COUNSELOR SUPERVISEES’ EXPERIENCES OF SUPERVISION WHEN WORKING WITH CLIENTS DIAGNOSED WITH AN EATING DISORDER

A dissertation submitted to the Kent State University College of Education, Health and Human Services in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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The purpose of this phenomenological study was to reveal the supervisory experiences of counselor supervisees when working with clients diagnosed with eating disorders. Research questions were: “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?” The research questions guided the interview process with five female counselor supervisees who worked with clients diagnosed with eating disorders.

The data were analyzed according to Moustakas’ transcendental methodological approach (1994) that incorporated data analysis modified by Stevick (1971), Colaizzi (1973), and Keen (1975). The textural descriptive themes included: (a) time in supervision, (b) educational discussions about working with clients diagnosed with eating disorders, (c) modeling by the supervisor, and (d) individual and group supervision. The structural descriptive themes were: (a) competencies as a counselor, (b) population of clients diagnosed with eating disorders, (c) resources offered at specialized eating disorder treatment centers, (d) behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders, and (e) supervisory relationships. These textural
descriptive themes and structural descriptive themes emerged after analyzing the
transcripts and contributed to an initial and general understanding of the phenomenon. In
that regard, the descriptive themes provided a foundation for the individual and
composite textural and structural descriptions, and textural-structural synthesis. The
textural-structural synthesis detailed what was experienced in supervision, and the
meaning and underlying factors of the supervisory experiences across all participants.
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[A]lmost crumbling to the ground, she stopped. [L]ooking at how far she had traveled and all it had taken to get there, she recognized her strength. [T]he strengths she had inside of her, the strength she had gained along the way, her inner power, and so, she stood up. [S]tanding tall, she faced forward and continued on. (para. 1)
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CHAPTER I

INTRODUCTION TO THE STUDY

Individuals who meet criteria for the diagnosis of an eating disorder may seek professional treatment, including counseling, psychiatric, medical, and dietetic resources to decrease their symptoms. When these individuals seek counseling services, they often present with a myriad of symptoms, which include health complications, comorbidity, and suicidal ideation (Escobar-Koch et al., 2010; Franko & Keel, 2006; Milos, Spindler, Hepp, & Schnyder, 2003; Warren, Crowley, Olivardia, & Schoen, 2009). When facilitating a decrease of symptoms for eating disorders, mental health providers presented the following feelings: (a) anxiety and worry (Costin, 2009; Franko & Rolfe, 1996; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009; Zerbe, 2008), (b) anger (Hamburg & Herzog, 1990; Satir et al., 2009; Zerbe, 2008), (c) boredom (Hamburg & Herzog, 1990; Satir et al., 2009; Zerbe, 2008), (d) despair (Delucia-Waack, 1999; Hamburg & Herzog, 1990), (e) exhaustion and guilt (Hamburg & Herzog, 1990), and (f) helplessness (Delucia-Waack, 1999; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Satir et al., 2009). Further complicating the work of counselors in the United States who specialize in the treatment of clients with eating disorders are sociocultural factors aligned with the female physique, also known as the thin ideal (Bordo, 1993; Costin, 2009; Hesse-Biber, Leavy, Quinn, & Zoino, 2006; Maine & Kelly, 2005; Mensinger, Bonifazi, & LaRosa, 2007; Tylka, 2004; Wolf, 1994).

In the face of these challenges, counselors may rely on supervision for support (Delucia-Waack, 1999; Hamburg & Herzog, 1990). In the case of counselors managing
stress associated with counseling clients diagnosed with eating disorders, Zerbe (2008) commented on the “importance of ongoing consultation or supervision to psychologically nourish the clinician and help master some of the powerful feelings that get stirred by a group of illnesses that are life threatening” (p. 268). Therefore, the experience of supervision for supervisees who work with clients with eating disorders was investigated to better understand helpful aspects of the supervision process, such that the process can be refined as necessary.

**Supervision**

Supervision is one of the main components of counselor training (Rønnestad & Skovholt, 2001). It is a mandated activity for counselors-in-training. Supervision assists counselors with treatment planning and provides an additional perspective on their facilitation of client growth, while ensuring adherence to ethical and safety standards, under the instruction of a licensed supervisor. Though the definition of this process varies, Bernard and Goodyear’s (2009) definition is widely accepted. They stated,

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 and hierarchical, 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. 7)
This definition prioritizes supervisees’ development and insurance of client care. Supervisors facilitate development of supervisees to enhance supervisees’ work with clients by considering the unique needs of supervisees and their clients. These unique needs are considered throughout the working alliance as the supervisor and supervisee collaborate to attain goals. When supervisees’ unique needs fail to be met, resistance may surface in the supervisory relationship (Bernard & Goodyear, 2009).

Resistance commonly appears in a relationship absent of trust. Bernard and Goodyear (2009) stated that similar to a counseling relationship, the supervisory relationship mandates a foundation of trust to enable vulnerability in disclosure, and such trust takes time to build. If the relationship is absent of trust, a supervisee’s disclosure may feel too personal and resistance may occur. For example, if a supervisee feels too vulnerable with a supervisor when asked about his or her behaviors, feelings, and thoughts in response to clients, the supervisee may attempt to redirect the focus back to the client (Epstein, 2001). According to Hayes, Gelso, and Hummel (2011), inattention to the supervisee’s behaviors, feelings, and thoughts in response to clients may create an impasse in the counseling relationship, and client care may suffer. Therefore, the supervisor must delicately balance a focus on both the supervisee and client to ensure client care.

The supervisor is held professionally responsible if the supervisee fails to uphold client care intentionally or unintentionally. Faced with negligence, the supervisor’s liability is considered either direct or vicarious (Falvey, 2002). According to Falvey, the supervisor’s direct liability is defined as:
Failure to participate in the preparation, process, and outcome of supervisees’ work with clients; provision of incorrect advice; failure to understand clients’ needs through faulty listening; or assigning a client to a supervisee who is unprepared to counsel the presenting problems effectively. (p. 17)

Supervisors can be held vicariously liable for any harm done to a client even when they provide appropriate instruction to supervisees since the supervisee is practicing under the supervisor’s license. For example, the supervisor’s license may be suspended or revoked when client care is not upheld, even when the supervisee acts in opposition to the supervisor’s instruction. In the case of counselor supervisees working with clients with eating disorders, supervisors are challenged in their efforts to uphold client care via their supervisees because clients with eating disorders present with a complexity of the diagnoses, comorbidity, and increased suicidal risk and ideation (Escobar-Koch et al., 2010; Franko & Keel, 2006; Milos et al., 2003; Warren et al., 2009). The current study is important because it addresses the topic of supervisory experiences of counselor supervisees working with clients with eating disorders. Second, the investigation may illuminate these supervisees’ perspectives on what is helpful in the process of supervision.

**Rationale for the Study**

The complexity of symptoms of clients with eating disorders has been shown in previous literature to impact mental health providers’ behaviors, feelings, and thoughts (e.g., concerns about clients; Delucia-Waack, 1999; Franko & Rolfe, 1996; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Satir et al.,
2009; Zerbe, 2008). If these behaviors, feelings, and thoughts in response to clients are not managed effectively, they may create an impasse in the client’s progress. A suggested resource for effective management of these behaviors, feelings, and thoughts is supervision (Delucia-Waack, 1999; Hamburg & Herzog, 1990; Franko & Rolfe, 1996; Zerbe, 2008).

Based on the challenges presented in working with clients with eating disorders, supervision may also be difficult (Delucia-Waack, 1999; Hamburg & Herzog, 1990). For example, client challenges may make it difficult to balance the development of the supervisee with client care. If this balance is upheld and the supervisory process of working with clients diagnosed with eating disorders is successful, supervisee development may increase and client care may be sustained. Unfortunately, supervisees’ experiences of supervision, including their perceptions of balancing client and supervisee development, have not been captured beyond theoretical perspectives or limited research that dates back over 15 years (Delucia-Waack, 1999; Hamburg & Herzog, 1990).

Franko and Rolfe’s (1996) quantitative study about supervision for supervisees working with clients with eating disorders suggested supervision as a helpful resource. However, the research focused on managing countertransference (described as supervisees’ behaviors, feelings, and thoughts in response to clients) through supervision, rather than investigating supervision comprehensively (Delucia-Waack, 1999; Hamburg & Herzog, 1990; Franko & Rolfe, 1996). Details and various aspects of the supervisory experience were not investigated.

The absence of such research supports Creswell’s belief that
The strongest and most scholarly rationale for a study . . . comes from the scholarly literature: [when] a need exists to add or fill a gap in the literature or to provide a voice for individuals not heard in the literature. (Creswell, 2007, p. 102)

The current investigation will fill some gaps by documenting the supervisory experiences of counselor supervisees who worked with clients with eating disorders. Also, this study, rather than those referenced from the 1980s and 1990s, may yield different results. The results of this research may increase the understanding of helpful approaches in the supervision of supervisees working with clients with eating disorders. This additional knowledge could then be used to revise approaches in supervision to better meet the needs of supervisees and to enable them to meet their clients’ needs more effectively.

**Research Questions**

The current study explored the following research questions: “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?”

**Definition of Terms**

*Body dissatisfaction.* Body dissatisfaction refers to the thoughts and feelings about one’s inability to meet the standard of the thin ideal, which are commonly linked to eating disorders (Tylka, 2004).

*Body image.* This is defined as, “not so much [individuals’] actual appearance or how [they] seem to others but [their] own internal view of how [they] look, how [they]
think [they] appear to others, and how [they] feel about [their] looks” (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999, p. 3). Body dissatisfaction is a precursor to poor body image.

_Counselor supervisee._ This is an individual permitted to work with clients while under regular supervision by a licensed counselor with more experience in the field (Bernard & Goodyear, 2009). The counselor supervisee meets his or her state counseling board qualifications as a licensed counselor under supervision where he or she practices. For example, in the state of Ohio, this supervisee would be considered an LPC (Licensed Professional Counselor) working under supervision to obtain the independent LPCC license (Licensed Professional Clinical Counselor).

