.D., is Associate Professor, Department of Child & Family Development, University of Georgia, Athens, GA 30602. Anthony W. Heath, Ph.D., is Assistant Professor, Department of Human and Family Resourses, Northern Illinois University, DeKalb, IL 60115-2854.

The American Journal of Family Therapy, Vol. 14, No. 4, 1986 © Brunner/Mazel, Inc.

The number of Approved Supervisors in the American Association for Marriage and Family Therapy has almost quadrupled in the last 8 years, from 233 in 1976 (Everett, 1980) to 900 in 1984. Training programs in marital and family therapy have grown from four doctoral programs in 1950 (Nichols, 1979) to over 175 masters, doctoral and nonacademic training programs in 1981 (Bloch & Weiss, 1981). Institutes and internships are surfacing in almost every medium-sized city, and a rapidly increasing number of academic institutions are applying for accreditation by the AAMFT.

With this momentum in the field, it is clear that there are greater opportunities for clinical training and more diversity in training approaches and facilities, thereby prompting more choices among interested participants. The topic of training and supervision is important to the field of family therapy because today's training will likely play a major role in the shaping of tomorrow's clinicians. Methods and ideas about supervision, then, may be central elements influencing the future of family therapy as a profession.

Research on family therapy training and supervision consists largely of clinical observations and descriptions of specific training models (Berger & Dammann, 1982; Connell, 1984; Halpern, 1985; Heath & Storm, 1985; Keller & Protinsky, 1984; Liddle, 1980; Liddle et al., 1984; Olson & Pegg, 1979; Quinn et al., 1985; Wendorf, 1984; Whiffen & Byng-Hall, 1982). These individual supervisory models have been important in providing necessary structure to clinical supervision.

While these contributions are useful, very few data have been presented which examine globally the supervisory practices and theoretical orientations in the field at the present time. An assessment of this kind would add an important dimension to the literature on training issues and implications. A knowledge of the diversity of approaches currently available would enable trainees to make more informed choices when seeking clinical supervision. Furthermore, since a clinical supervisor is likely to affect the beliefs and practices of a trainee, an examination of individuals presently serving as supervisors may provide a preview of future trends in clinical training and practice. To date, there has been only one empirical study published (Everett, 1980) that provides an overview of the supervisory practices and individual characteristics of clinical supervisors. However, since the number of Approved Supervisors in the AAMFT has almost quadrupled since the time of Everett's study (conducted in 1976), there is a need for updating information on current supervisory practices.

This paper is a report on the results of a recent national survey of AAMFT Approved Supervisors.

METHODS

Subjects

In January 1984, a current list of AAMFT supervisors was obtained from the AAMFT in Washington. At that time the entire roster of su-

pervisors (890) was surveyed. A total of 409 responses (45%) were received from the first mailing. Another updated list of supervisors (n = 900) was obtained in May 1984. A second copy of the survey was mailed to all nonrespondents and to the supervisors who were added to the roster after the initial mailing. The second mailing resulted in an additional 141 surveys, which brought the total response to 550 questionnaires (61% of all Approved Supervisors surveyed).

Measures

A questionnaire was designed to obtain information from respondents on supervision attitudes and behaviors. Specifically, data were collected on demographic variables, current methods of supervision, professional goals and priorities, and theoretical models of training and practice. Much of the questionnaire content and format was obtained from a similar survey used in a pilot study targeting the attitudes of AAMFT members in Texas (Quinn & Davidson, 1984).

RESULTS

Demographic Variables

Many of the present findings reflect a shift from the 1976 figures (Everett, 1980). The number of female respondents (33%) has increased from the 1976 figure of 21.5%; however, males (67%) continue to outnumber the females by a 2:1 ratio. The average age of a supervisor (47.4) has decreased only slightly since Everett's figure of 49.5. However, 9.1% of the present sample were younger than 35, whereas only 2.3% of the 1976 respondents fall into that category.