_Counselor supervisor._ This is an experienced, independently licensed counselor who oversees the counseling work of a supervisee to ensure client care and adherence to ethical and legal standards (Bernard & Goodyear, 2009). The counselor supervisor meets his or her state counseling board qualifications as an independently licensed counselor with the supervisory credential for the state board where he or she practices, if available. For example, in the state of Ohio, the individual would be an LPCC-S (Licensed Professional Clinical Counselor with the counselor supervisor designation).

_Supervision._ For the purposes of the current investigation, Bernard and Goodyear’s (2009) widely accepted definition is referenced to define supervision. According to Bernard and Goodyear, supervision is when a senior counselor provides supervision to a counselor-in-training to aid in his or her professional development, while monitoring client care.
Review of the Literature

The literature review provides background information on the supervisory experiences of supervisees who work with clients diagnosed with eating disorders. Some of the research literature referenced dates back to the 1980s and 1990s because supervisory experiences of counselor supervisees who work with clients with eating disorders are underrepresented in current research. The researcher also references theoretical frameworks and books to provide groundwork for the current study. The present study may yield different results from previous research, thus updating the line of inquiry to make it more relevant for practicing supervisors today.

At the onset of the literature review, Grant’s (2006) mixed methods research on the supervision of counselors working with complex clients is presented as foundational research. Then, the current investigation’s focus on complex clients diagnosed with eating disorders is emphasized. The prevalence of eating disorders and counselors’ behaviors, feelings, and thoughts in response to their clients with eating disorders are discussed, with a focus on health professionals and then mental health professionals. The literature on supervision of counselors with clients with eating disorders focuses on the management of the counselors’ behaviors, feelings, and thoughts as a predominant challenge, and this perspective may be limiting. The current investigation may broaden the description of supervisory experiences of counselors working with clients with eating disorders and challenge the limited perspectives found in previous literature. Next, previous theoretical frameworks for understanding the supervision of counselors who work with clients with eating disorder diagnoses are presented. This review then
provides a general understanding of four supervision models, which may be illuminated in the data. These include the Integrated Development Model (IDM; Stoltenberg, 2005), the Systems Approach to Supervision (Holloway, 1995), the Discrimination Model (Bernard, 1979; Bernard & Goodyear, 2009), and constructionists’ supervisory approaches, including solution-focused (Molnar & de Shazer, 1987) and narrative supervision (Parry & Doan, 1994). Next, broadening and narrowing practices of supervision, as they contribute to the supervisee’s empowerment, are discussed. The supervisory relationship is explored to better understand how this connection may impact the supervisory experience for supervisees who work with clients with eating disorders. Last, aspects of multiculturalism and gender within the supervisory relationship are covered. This literature review prepares the reader for the current investigation focusing on the experience of supervision for counselors working with clients with eating disorders.

**Grant’s (2006) Research on the Supervision of Counselors Working With Complex Clients**

The current investigation builds on Grant’s (2006) mixed methods (qualitative and quantitative methods) exploration of the supervisory experience for student counselors working with complex clients. These participants were counseling students enrolled in a course titled “Advanced Psychotherapy Process and Psychopathology” (p. 218). The objective of the course was to train student counselors to work more effectively with complex clients through the use of counseling vignettes. After the course was completed, the researcher evaluated students’ training through quantitative surveys
and focus groups. The researcher did not include the number of student counselors enrolled in the course in her article. In working with complex clients, Grant’s findings revealed progress through the student counselor’s ability to: (a) create and repair a strong therapeutic relationship; (b) understand client transference, when the client works through past unresolved problems in a previous relationship by placing characteristics from this past relationship onto the counseling relationship; (c) understand his or her (student counselor’s) behaviors, feelings, and thoughts while in session with clients; and (d) comprehend how the client’s personality might impact case conceptualization and treatment planning. The researcher assessed the students’ progress through a quantitative evaluation and focus group format after the students received their grades for the course. The focus group themes included: (a) impact of the learning process, (b) effective and ineffective teaching elements, and (c) suggestions for improvement. According to Grant’s findings, “experiential and interpersonal learning, direct practice, supervision, and personal therapy” all contributed to students’ progress in working with complex clients (p. 220). Grant’s research contributes to the current literature review by describing the focus of supervision with complex clients as creating and repairing the therapeutic relationship, and aligning case conceptualization and treatment planning to the client’s personality characteristics.

Similar to Grant’s (2006) research, the current investigation focuses on counselors who work with complex clients. More specific than Grant’s research, the current research identifies the complex clients as those individuals diagnosed with an eating disorder and investigates how counselors working with these clients experience
supervision. Research focusing on the supervisory experiences of counselors who work with clients with eating disorders has not yet been addressed. Considering Grant’s findings, it was interesting to see if counselor supervisees interviewed in the current investigation discussed supervision as a training resource used to improve their work with complex clients diagnosed with eating disorders.

**Sociocultural Factors, Prevalence, Relapse, and Mortality for Eating Disorders**

According to the American Psychiatric Association (APA, 2013), eating disorders are defined according to three diagnoses: Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder. Clients with eating disorders often obsess about their relationship with their body and food, which is further exacerbated by body dissatisfaction (American Psychiatric Association [APA], 2013). The prevalence rates for eating disorders in the United States are difficult to determine because many individuals do not recognize their symptoms as problematic and fail to seek professional counseling (National Association of Anorexia Nervosa and Associated Disorders [ANAD], 2011; National Eating Disorders Association [NEDA], 2011).

According to Levine and Harrison (2004), symptoms of eating disorders are perpetuated by sociocultural factors. Sociocultural factors are described as a combination of social and cultural influences. Definitions of society and culture are needed to understand the term. Society is “organized life in groups; typical of humans and other animals” (Kottak, 2004, p. G13). According to Kottak (2004), culture is “distinctly human, transmitted through learning; traditions and customs that govern behavior and beliefs” (p. G4). “Culture is an organizing and stabilizing influence. It encourages or
discourages particular behaviors and thoughts; it also allows people to understand and know what to expect from others in that culture” (Bernstein, Penner, Clarke-Stewart, & Roy, 2006, p. 23). Culture describes an individual’s gender, race, ethnicity, socioeconomic status, social class, religion and context, which directly impacts his or her emotional, behavioral, and mental processes (Miller, 2002).

Contemporary culture inundates individuals with the thin ideal body (e.g., models and actresses). This term, thin ideal, describes a slim physique that is often unnatural and unattainable for most women (Maine & Kelly, 2005). As media bombards women with this model, it “sends a powerful signal to women—that only the beautiful, and the thin are valued and loved, catalyzing an American ideal of female body image where thinness is a sign of success, health, and being in charge of your life” (Hesse-Biber et al., 2006, p. 208).

According to Levine and Harrison (2004) many women focus on weight management and dieting as goals to attain the thin ideal. Therefore, instead of seeing this disconnection between nutrition and the body as harmful, many Americans view this as normative and even a standard of success (Costin, 2009; Kilbourne, 1999). Therefore, the dysfunctional behaviors, feelings, and thoughts associated with controlling one’s weight that are often the precursors of eating disorders are considered a cultural norm (Maine & Kelly, 2005). For those exhibiting symptoms of an eating disorder, their desire for the thin ideal body outweighs the personal physical, emotional, and mental costs.

Though some are desensitized to eating disorder problems, many do seek professional counseling, and estimated prevalence rates have been obtained from this
population. According to the American Psychiatric Association (APA, 2013), prevalence rates for individuals in the United States who have received professional treatment and have received a diagnosis for an eating disorder have been identified, though these percentages do not take into account many others who fail to recognize their problem and seek professional help. The APA’s (2013) prevalence rate for individuals seeking treatment for Anorexia Nervosa was approximately 0.5%, whereas Bulimia Nervosa ranged between 1.0% and 3.0% of the United States population. Thompson and Kinder (2003) reported an estimated 1.0% to 3.0% of Americans who sought treatment met criteria for Binge Eating Disorder.

Though recent prevalence rates (percentages) for individuals diagnosed with an eating disorder were known, the number of people diagnosed with an eating disorder was not available. Therefore, the current researcher compiled the most recent research estimates from studies to find approximations. The current researcher multiplied the percentages of individuals with eating disorders from the research studies of Hudson, Hiripi, Pope, and Kessler (2007) and Merikangas et al. (2010) by the U.S. Census Bureau 2009 population statistics. Both studies attempted to consolidate their results on eating disorders through their use of the National Comorbidity Survey Replication (NCS-R) to uncover the prevalence of eating disorders. From Hudson et al.’s research, adults who sought treatment had lifetime prevalence estimates of 0.6%, 1.0%, and 1.2% for Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder, respectively. Lifetime prevalence refers to the number of respondents who had ever had symptoms of an eating disorder (National Institute of Mental Health [NIMH], 2012). Merikangas et al. (2010) estimated
2.7% of adolescents, who sought treatment, had lifetime prevalence for Anorexia Nervosa, Bulimia Nervosa, or EDNOS. For both adults and adolescents, the National Institute of Mental Health (NIMH, 2009) supported these research percentages when applied to the United States population. The current researcher multiplied the percentages obtained from the studies of Hudson et al. (2007) and Merikangas et al. (2010) by the 2009 U.S. Census population data to reveal an estimated 8,300,000 individuals with a lifetime prevalence of an eating disorder (U.S. Census Bureau, 2011). This approximates National Eating Disorder Association’s (2011) unsubstantiated estimates of 10 million women and one million men with an eating disorder in the United States. Therefore, the number of Americans who have or have ever had symptoms of an eating disorder warrants concern.

The severity of this concern increases when evaluating the outcome research for eating disorders. Negative outcome for all eating disorders was evidenced by relapse and mortality (Chen, 2011). Further, this negative outcome for all eating disorders was common even when focusing on conservative approximations (Judd, 2011). These approximations were complicated by variance in defining recovery, remission, and relapse. While some researchers label recovery as an absence of the physical symptoms for the diagnosis of an eating disorder, Bardone-Cone and Maldonado (2008) believed in addressing recovery from a comprehensive lens, including physical (e.g., weight restoration), psychological (diminished obsession about food and weight), behavioral (e.g., flexibility and balance in lifestyle), and social (e.g., restoring relationships) aspects with each individual. From Bardone-Cone’s and Maldonado’s perspective, recovery is
unique to each individual and depends on each individual’s causes and symptoms of an eating disorder, and definition of health.

Negative outcomes of eating disorders are further illustrated through detailed statistics for Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder. For the diagnosis of Anorexia Nervosa, relapse rates are severe, and mortality estimates are the highest of any mental illness (NIMH, 2009). According to the Cleveland Clinic Center for Continuing Education (2008), relapse estimates ranged from 24% to 56% for individuals receiving counseling treatment. Despite counseling treatment, many individuals continue to struggle with Anorexia Nervosa after initial remission. Of particular concern is the potential for mortality, commonly a result of health failure (NEDA, 2011) or suicide attempts (Milos et al., 2003). The mortality rates for individuals diagnosed with Anorexia Nervosa in the United States population were estimated at 0.56% per year (NIMH, 2009). Further clarification revealed 5% of those presenting with symptoms of Anorexia Nervosa died within 10 years, whereas 20% of these individuals died within 20 years (APA, 2003). For these statistics, the individuals died from the symptoms of Anorexia Nervosa (e.g., starvation or electrolyte imbalance). The Renfrew Center Foundation for Eating Disorders (2003) specified that 20% of individuals who suffered from Anorexia Nervosa died from health consequences of the disorder. ANAD (2011) detailed these statistics further by focusing on gender and age. ANAD stated that young women (aged 15–24) with Anorexia Nervosa hold the most severe mortality statistics among all individuals with Anorexia Nervosa. Also, in
comparison to women similar in age, young women with the diagnosis of Anorexia Nervosa were 12 times more susceptible to death.

Similar to Anorexia Nervosa, the statistics of relapse and mortality for Bulimia Nervosa mandate concern. Though the definition of relapse varies for females diagnosed with Bulimia Nervosa, estimates ranged from 30% to 63% (Stein, 2005). More concerning than relapse are the estimates of mortality for Bulimia Nervosa. According to Keel and Mitchell’s (1997) study, the mortality rate for female participants diagnosed with Bulimia Nervosa was 0.3% or 7 out of 2,194 participants. More recently in their study, Crow et al. (2009) reported 3.9%, or 35 females of 906 female participants diagnosed with Bulimia Nervosa died from complications of Bulimia Nervosa over a time span of 8 to 25 years.

Binge Eating Disorders also contribute to the high relapse and mortality statistics for eating disorders. Agras, Crow, Mitchell, Halmi, and Bryson (2009) reported an 18% relapse rate for clients with Binge Eating Disorder, four years after recovery. At a 12-year follow-up, 33% of clients had relapsed. Fichter, Quadflieg, and Hedlund (2008) reported two deaths, resulting from symptoms, out of 425 female participants at their 12-year follow-up of clients with Binge Eating Disorder.

Eating disorders (Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder) are reported as severe, as they have higher mortality statistics than any other mental illness (NIMH, 2009). Currently, the relapse statistics are also high; therefore, research designed to enhance treatment of clients with eating disorders is necessary. A clearer understanding of the impact of these statistics on counselors who work with
clients with eating disorders may be helpful. Further, these prevalence statistics provide support for continued exploration of counseling clients with eating disorders. The current researcher specifically focused on the experience of supervision for counselor supervisees in their efforts with clients diagnosed with an eating disorder.

**Behaviors, Feelings, and Thoughts in the Treatment of Individuals With Eating Disorders**

Both medical and mental health professionals working with clients with eating disorders have reported behaviors, feelings, and thoughts in response to clients and have noted these responses as challenging to treatment (Brotman, Stern, & Herzog, 1984; Bunnell, 2009; Burket & Schramm, 1985; Delucia-Waack, 1999; Fleming & Szmukler, 1992; Franko & Rolfe, 1996; Goldner, 1989; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Ramjan, 2004; Sansone, Fine, & Chew, 1988; Satir et al., 2009; Strober, 2004; Warren et al., 2009; Zerbe, 2008). Zerbe (2008) reported common unhelpful feelings of counselors working with clients with eating disorders as: anxiety, anger, boredom, despair, exhaustion, guilt, and worry resulting from clients’ presenting symptoms. According to Costin (2009), counselors’ behaviors, feelings, and thoughts may also be magnified for them, as they (counselors) are exposed to sociocultural factors. These sociocultural factors include the thin ideal for female physique, which is often correlated with body dissatisfaction (Bordo, 1993; Hesse-Biber et al., 2006; Maine & Kelly, 2005; Mensinger et al., 2007; Tylka, 2004; Wolf, 1994). The current researcher sought a better understanding of supervisees’ experiences of supervision.
Warren et al.’s (2009) work is the most current research focusing on the behaviors, feelings, and thoughts of treatment providers who work with clients with eating disorders. Specifically, the purpose of Warren et al.’s investigation was to explore 1) the frequency and management of feedback from eating disordered patients about the treatment providers’ appearance, 2) personal change in affect, vigilance around appearance, and eating behaviors in treatment providers after working with patients, and 3) recommendations about effectively and constructively working with the population. (pp. 29-30)

Warren et al. (2009) recruited 43 participants at the Multiservice Eating Disorder Association’s (MEDA) annual meeting for their study. In this sample, the participants represented were 13 social workers, 8 clinical psychology or counseling Ph.D.s, 8 masters degree professionals, 7 mental health counselors, 7 bachelor degree personnel, 4 Psy.D.s, 4 nurses, 3 dietetic nurses, and 2 medical physicians. Some of these participants had more than one degree. The majority of these treatment providers indicated over 50% of their current patients had an eating disorder. None of these participants reported currently having an eating disorder, though 13 (over 30%) reported having an eating disorder in the past.

Warren et al.’s (2009) participants were assessed using both quantitative and qualitative approaches, as the questionnaires encompassed both closed and open-ended questions to capture the experiences of treatment providers who worked with clients and patients with eating disorders. In response to these questions, 83% (36) of the participants believed the eating disordered patient was assessing her (the participant’s)
appearance. However, only 34% (15) of the participants who believed their appearance was being assessed chose to discuss this with their patients. Thirteen percent (6) of the participants had received direct criticism from their clients about their appearance. One participant disclosed being called “old” and “fat” (Warren et al., 2009, p. 34). Five of the six participants who received this direct criticism chose to discuss these comments within the session when they were made. The rationale for the one participant’s decision to not address these situations of physical assessment or direct criticism from clients in session was not provided. In response to the questions about an altered relationship with food and eating, 70% (30) of the providers indicated a change in their relationship with food in response to their work with clients with eating disorders (e.g., viewing food items as “good” or “bad”). Fifty-four percent (23) of the participants stated their eating patterns had changed in response to their work with clients with eating disorders (e.g., limiting or portioning). Although 28% (12) of these individuals felt they were more intentional and mindful while eating, 20% (9) disclosed increased engagement in disordered eating (e.g., restricting or bingeing on food). Seven percent (3) of participants disclosed engagement in disordered eating after a session. In response to the questions about appearance vigilance, 71% (31) expressed vigilance about their appearance in regard to weight, and 39% (17) reported increased negative feelings about their overall appearance resulting from their work with clients diagnosed with eating disorders. Fifty percent (22) of participants were more aware of other individuals’ appearances after a session with a patient. Warren et al. concluded, from the results of their study, that working with patients who exhibited eating disordered symptoms altered some treatment providers’
relationship with food both positively and negatively, and made some more aware of socio-cultural messages associated with the thin ideal. When asked what they did to cope with issues like socio-cultural messages associated with the thin ideal, they spoke about the importance of utilizing self-care practices and seeking supervision or consultation.

Medical health professionals. For medical health professionals (physicians, medical residents, and nurses) who work with clients diagnosed with eating disorders, unhelpful responses to clients have been reported (Brotman et al., 1984; Fleming & Szmukler, 1992; Goldner, 1989; Ramjan, 2004; Sansone et al., 1988; Strober, 2004). Medical health professionals’ unhelpful behaviors, feelings, and thoughts included: (a) frustration in response to clients’ resistance (Goldner, 1989; Ramjan, 2004; Strober, 2004), (b) helplessness in their ability to decrease clients’ symptoms (Brotman et al., 1984; Fleming & Szmukler, 1992; Sansone et al., 1988), and (c) anxiety about the complexity of both medical and psychological symptoms for the diagnoses of eating disorders (Brotman et al., 1984). According to Brotman et al. (1984), Fleming and Szmukler (1992), and Sansone et al. (1988), these examples of medical health professionals’ reported behaviors, feelings, and thoughts in response to clients led to negative perceptions of clients and low job satisfaction.

Medical health professionals’ negative perceptions of individuals with eating disorders have been illuminated in previous research. For example, Brotman et al.’s (1984) quantitative investigation of 46 first year medical residents’ emotional responses evidenced that patients with Anorexia Nervosa evoked significantly higher levels of anger, helplessness, and stress in the medical residents than patients diagnosed with
diabetes or obesity. These responses were obtained after residents read hypothetical cases of patients who they may potentially be treating in the future. Their reactions were rated from one to four in severity of presence of five emotions including anger, sadness, helplessness, anxiety, and stress. Medical residents felt that these emotions negatively impacted their work with the hypothetical patients. Similarly, Fleming and Szmukler (1992) found negative responses for the 352 medical and nursing staff they assessed through a quantitative questionnaire. The results indicated that medical and nursing staff reported blaming patients with eating disorders based on their beliefs that the patients caused the symptoms. The medical and nursing staff believed the patients were responsible for their symptoms, and thus exhibited a lack of empathy toward them. In Fleming and Szmukler’s discussion, they stated that lack of time treating these patients exacerbated the participants’ negativity. This lack of time referred to the duration in which these nurses were in contact with patients. Nursing staff were also participants in the research of Sansone et al. (1988). Through their investigation, inpatient nursing staff reported negative perceptions of their predominantly adolescent population, further evidenced by experiencing lower job satisfaction in comparison to nurses in other inpatient units. The age of this quantitative research, dating back 25–35 years ago, is a limitation. Because of increased awareness and education in the field of eating disorders, similar studies today may yield different results.