The majority of supervisors (96.5%) described themselves as Caucasian. Minority respondents were few: Hispanics (1.1%), American Indians (.7%), and Blacks (.5%), attesting to the dearth of minority representation among the Approved Supervisors in AAMFT.

In terms of education, the largest number of respondents (36%) possessed a Ph.D. The next largest group was M.S.W. (21.4%), followed by M.S. (11.3%), Ed.D. (10.5%), and D.Min. (8.1%) degrees. A total of 54.7% of the respondents possessed a doctorate. This percentage is lower than Everett's (1980) figure of 66%, indicating a slight increase in master's level supervisors.

Another difference occurring within the last 8 years is the degree of supervisory experience. Only 20% of the 1976 sample had been supervising for fewer than 5 years, while the present data shows that 60.4% of the respondents reported fewer than 5 years of supervisory experience.

When questioned regarding the supervisory setting, the majority of respondents (42%) reported that they supervised within their private practice. The next highest category, private agencies (23.1%), is followed by public agencies (10.2%), public education (8.1%), private education (7.2%), medical (7.1%), and other (1.9%). Everett (1980) reported that

26.3% of respondents were supervising within an educational setting, compared with 15.4% of the present sample (total private and public educational settings).

The largest percentage of supervisors received their primary training in marriage and family therapy from either a training institute (38.4%) or an academic institution (37.1%). A substantial percentage indicate, however, that their major source of training in marriage and family therapy consists of independent workshops and readings (24.3%).

The Supervisory Experience

The major focus of the survey dealt with describing the nature of the supervisory experience. The results can be broken down into the following areas:

Supervision Methods. Information regarding supervision methods was gathered in two ways. First, respondents were asked to indicate whether they used a particular method of supervision, and second, they were asked to rank order those methods used with regard to frequency of use (e.g., most frequently used, next most frequently used, etc.). Table 1 illustrates the breakdown of supervisors' responses. The first two columns represent the number and total percent of respondents who indicated whether they ever used a particular supervisory method. The most commonly reported methods of supervision in order of frequency were audiotaping sessions, videotaping sessions, and performing cotherapy with trainees. The least commonly utilized method was listening to a case on an audio monitor (i.e., live supervision using only an audio speaker).

Individuals who selected "other" as a method of supervision were asked to describe that choice. The most frequently described method in this category (58 of the 124 respondents who selected "other") involved trainees verbally describing cases while the supervisor commented on therapy dynamics. The balance of the 124 respondents either failed to specify their choice or fell into categories too small to report, such as reading clinical texts and discussing case studies.

Besides specifying the use of a method, supervisors were also asked to rank each method according to the frequency of use. Column 4 and 5 represent the number and total percent of respondents who rank a method as the one they use most frequently. Rank ordering the frequency of these choices results in a somewhat different perspective. For example, although 357 supervisors utilize cotherapy with trainees as a method of supervision, only 29 (5.3%) rank it as the most frequently used method. A procedure utilized by Quinn and Davidson (1984) for the purpose of comparing the prevalence of ranked categories was used in further analysis of the data. The total number of all first choices ("used most frequenly") was summed, yielding a total of 551 first preferences. Next, a percentage was computed by dividing the number of respondents who indicated ranking a particular method as most frequently used by 551. For example, 149 supervisors indicated audiotape supervision as the most

TABLE 1

Frequency and Ranking of Supervisory Methods

Method	Supervisors Who Use Method			Use Method Most Frequently		
	n	%	rank	n[1]	%	rank
Listening to an audiotape	424	77.1	1	149	27.0	1
Viewing a videotape	364	66.2	2	67	12.2	4
Cotherapy with trainees	357	64.9	3	29	5.3	6
Written process notes	339	61.6	4	108	19.6	2
One-way mirror	299	54.4	5	85	15.4	3
Feedback outside of the room during a session	263	47.8	6	28	5.1	7
Using a telephone to call into a session	153	27.8	7	14	2.5	8
Watching a live case on a video monitor	150	27.3	8	12	2.2	9
Entering the room throughout a session	128	23.3	9	3	1.0	10 (tie)
Other	124	22.5	10	53	9.6	5
Listening to a live case on an audio monitor	44	8.0	11	3	1.0	10 (tie)