As opposed to quantitative results of the previously mentioned studies (Brotman et al., 1984; Fleming & Szmukler, 1992; Sansone et al., 1988), Ramjan (2004) used a qualitative investigation to study 10 registered nurses in an Australian children’s hospital
in the acute ward who had been working with patients struggling with Anorexia Nervosa for at least two years. Of the participants, three were male, seven were female, and their ages ranged from 26 to 48 years. Several themes emerged from semi-structured interviews including: “struggling for understanding, struggling for control, and struggling to develop therapeutic relationships” (Ramjan, 2004, p. 498).

Ramjan (2004) found that nurses misunderstood these patients because they had no formal training in eating disorders. Being unaware that some of these patients inflict self-harm and refuse help led to lack of empathy toward the patients. The nurses admitted to their labeling of the patients as “anorexic” or “bad” and acknowledged their perceptions as a barrier within their clinician-patient relationship. By labeling the patient, interchanging “anorexic” with “bad,” the nurses “cast patients metaphorically as ‘criminals’” who “[did] their time,” “[ate] to get out” of “prison,” and were often repeat offenders with “suspended sentences” (Ramjan, 2004, p. 500). These perspectives commonly led to nurses’ feelings of anger toward the patients.

A second theme, “struggling for control,” emerged from the nurses’ interviews and addressed patients’ control in the recovery process (Ramjan, 2004, p. 498). The nurses stated that they felt angry in response to patients’ attempts to control the recovery process. According to Ramjan (2004), the nurses disclosed that they often felt the patients were “manipulative” and made efforts to sabotage their treatment by refusing to eat or deceiving the nurses about food intake (Ramjan, 2004, p. 499). The term “manipulative” was defined in various ways: “playing off one nurse against another,” “lying,” “twisting words around for control,” “upsetting the boat,” “causing infighting,”
“getting away with blue murder,” or “non-compliance” with the treatment (Ramjan, 2004, p. 499). The following summarizes the themes, “struggling for understanding” and “struggling for control” (Ramjan, 2004, p. 498):

Participants [nurses] reported the adolescents’ view of nasogastric feeding as “punitive,” and they would do anything to “sabotage” it. They would fight the nurses “tooth and nail” to regain “control” over the predicament. Nurses were thus unconsciously acting like jailers; participants understandably found this constant “battle for control” an impediment to therapeutic alliance. (Ramjan, 2004, p. 499)

According to Ramjan (2004), both themes of “struggling for understanding” and “struggling for control” were considered unhelpful by these nurses (p. 498). They stated that their unhelpful behaviors, feelings, and thoughts may have prevented them from effectively working with these patients.

Ramjan (2004) stressed the mutual mistrust within the relationship as a challenge in effectively working with patients with eating disorders. Whereas the nurses viewed the patients as “manipulative” (Ramjan, 2004, p. 499), the adolescents mistrusted the nurses and viewed them as authority figures who were punishing them by taking away their control and forcing them to eat. As a result, the participants felt their treatment efforts were fruitless, whereas the patients thought the nurses were “trying to make them fat” (Ramjan, 2004, p. 500). Therefore, Ramjan’s research provided a rationale for addressing these challenges when struggles for understanding, control, and the development of the therapeutic alliance surface. The current research study may
illuminate supervision as a resource to aid supervisees working with clients with eating disorders and to assist them with these challenges.

In comparison to the previous studies, Shisslak, Gray, and Crago (1989) reported changes in their study of health care professionals in response to working with patients with eating disorders. Shisslak et al. reported changes in 19 (28%) of 71 health care professionals when surveyed about their perceptions of their bodies and their relationships with food. These participants stated that working with patients with eating disorders made them more aware of feelings about their body, clothes, and appearance; however, this awareness was not labeled as either positive or negative. The current researcher’s investigation may illuminate supervision as a resource for counselor supervisees who are presented challenges similar to those of medical health professionals.

**Mental health professionals.** Similar to these medical professionals, unhelpful responses from mental health professionals have been captured in previous research (Burket & Schramm, 1985; Kaplan & Garfinkel, 1999; Satir et al., 2009). The research referenced may be dated, yet was cited because no other research on this topic was available. For example, Burket and Schramm’s (1985) quantitative questionnaire illuminated mental health professionals’ unfavorable behaviors, feelings, and thoughts in response to clients, treatment, and prognosis of clients with eating disorders. When 90 mental health professionals, comprised of 44 males and 46 females, were queried, 28 (31%) of the participants expressed desires to avoid work with these clients because of (a) negative behaviors, feelings, and thoughts in response to clients; (b) clients’ presenting transference of past relational problems onto their relationship with the
clinician; (c) health complications; (d) comorbidity; and (e) excessive time demands from clients. These 28 participants were comprised of 19 of the 44 males and 9 of the 46 women. Satir et al. (2009) supported Burket and Schramm, when they discovered clinicians’ feelings of helplessness in their ability to facilitate a decrease in clients’ symptoms. Mental health professionals also disclosed feelings and behaviors in Burket and Schramm’s investigation. For example, Burket and Schramm reported 28 (31%) participants disclosed a need to overcome feelings of frustration, anger, helplessness, and anxiety toward these clients in order to work with them effectively.

Of mental health professionals, counselors also reported unhelpful feelings toward their clients (Kaplan & Garfinkel, 1999). When female counselors were surveyed, Kaplan and Garfinkel (1999) uncovered feelings of comparison, competition, and jealousy when working with what the participants described as physically attractive female clients who dwelt in “self-pity.” Their conclusions showed female counselors responding negatively to female clients’ scrutiny of body weight, shape, food, and eating.

**Female mental health professionals.** According to the National Eating Disorder Association (NEDA, 2011), the majority of clients with eating disorders are female, as 10 females were diagnosed for each male. One reason for higher numbers of females with eating disorders may be sociocultural messages (Hesse-Biber et al., 2006). According to Hesse-Biber et al., these sociocultural messages send “a powerful signal to women—that only the beautiful, and the thin are valued and loved, catalyzing an American ideal of female body image where thinness is a sign of success, health, and being in charge of your life” (p. 208). Previous studies have shown that these messages,
often aligned with media images, are often precursors of body dissatisfaction and eating disorders (Maine & Kelly, 2005; Siever, 1994; Stice, Schupak-Neuberg, Shaw, & Stein, 1994; Tylka, 2004; Wiseman, Gray, Mosimann, & Ahrens, 1992).

Females were in greater numbers as clients, and females also outnumbered males as specialists in the field of eating disorders (Barbarich, 2002). Counselors were often drawn to the specialty of eating disorders after having experienced the disorders directly through a previous diagnosis themselves or indirectly through relationship with a friend or family member (Barbarich, 2002; Bloomgarden, Gerstein, & Moss, 2003; Costin & Johnson, 2002). Through Barbarich’s (2002) research conducted with the Academy of Eating Disorders (AED), the lifetime prevalence of an eating disorder diagnosis for her 399 participants who were professionals in the field of eating disorders was 33.2% (107), and 38.8% (40) of 104 treatment facilities represented in this study hired counselors with a previous eating disorder diagnosis. The findings from Bloomgarden et al. (2003) expanded on these statistics; their survey among staff members at the Renfrew Center in Philadelphia, PA, which specializes in the treatment of eating disorders, revealed: (a) 24% had a previous history with an eating disorder approximately 12 years ago (some participants were diagnosed less than 12 years ago and some were diagnosed more than 12 years ago), (b) 13% had a family member who struggles or struggled with an eating disorder, and (c) 44% had a personal connection via a friend or an acquaintance with an eating disorder.

According to Zunino, Agoos, and Davis (1991), gender commonality in the therapeutic relationship impacted both transference and countertransference.
Transference was described as clients’ behaviors, feelings, and thoughts in response to the counselor, whereas countertransference was described as counselors’ behaviors, feelings, and thoughts in response to the client. The relevance of transference and countertransference was identified in four themes, which resulted from qualitative interviews with two counselors who worked with clients diagnosed with bulimia nervosa. The four identified themes were: (a) body image comparisons, (b) mother-daughter conflict, (c) gender identity development, and (d) the client’s desire for a female role model in her counselor. Body image comparisons meant that both the client and counselor may compare their bodies with the other. In this study, these comparisons fueled “competition, envy, and admiration” (Zunino et al., 1991, p. 261).

Mother-daughter conflict emerged as an area that described the client’s transference with regard to her relationship with her mother. According to Zunino et al., the client may attempt to have her unfulfilled needs within her relationship with her mother met through her counselor. Regarding gender identity development and the client’s desire for a female role model in her counselor, an opportunity for positive transference and countertransference is provided. Gender identity development was explained as a holistic and androgynous understanding of gender and this understanding may be modeled by a counselor in session with her female clients. The counselor may also have the opportunity to model assertiveness and empowerment with her clients as a female, which may oppose socially constructed definitions of gender. Participants’ perspectives about (a) body image comparisons, (b) mother-daughter conflict, (c) gender identity development, and (d) the client’s desire for a female role model in her counselor, may aid
in the advancement of supervision of counselor supervisees working with clients with eating disorders.

**Some Limitations of the Literature Reviewed: Countertransference and Self-Disclosure**

There are limitations in the literature on eating disorders with regard to the use of supervision for supervisees’ presentations of countertransference and self-disclosure in their counseling relationships with clients with eating disorders. Specifically, the literature on supervision for counselors working with clients with eating disorders emphasized supervision as a resource to predominately manage supervisees’ countertransference in their relationships with clients (Costin, 2009; Delucia-Waack, 1999; Franko & Rolfe, 1996; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Satir et al., 2009; Zerbe, 2008). This focus on the management of countertransference for supervisees may present supervision as a narrow resource, when, in fact, supervision may be a more comprehensive resource for supervisees who work with clients with eating disorders. For example, supervision may also include facilitating supervisees’ development (Stoltenberg, 2005), considering the contextual systems of the supervisee (Holloway, 1987), balancing the roles of teacher, consultant, and counselor (Bernard, 1979), facilitating an egalitarian relationship with supervisees (Gray & Smith, 2009), focusing on the supervisees’ strengths to find solutions (Molnar & de Shazer, 1987), and collaborating in the recreation of supervisees’ professional stories (Parry & Doan, 1994). Further, the definition of countertransference presented in literature on the supervision of counselors who work with clients with eating disorders is not clear.
Varying definitions exist for the term countertransference, leading to misunderstanding of the literature. The current researcher discusses the different definitions for the term countertransference to justify the avoidance of this term in her research procedures (Bernard & Goodyear, 2009; Freud, 1910; Hayes et al., 1998; Kernberg, 1965; Ruderman, 1986; Slakter, 1987; Watkins, 1985; Zachrisson, 2009).

A second limitation presented in the literature about eating disorders is an emphasis on unhelpful uses of self-disclosure when working with clients with eating disorders (Costin, 2009; Rabinor, 2010). Parallel process, as related to self-disclosure, is described in greater detail in the next section. According to Bunnell (2009), Costin (2009), and Rabinor (2010), the literature does not include helpful uses of self-disclosure; instead it focuses on how self-disclosure may impede the counseling and supervisory processes. Therefore, supervision based on this literature may be missing a focus on the helpful uses of self-disclosure with clients with eating disorders, by instead advising supervisees to avoid its use in both counseling and supervision. The current researcher explores both topics of countertransference and self-disclosure in greater depth to consider their relevance in her investigation about the supervision of counselor supervisees working with clients with eating disorders.

**Countertransference.** The literature on eating disorders references the term countertransference, yet at least three distinct definitions exist for this term. Each definition is broad and the definitions focus on varying aspects of the term. This leaves...
the research unclear as to the meaning of countertransference in the previous literature.

More clarity is needed for this concept.

In the background literature, Watkins (1985) best represented a broad definition of countertransference; the focus is on the counselor’s positive or negative behaviors, feelings, and thoughts within the therapeutic relationship, in response to the client. These behaviors, feelings, and thoughts of the counselor can be used to facilitate client growth (e.g., counselors’ identification with clients) or create an impasse (e.g., rejection of or hostility toward the client by the counselor). Watkins stated that the nature of these behaviors, feelings, and thoughts within the therapeutic relationship could be helpful in enabling the counselor to identify with the client more easily, or they could be unhelpful, as the counselor’s unresolved issues with others may be projected onto the client.

Similar to Watkins’ (1985) definition, Ruderman’s (1986) definition of countertransference described counselors’ positive and negative behaviors, feelings, and thoughts in response to clients. Ruderman presented her definition of countertransference in her research on female psychologists working with female clients. In this research, Ruderman described countertransference as:

The therapist’s consciously felt attitudes, experiences and attributes evoked by the stimulus of the psychotherapist-patient relationship. Countertransference reflects the therapist as a total person: her age, stage of life development; her life experience and performance in multiple roles; her experience of acute life crises, separations and losses. It is the sum total of what she feels toward the patient and within herself in the context of the treatment process. (p. 105)
When countertransference is helpful, the counselor’s previous life experiences may facilitate an understanding of the client more fully, and it can be referred to as either constructive countertransference or associative identification (Shechter, 2010). However, these countertransference reactions could also be unhelpful if the counselor responds with stress and anxiety to the client’s disclosure (Franko & Rolfe, 1996). Franko and Rolfe (1996) stated that the presentation of unhelpful countertransference may impede the therapeutic process.

The countertransference definitions of Watkins (1985) and Ruderman (1986) differed from Freud’s (1910) psychoanalytic interpretation when he originally coined the term countertransference. Freud’s definition of countertransference focused on the counselor’s unresolved issues being projected onto the client in response to the client’s transference within the therapeutic relationship because of a narrow focus on the counselor’s unresolved issues. The emergence of countertransference meant a shift in focus from the client to the counselor. Countertransference was viewed unfavorably, as it interfered with the counselor’s ability to facilitate client growth (Freud, 1910; Gordon, 2003).

Some current researchers support Freud’s definition. For example, Bernard and Goodyear (2009) supported Freud’s definition of countertransference by first describing transference as a process during which a person transfers responses and feelings that he or she had for someone in the past onto someone in the present. For example, in the field of counseling, transference may refer to a male client placing feelings from his relationship with his mother onto the counselor, in an attempt to work through a
relational impasse with his mother. Countertransference is similar to transference, yet refers to a phenomenon when a counselor’s needs and unresolved relational issues become the focus of the therapeutic alliance (Bernard & Goodyear, 2009; Corey, 2001). Instead of using the therapeutic relationship to work toward client growth, the counselor’s needs and unresolved relational issues become a priority in conversation.

In response to Freud’s 1910 definition of countertransference, Kernberg (1965) created “totalistic” countertransference. “Totalistic” countertransference refers to all of the counselor’s behaviors, feelings, and thoughts, conscious and unconscious, in response to the client within session. More recently, a more moderate definition has been used, which describes counselors’ conscious behaviors, feelings, and thoughts in response to clients (Hayes et al., 1998; Slakter, 1987; Watkins, 1985; Zachrisson, 2009).

Clarity is needed because of the varied definitions of countertransference. Previous literature on the treatment of clients with eating disorders does not specify which meaning of the word is used and readers are left to ponder the exact nature of this term with regard to the study in question. This limitation could impact readers’ understanding of the current literature about the supervisory experiences of counselors working with clients with eating disorders. The current investigation sought to avoid misunderstanding of the term countertransference by inquiring about counselor supervisees’ behaviors, feelings, and thoughts in response to their clients. By using these exact words, the researcher included everything that may be considered countertransference without needing to reference the term, countertransference. By using
these exact words, both the researcher’s and the participants’ interpretation of the term countertransference was avoided, and confusion was eliminated.

In response to clients with eating disorders, mental health providers presented predominant feelings of: (a) anxiety and worry (Costin, 2009; Franko & Rolfe, 1996; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Satir et al., 2009; Zerbe, 2008), (b) anger (Hamburg & Herzog, 1990; Satir et al., 2009; Zerbe, 2008), (c) boredom (Hamburg & Herzog, 1990; Satir et al., 2009; Zerbe, 2008), (d) despair (Delucia-Waack, 1999; Hamburg & Herzog, 1990), (e) exhaustion and guilt (Hamburg & Herzog, 1990), and (f) helplessness (Delucia-Waack, 1999; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Satir et al., 2009). The current researcher hoped to illuminate how supervision may or may not be helpful in managing these feelings, in addition to behaviors and thoughts, in response to working with clients with eating disorders.

**Self-disclosure.** Caution with regard to self-disclosure of counselors’ behaviors, feelings, and thoughts in response to their clients with eating disorders is displayed throughout the literature (Costin, 2009; Rabinor, 2010). According to Costin (2009) and Rabinor (2010), this cautious perspective focuses on inappropriate self-disclosure and fails to present appropriate uses of self-disclosure to facilitate client progress. For example, Rabinor stated that appropriate self-disclosure creates a safer therapeutic environment, which in turn strengthens the relationship between the counselor and client and encourages more openness from the client. Bunnell (2009) explored appropriate uses of self-disclosure for counselors and supervisors. It was reported that with the help of supervisors, counselors may be able to use their behaviors,
feelings, and thoughts in response to their clients to enhance the therapeutic relationship.

Through supervision, counselors can learn to differentiate between their (counselors’) emotions stirred in the therapeutic relationship and their (counselors’) personal issues from outside of the therapeutic relationship, and, consequently, make better decisions about self-disclosure. Through this educational process, counselors may begin to appropriately use self-disclosure to aid clients in their growth. Further, this focus on allowance of self-disclosure in the therapeutic relationship may also carry over to the supervisory relationship through parallel process (Bernard & Goodyear, 2009; Bunnell, 2009). That is, the supervisor’s understanding of the counselor’s behaviors, feelings, and thoughts in the therapeutic relationship may also impact the supervisory relationship. The counselor may be more open to disclosing behaviors, feelings, and thoughts about the counselor’s relationship with the client when a helpful supervisory relationship has been established (Bunnell, 2009).

Self-disclosure has been broadly used in the field of counseling. However, according to Yalom (2002), three variations exist. First, as a mechanism of therapy, the counselor informs the client about counseling processes, “its basic assumptions, rationale, and what each client can do to maximize his or her own progress” (Yalom, 2002, pp. 84-85). Specifics covered in individual counseling include consent for treatment, the limitations of confidentiality, and the importance of a therapeutic relationship built on trust. The second type of self-disclosure refers to sharing feelings with clients in the here-and-now. Yalom stated that sharing these feelings should be conducted with caution and communicated only if they are in the best interest of the client by facilitating the
client’s progress in treatment. The third type of disclosure describes a counselor’s 
communication about his or her life with the client. He stated that a counselor’s 
disclosure, as a form of modeling, may encourage client disclosure. Also, self-disclosure 
may be in response to the client’s questions. For example, the client may pose a question 
to the counselor such as: have you struggled with an eating disorder? In response to the 
counselor’s stomach growling, the client may ask, did you skip breakfast this morning? 
Yalom suggested that timing is to be considered for this last variation of self-disclosure to 
be effective in facilitating client progress.

An example of self-disclosure is provided to understand the relevance of the term 
to supervision. For instance, a counselor may grow saddened when a client talks about 
death because of feelings for the client’s experience or because he or she (the counselor) 
recently experienced a loss. Self-disclosure would only be appropriate if it was rooted in 
the empathic response for the client’s experience and if it would aid the client in 
treatment (Yalom, 2002). Through supervision, counselors may process appropriate 
versus inappropriate self-disclosure, while also having an opportunity to grow more 
tolerant of their own emotions and their clients’ emotions. Through this enhanced 
acceptance, counselors may be able to understand their clients on a deeper level, and 
model vulnerability and empathy when self-disclosure may be in their clients’ best 
interests (Costin, 2009; Rabinor, 2010). According to Bunnell (2009), supervisors may 
encourage helpful self-disclosure within both the counseling and supervisory 
relationships. Further, this encouragement may facilitate openness in the counseling 
relationship, which then may spread to the supervisory relationship. Within the
supervisory relationship, this openness may facilitate disclosure about the counselor supervisee’s behaviors, feelings, and thoughts about clients and also about the supervisory relationship and processes.