[1]The total of most frequently used methods (N = 551) is different than the total number of respondents (550) because 1) subjects did not respond to the question, or 2) subjects responded more than once.

frequently used method. Dividing that number by the total first choices (149/551) yields a percentage of 27%, which happens to be the highest reported percentage of all first choices, and consequently has a rank of one. The last two columns of Table 1 reflect the ratio and rank representing the prevalence of the most frequently used methods.

Effectiveness of Supervisory Techniques. Besides indicating use of a particular method, supervisors were also asked to rate the effectiveness of these various supervision techniques. This was done in order to determine if the methods used were also considered to be the most effective options available. It is important to note that such data reflect the respondents' opinions, and are not to be confused as measures of the supervisory techniques' demonstrated clinical utility.

Although audiotape supervision was the most frequently utilized method reported (Table 1), the most effective form of supervision according to the respondents was live supervision with immediate feedback (48.3% rated it as "very effective"). While reviewing case notes was ranked second in terms of frequency of use (Table 1, column 6), few respondents considered it as a very effective means of supervision (8.5%). The percentage of respondents rating other techniques as "very effective" is as follows: videotape (34.3%), individual supervision (44.1%), group

supervision (20.1%), cotherapy with trainees (28.7%), and focus on therapist's family-of-origin (16.1%).

Use of Live Supervision. The 178 individuals (33% of total sample) who do not use live supervision were asked to specify their rationale. The largest number of respondents, 148 (27% of the total sample) did not use live supervision because of lack of proper facilities. Other reasons for not using live supervision were: live supervision is disruptive to the therapeutic process (13.3%, n = 73); it facilitates dependence on the supervisor (6.0%, n = 32); supervisees and/or their families of origin are the central focus of supervision (2.8%, n = 15); and finally, live supervision is unethical (1.3%, n = 7).

Use of Cotherapy and Modeling. There are a substantial number of Approved Supervisors who do not utilize cotherapy or modeling as supervisory techniques: When asked how often the supervisor performs cotherapy with trainees, 122 respondents (22%) indicated "never," 314 respondents (57.1%) indicated "sometimes," 74 respondents (13.5%) answered "often," and 5 respondents (.9%) indicated "always."

When asked how often trainees have the opportunity to watch the supervisor during clinical practice (other than during cotherapy), 23.1% (n = 127) indicated "never," 57% (n = 313) responded "periodically," and 13.8% (n = 76) answered "often."

Theoretical Models Used in Supervision. Information regarding theoretical models used in supervision comprised a large portion of the survey. Individuals were asked to indicate which models were used during supervision, and to rank those choices according to frequency of use. Table 2 represents the responses. The most frequently reported theoretical model was structural, with 73.8% of the respondents indicating use of this orientation. Structural was also the most frequently cited first choice.

Although more individuals use a strategic orientation than the communication/humanistic model (Table 2, column 1), fewer respondents indicate strategic as the most frequently used method when compared with communications/humanistic (Table 2, column 4). Functional family therapy is the least reported model, with 58 respondents (10.5%), as well as the least reported first choice (n = 3). When one examines the rank and percentage representing the most frequently used models (Table 2, columns 6 and 7), just less than 50% of the respondents use structural, strategic, or communication models more often than any other theoretical framework (although it should be noted that the fourth and fifth ranked first choices, intergenerational and experiential, respectively, are quite close to the third, being separated by only a few percentage points).

Emphasis in Supervision. Individuals were asked to select those facets of the therapeutic process on which they regularly concentrated during supervision and to rank those selections according to frequency of use. The results are indicated in Table 3. According to the rank ordering of concentrations used most frequently (column 6), the predominant focus during supervision is identifying and altering family structures, followed by a focus on conceptualization of family organization and operation, and alleviation of presenting problems.