In the current investigation of the supervisory experiences of counselor supervisees who worked with clients with eating disorders, the researcher hoped to expand the understanding of supervision as more than simply a resource to manage countertransference or a method to warn against unhelpful self-disclosure. Through interviews, the current researcher attempted to broaden supervision as a resource and illuminate helpful aspects of the process. The findings may or may not support previous literature about the management of behaviors, feelings, and thoughts in response to clients.

**Supervision of Mental Health Professionals Who Work With Clients With Eating Disorders**

Some authors suggested that supervision may be one way to improve mental health professionals’ ability to manage their unhelpful behaviors, feelings, and thoughts in response to clients and facilitate growth in clients with eating disorders (Dixon, 2009; Delucia-Waack, 1999; Franko & Rolfe, 1996; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Hayes et al., 2011; Zerbe, 2008). Franko and Rolfe’s (1996) quantitative study supports this belief. Through a quantitative questionnaire, they found that 69 (98%) of 71 mental health professionals who worked with clients with eating disorders felt better equipped to manage feelings through supervision or consultation. Hayes et al. (2011) used qualitative interviewing approaches with eight psychologists about their
perspectives of working with clients diagnosed with an eating disorder immediately after their sessions with the clients. A total of 127 interviews were conducted overall. From the participants’ perspectives captured in interviews, supervision facilitated growth in psychologists who work with clients with eating disorders. The researchers concluded that supervision increased psychologists’ “self-insight” or awareness, which may then be used to establish more appropriate boundaries with clients (p. 96). Enhanced “self-integration,” which Hayes et al. (p. 96) described as ability to work through conflicts and grow in acceptance of self, may also come as a benefit of supervision. Studies by Franko and Rolfe (1996) and Hayes et al. (2011), however, failed to identify specifics of supervision that were helpful for mental health professionals. The current investigation may illuminate helpful details of supervision for counselor supervisees.

Theoretical Frameworks of Supervision

Both Hamburg and Herzog (1990) and Delucia-Waack (1999) addressed supervision from a theoretical framework, rooted in the authors’ personal experiences as supervisors of supervisees who worked with clients with eating disorders. These were theoretical frameworks because no formal qualitative or quantitative investigations were carried out with participants about their experiences. Both Hamburg and Herzog (1990) and Delucia-Waack (1999) used parallel process to describe some of the behaviors, feelings, and thoughts in the supervisory relationship that stemmed from supervisees’ work with clients. Therefore, they proposed that parallel process illuminates some of the presenting issues for counselors who work with clients diagnosed with eating disorders.
and they suggested how this may be addressed in supervision. First, a description of parallel process is offered prior to presenting an illustration.

Parallel process describes similar patterns of interaction, with regard to behaviors, feelings, and thoughts, which reappear in supervision after first being noticed in the counselor-client relationship (Bernard & Goodyear, 2009; Friedlander, Siegel, & Brenock, 1989; Morrissey & Tribe, 2001). According to Friedlander et al. (1989), the supervisee may consciously or unconsciously act out similar patterns to his or her client in supervision. Therefore, supervisees may relate to their supervisors in a manner that stems from their interactions with clients. In supervision, when the supervisee mirrors the client’s behaviors, feelings, or thoughts, the supervisor can teach the supervisee how to respond to the client differently. By demonstrating helpful ways of responding to the supervisee, the supervisor models appropriate ways of responding to clients. Then, when the supervisee displays with the client, behaviors, thoughts, and feelings demonstrated by the supervisor, this is referred to as symmetrical parallel process (Bernard & Goodyear, 2009). When symmetrical parallel process is carried out, supervisees may be able to resolve or prevent impasses in the counseling relationship.

For example, if a client discloses helplessness in session, the supervisee may also present with helplessness in supervision. Using parallel process, the complex presenting problems of clients diagnosed with eating disorders may also be present in supervision, manifesting as supervisees’ resistance to their supervisors’ influence (Ekstein & Wallerstein, 1972). Both Delucia-Waack’s (1999) and Hamburg and Herzog’s (1990) articles provided suggestions for supervisors whose supervisees work with clients with
eating disorders by first identifying the counselors’ challenges with clients and then making suggestions for supervisors when behaviors, feelings, and thoughts from the counseling relationship arise in supervision.

**Hamburg and Herzog (1990).** Hamburg and Herzog addressed challenges in supervision by first identifying counselors’ common behaviors, feelings, and thoughts in response to clients with eating disorders and then how a supervisor may assist supervisees. During counseling sessions, Hamburg and Herzog proposed that supervisees who work with clients with eating disorders may struggle with their feelings of frustration resulting from clients’ secrecy, deception, resistance, desire for control, and lack of affect. Hamburg and Herzog stated that the supervisees’ behaviors, feelings, and thoughts may cause an impasse in both counseling and supervision if left unresolved. This was evidenced by counselors’ behaviors, feelings, and thoughts; that is, they may pressure clients for disclosure about their secrets, and disconnect through expressions of anger, helplessness, and hopelessness about client recovery. Counselors may engage in power struggles with clients about the direction for sessions or the attention to safety issues, and counselors may overidentify demographically with clients (e.g., gender), replacing curious inquiry with assumptions about their clients’ experiences.

According to parallel process, feelings within the counseling relationship may reappear in supervision. Therefore, Hamburg and Herzog (1990) recommended that supervisors model openness, flexibility, and balance of support and challenge with their supervisees to broaden their understanding of themselves and their clients. Through supervisors’ modeling, supervisees may be more open to working with their clients in this
manner. The current researcher interviewed counselor supervisees who currently or previously worked with clients with eating disorders to further understand supervisory experiences.

**Delucia-Waack (1999).** Shisslak et al.’s (1989) quantitative research and Zerbe’s (1993) personal reflections provided background information for Delucia-Waack’s (1999) theoretical framework on counselors’ behaviors, feelings, and thoughts in response to clients with eating disorders. Shisslak et al. conducted a survey with 71 medical health professionals. Shisslak et al.’s professionals reported more conscious feelings about food and their physique when working with patients with eating disorders. This consciousness was evidenced as these professionals altered their eating patterns, and focused more on their body image and overall appearance in response to working with patients with eating disorders. Zerbe (1993) cited a personal example of her changes in eating and exercise patterns. In response to a client’s criticism about Zerbe’s body within counseling sessions, she used healthy eating and consistent exercise to cleanse her body of this client’s negative transference and regain positive self-appraisal.

Zerbe (1993) shared her reflections about her changes as a counselor working with clients with eating disorders. Zerbe stated that she was aware of her clients’ negativity and established appropriate boundaries with clients through her coping mechanisms of healthy eating and scheduled exercise. However, Zerbe did not believe that she was free from body dissatisfaction as a counselor who worked with clients with eating disorders and did not view her body dissatisfaction as atypical. She stated that this
lack of acceptance of one’s body as a female, regardless of one’s status as a counselor, may be the norm in a society where many women feel pressured to attain the thin physique ideal. “As ease with one’s body is always more an ideal than a reality for any of us; treaters must be attuned to their own potential psychosomatic vulnerabilities and body image struggles” (p. 173). Therefore, self-awareness was crucial to prevent the client’s issues from negatively impacting the counselor’s self-appraisal.

Similar to Herzog and Hamburg (1990) and Zerbe (1993), Delucia-Waack (1999) stressed the importance of counselors’ reflection on how their clients’ presenting problems may negatively impact them (counselors) and then how supervision could enable counselors to work through these professional and personal setbacks. Delucia-Waack’s theoretical article is referenced because it stands as one of the only articles in the literature that specifically addresses the topic of the current investigation: the supervision of counselors working with clients with eating disorders.

In her theoretical framework, based on her experiences with supervisees who worked with clients with eating disorders, Delucia-Waack (1999) addressed counselors’ behaviors, feelings, and thoughts, as related to body image, food, and weight, when they work with clients with eating disorders. Woven throughout the framework, parallel process is mentioned to show how some of the clients’ behaviors, feelings, and thoughts surface again in supervision. In supervision, supervisees often identify with their clients’ behaviors, feelings, and thoughts. Counselors’ behaviors, feelings, and thoughts included demographic (e.g., gender) or experiential overidentification (e.g., experiencing the thin ideal) with clients; control of food and weight for attainment of the thin ideal; desire to
control life factors; secrecy with regard to food and weight behaviors; helplessness in their ability to challenge clients’ body image and dysfunctional ways of relating to food; and avoidance of affect about body image, food, and weight. Delucia-Waack relied on counselors’ reflections surrounding body size and weight to tease out behaviors, feelings, and thoughts in response to clients, as related to body image, weight, and food. In the following disclosure, one counselor expressed distressed feelings about body size:

She [the client] is comparing her thighs with mine, and mine are bigger. I know how disgusted she feels about fat. What must she be thinking about me? Am I fat? Do I need to lose weight? Do I sometimes judge people based on their physical appearance and size? Am I not paying attention to my body? Am I sending out messages to others that I do not care about myself? (Delucia-Waack, 1999, p. 382)

In this situation, the counselor may have compared herself to the client and may have spent more time focusing on self, rather than balancing the focus on client and self. A balanced focus on the client and self as a counselor displays increased professional development (Leach & Stoltenberg, 1987). When counselors focus more on themselves, they may be unable to listen as fully to the clients’ disclosures and be attentive to clients’ body language. Instead counselors’ emotions may overwhelm their mind and body, preventing them from connecting with their clients. Supervision may help counselors grow in their professional identity development so to balance a focus on themselves and their clients.
The projection of a client’s behaviors, feelings, and thoughts in supervision by the supervisee is an example of parallel process (Shulman, 2005). Supervisors may need to be aware that supervisees can replicate their clients’ attempts to please others through hiding behaviors, feelings, and thoughts. Similar to their clients, these supervisees may withhold information from their supervisors because of their fear of rejection if they reveal their authentic self. For example, if a client is secretive about food patterns in session, the supervisee may unknowingly internalize this negativity towards personal food patterns. For fear of being seen as incompetent or unhealthy, the supervisee may withhold this information from her supervisor (Costin, 2009; Costin & Johnson, 2002).