TABLE 2

Frequency and Ranking of Theoretical Models in Supervision

Model	Number of Supervisors Who Use Model			Number Who Use Model Most Frequently		
	n	%	rank	n[1]	%	rank
Structural (Minuchin)	406	73.8	1	107	19.6	1
Strategic (Haley, Madanes)	393	71.4	2	72	13.2	3
Communication/humanistic (Satir)	375	68.2	3	89	16.3	2
Intergenerational (Bowen, Framo)	340	61.8	4	63	11.6	4
Experiential (Whitaker)	302	54.9	5	58	10.6	5
MRI (Watzlawick, Weakland, Fisch)	230	41.8	6	16	2.9	8 (tie)
Psychodynamic (Meissner, Dicks)	217	39.4	7	49	9.0	7
Behavioral (Stuart, Patterson)	216	39.2	8	14	2.6	10
Milan (Palazzoli, Boscolo)	162	29.4	9	16	2.9	8 (tie)
Social skills training (Guerney)	134	24.3	10	6	1.1	11
Other[2]	93	16.9	11	51	9.5	6
Functional (Alexander, Parsons)	58	10.5	12	3	1.0	12

[1]The total of most frequently used models (N = 544) is different than the total number of respondents (N = 550) because 1) subjects did not respond to the question, or 2) subjects responded more than once.
[2]Individuals who chose "other" as a response to this question, and specified the nature of that choice, fell into categories too small to report.

The lowest ranked choices were focusing on unconscious processes (n = 12), and altering patterns of reinforcement and punishment (n = 9).

Professional Issues in Clinical Supervision

A small number of questions on the survey dealt with how supervisors view their professional identity and the nature of their professional goals.

Professional Identification. Subjects were asked to indicate their primary professional identification. Although the largest category of respondents considered themselves to be marriage and family therapists (46%, n = 253), this total still comprises less than half of the sample. The next most common identifications were psychologist (19.6%, n = 108), social worker (13.6%, n = 75), minister (8.9%, n = 49), psychiatrist (2.9%, n = 16), and sociologist (.5%, n = 3).

Specialization. Supervisors were asked to indicate any specialization or expertise that they held in marital and family therapy. The majority of supervisors (78.2%, n = 430) consider their specialization to be marital therapy, not family therapy (65.1%, n = 358). Other responses were: divorce therapy (27.1%, n = 149), sex therapy (23.2%, n = 128), and none (2.7%, n = 15). Those subjects who chose "other" (13.3%, n = 73)

TABLE 3

Frequency and Ranking of Therapeutic Concentrations Employed by Supervisors

Concentration	Supervisors Using a Concentration n	%	rank	Number Using a Concentration Most Frequently n[1]	%	rank
Identifying and altering family structures	438	79.6	1	122	16.8	1
Identifying and altering nonproductive family solutions	431	78.3	2	79	10.9	4
Conceptualizing family organization	430	78.2	3	104	14.3	2
Alleviation of presenting problem	428	77.8	4	101	13.9	3
Identifying and blocking maladaptive behavior sequences	406	73.8	5	55	7.6	6
Focusing on intervention techniques	395	71.8	6 (tie)	38	5.2	9
Therapist's interpersonal skills	395	71.8	6 (tie)	62	8.6	5
Teaching clients new skills	354	64.4	8	24	3.3	10
Personal growth of the therapist	324	58.9	9	50	6.9	8
Personal growth of the family	306	55.6	10	55	7.6	7
Altering patterns of reinforcement	246	44.7	11	9	1.2	13
Focusing on unconscious processes	172	31.3	12	12	1.7	12
Other	42	7.9	13	14	1.9	11

[1]The total of most frequently used concentrations (N = 725) is different than the total number of respondents (N = 550) because 1) all subjects did not respond to the question, or 2) subjects responded more than once.

most often indicated a specialization in individual therapy (n = 12, 2.2% of total respondents).

Professional Activities in the Present and Future. Supervisors were asked to specify the approximate number of hours spent per week performing various professional activities. The supervisors spend most of their time in clinical practice. According to the responses, research presently plays a relatively small role for the majority of supervisors.

Respondents were also asked to rank the frequency with which they anticipated participating in the same activities over the next 5 years (see Table 4). Respondents predict that research will continue to occupy a less important role for most clinical supervisors. Administration, which is ranked second in terms of time spent presently, drops to last place in predicted significance over the next 5 years. Supervision is predicted to increase in importance during the next 5 years, moving up from third to second rank.

TABLE 4

Average Number of Hours Presently Spent in Professional Activities along with Significance over the Next 5 Years

	Present			Over Next 5 years	
Activity	Mean Hours per Week	S.D.	Rank	#Indicating Most Important	Rank
Clinical practice	16.438	9.520	1	339	1
Administration	7.267	8.142	2	26	5
Clinical supervision	5.036	3.802	3	106	2
Teaching	4.884	5.976	4	63	3
Research	4.108	5.029	5	38	4
Other[1]	3.152	6.620	6	6	6

[1]Individuals who chose "other" as a response to this question and specified the nature of that choice, fell into categories too small to report.

DISCUSSION

Many of the present findings reflect a shift from Everett's (1980) survey of supervisory practices in 1976. If both surveys are representative samples, it can be said that present supervisors are younger, less experienced, and less formally educated than the 1976 group. More females are supervising, although the number of minorities continues to be minuscule. Fewer individuals are supervising within an educational setting (15.4% of the present sample versus 26.3% indicated by Everett). This shift seems surprising in light of the increase in marriage and family therapy degree programs (Bloch & Weiss, 1981). Also, more individuals are presently offering supervision within a private practice setting. This increase in private practice supervision may indicate a larger body of individuals desiring family therapy skills who do not pursue formal degrees in marriage and family therapy. It may also be a function of AAMFT clinical membership requirements, whereby a trainee could possibly need additional supervisory hours following the completion of academic requirements.

A comparison of the 1976 and 1984 samples also reveals that the techniques of supervision have changed during the last 8 years. More of the present supervisors are performing live and videotaped supervision. This may be attributed to the recent widespread acceptance and low cost of audio and video equipment. However, this increase in live and video supervision can also be misleading. A comparison of the 1976 with the present data suggests that the primary format has shifted from an emphasis on case notes to the use of audiotapes.

Furthermore, those techniques presently being used most frequently are not considered to be the most effective. The most effective supervisory method reported is live supervision with immediate feedback, yet the

most common technique utilized is listening to an audiotape of a session. This may be due to a lack of facilities (e.g., one way mirror, video monitor, etc.) for performing live supervision. Since most supervision is occurring within private practice, the cost of setting up live supervision facilities can be prohibitive. Furthermore, malpractice insurance problems may also arise.

The most frequently reported focus during supervision (Table 3, column 3) was identifying and altering family structures, followed by altering nonproductive family solutions, conceptualizing family organization, and alleviation of the presenting problem. When considering that the most popular theoretical orientations for the respondents were structural and strategic family therapy, the areas of primary focus do not seem surprising. These processes are theoretically consistent with both the structural and strategic schools.

One of the most surprising findings obtained from the survey has to do with the supervisor's professional identification. The majority of supervisors in the 1976 sample (Everett, 1980) and in the present group do not identify themselves as marriage and family therapists. This finding confirms the presence of multiple professional allegiances within the population of Approved Supervisors, and suggests the complicated political realities which the field must confront.

Another interesting finding suggests that Approved Supervisors, overall, do not spend many hours in supervision of marriage and family therapy (mean = 5.036, S.D. = 3.8), but would like to spend more time supervising in the future (supervision is second only to clinical practice, in terms of projected future time involvement). Administration, on the other hand, is the least projected future involvement for supervisors, yet more time is presently spent in administration than in supervision.