Also through the parallel process in supervision, these counselors can learn how to more appropriately manage feelings of overidentification. Overidentification is a term used by Delucia-Waack (1999) and Hamburg and Herzog (1990) to describe a type of countertransference, which represents too much similarity in demographics, personality, and experiences between a counselor and client. At times, these experiences may entail a matching between the counselor and the clients with regard to behaviors, feelings, and thoughts. These similarities may limit the counselor’s curiosity about the client’s situation. If the relationship is absent of curiosity, the counselor may make assumptions about the client, rather than asking questions to gain a greater understanding of the client’s behaviors, feelings, and thoughts. Delucia-Waack cited an example of overidentification through a counselor who experienced weight preoccupation similar to her clients. This counselor disclosed,
I weigh myself everyday and I experience negative feelings if I gain weight.

What is dysfunction and what is not? Am I dysfunctional because I think and do some of the same things this client does? Will I ever resort to some of the behaviors this client has (behaviors that sometimes shock and disgust me) in my efforts to control my weight? (p. 383)

This is an example of a counselor wrestling with her thoughts and feelings about her weight. She disclosed concern about her own ability to practice healthy self-care and avoid body dissatisfaction, one of the leading precursors for the diagnosis of an eating disorder (Maine & Kelly, 2005). If this counselor feels uncomfortable disclosing these concerns in supervision, she may feel inadequate in her ability to assist clients with eating disorders. Furthermore, she may avoid discussion of subjects that trigger these thoughts and feelings with clients, even when necessary for the client’s therapeutic growth (Maine & Kelly, 2005).

To facilitate further client growth, Delucia-Waack (1999) suggested that counselors reflect on overidentification individually and with their supervisors. According to Hamburg and Herzog (1990), overidentification is often a common experience for counselors who share similarities in demographic, educational, and cultural backgrounds with a client. Initially, these similarities have the potential to increase empathy for clients’ experiences. However, if the notion of “twinship” or “matching” becomes the foundation of the relationship, counselors may become limited in their perspective, making assumptions about clients, instead of remaining curious to facilitate their clients’ understanding of themselves (Hamburg & Herzog, 1990, p. 374).
According to Hamburg and Herzog, through these assumptions, the counselor takes ownership of the direction of progress, stripping the client of empowerment opportunities. Supervisors may prevent this by discussing overidentification with the supervisee. Supervisors have an opportunity to challenge counselors to reflect on their (counselors’) experiences with clients and they can attempt to help counselors view their (counselors’) experience with the clients from an alternative perspective. Supervisors’ perspectives may support and challenge counselors in their work with clients with eating disorders and they may help counselors become more aware of similarities, or identification, with their clients. Awareness of these issues may strengthen the counselor-client boundary and may limit counselors’ tendencies to overgeneralize their experiences to their clients. Instead, counselors may remain open to listening and facilitating the development of their clients’ unique stories (Hamburg & Herzog, 1990). The current investigation may illuminate these supervisory experiences of counselor supervisees working with clients with eating disorders.

Counselors may also struggle to remain open to clients who present issues of control, and supervision may aid counselors in managing this struggle more effectively (Delucia-Waack, 1999). Displays of control may be extreme in that clients may either want their counselor to take full responsibility for progress, or they may oppose their counselor’s influence. If the counselor takes too much ownership within treatment, the counselor does not challenge the client to take responsibility for changing dysfunctional behaviors, feelings, and thoughts. The client may leave treatment with insecurity and doubt about independently maintaining health and may be unable to uphold recovery
outside of a controlled environment. However, if the counselor takes no control, the client may feel encouraged to maintain the illness, believing that the symptoms are not a problem. Therefore, too much control from either the counselor or the client may impede the counseling process. Supervisors may limit control issues by supporting supervisees in balancing the clients’ needs for ownership of the treatment process, while challenging clients to progress toward symptom relief.

Delucia-Waack (1999) wrote about displays of control in counseling and supervision. The supervisor must be certain to balance control through support and challenge in order to focus on both the supervisee’s and the client’s development. Supervisees may also desire their supervisors’ direction, though they will never develop their unique professional identity if the supervisor limits their freedom to discover competencies and areas of potential growth. Yet, supervisors must also be attuned to ethical and safety issues, especially with clients presenting Axis I and II comorbidity (APA, 2013; Carpenter, Hasin, Allison, & Faith, 2000), health complications (Cleveland Clinic Center for Continuing Education, 2010; Mayo Clinic, 2010; NEDA, 2006; The Renfrew Center Foundation for Eating Disorders, 2003), mortality concerns (ANAD, 2011; APA, 2003; Crow et al., 2009; Fichter et al., 2008; Keel & Mitchell, 1997), and suicidal ideation (ANAD, 2011; Milos et al., 2003; NEDA, 2011). Supervisors must verify the ethical and safety standards of client care, despite clients’ initial lack of disclosure to their counselors.

Delucia-Waack (1999) encouraged supervisors to discuss the secretive nature of clients with eating disorders with their supervisees. Clients with eating disorders are
often secretive about their behaviors, feelings, and thoughts, thus supervisees may have
difficulty trusting disclosures. In the face of secrets, supervisees may express
“helplessness, ineffectiveness, and inadequacy” (p. 384), believing the client desires no
change. However, Delucia-Waack instructed supervisors to discuss patience with
supervisees. The client may be holding on to the secrets because they do not yet feel
comfortable enough in relationship with the supervisee to reveal the shame often aligned
with eating disorders. Per parallel process of supervision, the supervisee may replicate
the client’s shame, fear judgment from a supervisor, and avoid disclosure of
dysfunctional behaviors, feelings, and thoughts with regard to body image, food, and
weight. If neither relationship between the supervisee and client, nor supervisor and
supervisee progresses to a level of authenticity, the potential for progress in counseling
may remain limited.

According to Delucia-Waack (1999), supervisors must also understand
alexithymia, or impasses in counseling resulting from clients’ avoidance of affect.
Alexithymia describes a disconnection between verbiage and emotions (Barth, 2008).
Despite articulate disclosures about emotions, individuals presenting with alexithymia do
not feel them. When the conversation remains cerebral, lacking engagement of emotions,
the establishment of an effective therapeutic relationship is challenging for counselors
(Zerbe, 2008).

Instead of simply describing these clients as purposely evading emotions, Kaplan
and Garfinkel (1999) explained clients’ starvation as the cause for absence of emotions.
When a client is suffering from starvation, the cognitive deficits prevent treatment, as the
client is unable to express emotions and participate in the therapeutic session. Therefore, despite counseling and pharmacological interventions, clients often fail to respond positively to treatment until nutrition resumes. According to Zerbe (2008), counselors struggled to facilitate intimacy within their therapeutic relationships with eating disordered clients. Delucia-Waack (1999) suggested that this superficiality may impact counselors’ relationships with their supervisors, as they project their clients’ fears of vulnerability into supervision.

Delucia-Waack (1999) concluded that supervisees needed to examine their body image, and relationship with food and weight to effectively facilitate growth in clients diagnosed with eating disorders. This examination may take place through disclosure in supervision if they are able to be vulnerable with their supervisors. After processing their behaviors, feelings, and thoughts in response to clients in supervision, they may grow more aware of how their body image, and relationship to food and weight may impact their work with clients. This awareness may enable them to more effectively facilitate growth in clients. They may also be more intentional about maintaining self-care and seeking support from their supervisors for challenges in working with clients diagnosed with eating disorders. If these supervisees are unable to uphold a healthy relationship with their body, food, and weight, Zerbe (1993) indicated they may be unable to challenge their clients’ presentations of dysfunction.

Delucia-Waack (1999) recommended specific techniques to increase the examination of body image, food, and weight in supervisees working with clients with an eating disorder diagnosis. Recommended processes for supervisors to use in supervision
with supervisees included reading material with reflection exercises, guided imagery for supervisees to recognize overidentification with clients and increase their empathic responses, and probes about supervisees’ reactions to their clients’ disclosure. Through reflection, the supervisee is given an opportunity to become more aware of self in relation to the client. Through the probing technique, the supervisee is challenged to better understand self and the client within their unique therapeutic relationship. This probing may include questions, such as,

What was it like to hear a [client] talk about her behavior in that way? Who does the [client] remind you of? Why? How do you deal with this person? Is it effective? If not, why not? How are you similar or different? How do your similarities or differences influence your behavior with that [client]? Do you overtly or subtly reinforce dysfunctional behaviors or attitudes? Why?

(Delucia-Waack, 1999, p. 386)

Delucia-Waack (1999) stressed the importance of examination of behaviors, feelings, and thoughts in response to clients, regarding issues related to body image, food, and weight. Counselors’ behaviors, feelings, and thoughts included demographic or experiential overidentification (e.g., gender, experience of the thin ideal) with clients; control of food and weight for attainment of the thin ideal, desire to control life factors; secrecy with regard to food and weight behaviors; helplessness in their ability to challenge clients’ body image and dysfunctional ways of relating to food; and avoidance of affect about body image, food, and weight. Once specific behaviors, feelings, and thoughts were identified, Delucia-Waack focused on the supervisees’ management of
these in response to clients, through the supervision of the supervisees who work with clients with eating disorders. Specific supervisory interventions she addressed focused on increasing supervisees’ awareness and these included: reflection exercises, guided imagery, and probes about their reactions to clients. Delucia-Waack’s identification of potential challenges for counselors, as they work with clients with eating disorders, may enable greater understanding of the role supervision may play as a resource.