It is important that caution be exercised in generalizing the results of the present study to other populations. There is no research to date that indicates whether non-AAMFT supervisors are similar to Approved Supervisors on any of the reported variables. Furthermore, generalization to nonsupervisor populations (e.g., clinical members) is also questionable. There is, however, the possibility that the present data will be more representative of future clinical members than present, since the supervisors targeted within this study may affect the practices and attitudes of trainees.

Implications for Future Training and Research

The present data clearly suggest a wide diversity of supervisory opportunities available to trainees, yet questions are raised regarding the effectiveness of these practices. Although more supervisors may consider live supervision to be the most effective training technique, research in support of the effectiveness of this method is lacking. In addition, the possibility exists that certain supervisory techniques may be more appropriate, and thus more effective, when used with a particular theoretical model. It should also be noted that no research has yet examined

whether supervisors operating from different theoretical orientations differ significantly in terms of actual supervisory practices and attitudes.

Another question that remains unanswered is whether the overall quality of training is affected by the number of hours which Approved Supervisors have allocated for supervision. Research should examine whether a significant number of trainees desiring clinical supervision are unable to locate a supervisor with sufficient time to provide services.

A similarly important focus for future research lies in the match between an individual trainee and a specific supervisory approach. No research to date has examined whether a particular method of supervision is more useful with some trainees than with others. In fact, little has been written with regard to what criteria are employed in the selection or evaluation of individual trainees. Clearly, as more choices become available to those interested in obtaining clinical training in marriage and family therapy, these questions take on a vital importance.

REFERENCES

Berger, M., & Dammann, C. (1982). Live supervision as context, treatment, and training. *Family Process, 21,* 337–344.

Bloch, D., & Weiss, H. (1981). Training facilities in marital and family therapy. *Family Process, 20,* 131–146.

Connell, G. M. (1984). An approach to supervision of symbolic-experiential psychotherapy. *Journal of Marital and Family Therapy, 10,* 273–280.

Everett, C. A. (1980). An analysis of AAMFT supervisors: Their identities, roles, and resources. *Journal of Marital and Family Therapy, 6,* 215–226.

Halpern, E. (1985). Training family therapists in Israel: The necessity of indigenous models. *American Journal of Family Therapy, 13*(1), 55–60.

Heath, A. W., & Storm, C. L. (1985). From the institute to the ivory tower: The live supervision stage approach for teaching supervision in academic settings. *American Journal of Family Therapy, 13,* 27–32.

Keller, J. F., & Protinsky, H. (1984). A self-management model for supervision. *Journal of Marital and Family Therapy, 10,* 281–288.

Liddle, H. (1980). On teaching a contextual or systemic therapy: Training content, goals, and method. *American Journal of Family Therapy, 8,* 58–69.

Liddle, H. A., Breunlin, D. C., Schwartz, R. C., & Constantine, J. A. (1984). Training family therapy supervisors: Issues of content, form and context. *Journal of Marital and Family Therapy, 10,* 139–150.

Nichols, W. C. (1979). Doctoral programs in family therapy. *Journal of Marital and Family Therapy, 5,* 23–28.

Olson, V., & Pegg, P. F. (1979). Direct open supervision. *Family Process, 18,* 463–469.

Quinn, W. H., Atkinson, B. J., & Hood, C. J. (1985). The stuck-case clinic as a group supervision model. *Journal of Marital and Family Therapy, 11,* 67–73.

Quinn, W. H., & Davidson, B. (1984). Prevalence of family therapy models: A research note. *Journal of Marital and Family Therapy, 10,* 393–398.

Wendorf, D. J. (1984). A model for training practicing professionals in family therapy. *Journal of Marital and Family Therapy, 10,* 31–42.

Whiffen, R., & Byng-Hall, J. (Eds.). (1982). *Family therapy supervision: Recent developments in practice.* London: Academic Press.