The conversation about supervising counselors who work with clients with eating disorders has been initiated, though a limited amount of research about these counselors’ supervisory experiences exists. Further investigation of specific experiences of supervision for supervisees who work with clients with eating disorders may illuminate helpful practices. Findings from the current investigation may potentially enable further advancements in the practice of supervision as a resource for supervisees who work with clients with eating disorders.

**Supervision Models**

Supervision models that are discussed in this dissertation include (a) a developmental model (Stoltenberg, 2005), (b) a Systems Approach to Supervision (Holloway, 1987, 1995), (c) a social role model (Bernard, 1979), and (d) constructionist models (Edwards & Chen, 1999; Gazzola & Theriault, 2007; Gray & Smith, 2009; Molnar & de Shazer, 1987; Murphy & Wright, 2005; Parry & Doan, 1994; Worthen & McNeill, 1996). According to the Discrimination Model (Bernard 1979; Bernard & Goodyear, 2009), the Systems Approach to Supervision (Holloway, 1995), and the Integrated Development Model (Stoltenberg, 2005), the focus of supervision is on
supervisees and the manner in which supervisors facilitate their (supervisees’) growth. In comparison, constructionist approaches focus on the collaborative supervisory relationship where a balance of support and challenge empowers supervisees (Edwards & Chen, 1999; Gazzola & Theriault, 2007; Gray & Smith, 2009; Molnar & de Shazer, 1987; Murphy & Wright, 2005; Orlinsky, Botermans, & Rønnestad, 2001; Parry & Doan, 1994; Worthen & McNeill, 1996).

Clients diagnosed with eating disorders, counselors working with clients with eating disorders, and the therapeutic relationship between these counselors and clients have already been discussed in the research, and these must be considered. The current researcher investigated topics not explored, and these included how the treatment of eating disorders may ignite special consideration for the supervisor, the supervisee, and the supervisory relationship. Therefore, the remainder of this chapter focuses on how supervisors can work with supervisees to facilitate their development and enable them to effectively promote client growth for individuals diagnosed with eating disorders.

From previous literature referenced in this chapter, the reader is now aware that counseling clients diagnosed with eating disorders is challenging, since they present with complex needs. Due to clients’ complexity, supervisees may also present with unique needs. Four models that consider the unique needs of both supervisees and clients are the Integrated Development Model (IDM; Stoltenberg, 2005), the Systems Approach to Supervision (Holloway, 1995), the Discrimination Model (Bernard, 1979; Bernard & Goodyear, 2009), and constructionist approaches of Solution-Focused Supervision (Molnar & de Shazer, 1987) and Narrative Supervision (Parry & Doan, 1994). These
models are referenced because they each consider the unique individual differences and characteristics of both the supervisees and clients, though they are diverse in their theories and practices of supervision. Aspects of these models, including facilitating supervisees’ development (Stoltenberg, 2005), considering the contextual systems of the supervisee (Holloway, 1987), balancing the roles of teacher, consultant, and counselor (Bernard, 1979), facilitating an collaborative relationship with supervisees (Gray & Smith, 2009), focusing on the supervisees’ strengths to find solutions (Molnar & de Shazer, 1987), and collaborating in the recreation of the supervisees’ professional story (Parry & Doan, 1994) may be illuminated in the interviews of supervisees about their supervisory experiences.

**Stoltenberg’s Integrated Development Model.** Development of supervisees has been researched with regard to mastery of stages (Stoltenberg, 2005). Stoltenberg’s (2005) IDM described supervisee development as progressing through four stages: (a) Level One: self (counselor)-focus, (b) Level Two: self (counselor) begins to combine with other (client) focus, (c) Level Three: self (counselor) is balanced with other (client) focus, and (d) Level Three (i): self (counselor) is balanced with other (client) focus where client populations are diverse (Stoltenberg, McNeill, & Delworth, 1998). In each of these four stages, growth is evaluated on the following structures: self-other awareness, motivation, and autonomy. Stoltenberg et al. (1998) defined self-other awareness as ideally balancing the awareness of self with the awareness of the client in session. Motivation is noted as the supervisee’s interest and investment in his or her counselor development. Autonomy means that the supervisee feels confident working with clients,
making decisions, and taking responsibilities for his or her actions in sessions without constant supervisor direction. Therefore, a supervisee who has reached maturation with regard to these three structures refers to supervision primarily for consultation purposes. As the supervisee progresses through the four stages he or she grows in these three structures with the clients with whom he or she works. A supervisee may reach maturation when working with a specific group of clients, but fail to fully develop in these three domains when introduced to a new population, such as clients diagnosed with eating disorders. Regarding the current investigation, this may be mentioned in the participants’ disclosures about their supervisory experiences.

In addition to development in the three structures of self-other awareness, motivation, and autonomy, Stoltenberg, McNeill, and Crethar (1994) further discussed supervisee development across the following skills: (a) intervention skills competence, (b) theoretical orientation, (c) appreciation of individual differences, (d) interpersonal assessment, (e) assessment techniques, (f) diagnosis and treatment planning, (g) application of professional ethics, and (h) client case conceptualization. Intervention skills competence describes the supervisee’s ability to appropriately apply interventions in sessions. Theoretical orientation means that the supervisee is knowledgeable in viewing his or her clients’ presenting problems through a myriad of theoretical lenses. Individual differences means the supervisee is aware of cultural differences, including gender, race, and ethnicity, and how these may impact their clients’ experience in counseling. For clients diagnosed with eating disorders, this may include an awareness of the socially constructed thin ideal for female physique in the United States. With this
awareness, the supervisee may be more equipped to understand the impact of these messages on clients’ behaviors, feelings, and thoughts about their bodies. Interpersonal assessment is explained as a step beyond formal assessment, when supervisees are able to consider themselves and how their identity impacts their ability to conceptualize cases. Assessment techniques are defined as confidence and ability to conduct psychological evaluations with clients. Diagnosis and treatment planning refer to the clinician’s ability to accurately diagnose and then align goals and interventions with the diagnosis to reduce symptoms. Professional ethics means the counselor upholds the rules and regulations of their licensing board to avoid harm to clients. Client case conceptualization is closely linked to diagnosis and treatment planning. When conducted appropriately, the counselor is able to holistically contemplate the client’s symptoms by considering the history, manifestation, external context, and exacerbating factors which impact current functioning. According to Stoltenberg et al., a fully developed supervisee demonstrates all these skills.

Support for a focus on the development of the supervisee in supervision is noted through Worthen and McNeill’s (1996) phenomenological research of positive supervisory experiences. Through Worthen and McNeill’s study, they illuminated events that contributed to “good” supervision (p. 25). Worthen and McNeill noted that the supervisor’s level of support was directly dependent on the supervisees’ stage of development. For example, those supervisees in their first stage of development, who were counseling for the first time in practicum, needed affirmation to counter their global sense of inadequacy as a counselor. More experienced supervisees in a later stage of
development, often in internship, reported a need for direction and support in specific areas of their work with clients. For example, in Worthen and McNeill’s study, three of the four practicum supervisees reported negative supervisory experiences they believed were influenced by lack of support, responsiveness, respect, understanding, acceptance, and trust in the supervisory relationship. Worthen and McNeill purported that these negative supervisory experiences may be related to supervisors’ lack of training in developmental supervision models. For example, knowledge of the IDM model enables supervisors to first identify supervisees’ developmental stage and consider supervisees’ experience with specific clientele. Once this assessment is made, the supervisor hones in on skills that are developmentally appropriate for the supervisee when working with particular clientele. This awareness of the supervisees’ developmental stage may enable supervisors to meet their supervisees’ unique needs. When supervisees’ unique needs are met, they (supervisees) may experience more positive feelings about their (supervisees’) supervisory experiences. Last, Worthen and McNeill stated that positive experiences were more common within strong supervisory relationships. Within these strong supervisory relationships, supervisees described: (a) supervisor self-disclosure to normalize supervisees’ deficits; (b) an environment where the supervisee was free to try different approaches with clients; (c) the supervisor facilitated learning of skills that were developmentally aligned with the supervisee; and (d) the supervisor expressed support, acceptance, understanding, responsiveness, respect, and trust. Worthen and McNeill revealed the importance of understanding supervisees’ developmental stages in order to
provide “good” supervisory experiences (p. 25). The current study may reveal this as contributing to a positive supervisory experience as well.

Stoltenberg’s (2005) research is pertinent to the current investigation about the supervisory experiences of supervisees working with clients with eating disorders. Within Stoltenberg’s developmental process, the supervisee may progress from Levels One through Three, but then struggle at Level Three (i) when applying skills in working with the specific population of clients with eating disorders. Supervisors create a positive supervisory experience for supervisees when they facilitate learning of skills that are developmentally aligned with the supervisee. Therefore, assessment of the supervisees’ unique needs when working with clients with eating disorders may appropriately support them in their development with this specific population. The current investigation hoped to bring further understanding of what contributed to supervisees’ development as they worked with clients with eating disorders.

**Holloway’s Systems Approach to Supervision.** In comparison to Stoltenberg’s (2005) IDM model, Holloway’s focus on the systems of the supervisee places much more emphasis on the contextual features of the supervisory process, including the social systems, and the unique environmental influences of both supervisees and clients. For supervisees and clients with eating disorders, their social and environmental systems may be impacted by the social construction of the thin ideal physique for women in the United States. How supervision manages the impact of this social construction on supervisees may be one aspect that evolves from the current
investigation on the supervision of supervisees who work with clients with eating disorders.

Holloway (1987) created a tailored systems approach where the supervisor engages in a task (e.g., monitoring, instructing) to promote the supervisee’s function (e.g., counseling skill, case conceptualization) in order to enhance client care. In her approach, Holloway (1995) considered the factors of the supervisory relationship, including phases, contract, and structure; institutional context where supervision is conducted; and client, supervisee, and supervisor characteristics. Consideration of the unique characteristics of all parties within different contexts may be necessary when considering the unique needs of clients with eating disorders. With regard to the supervisory relationship, the phases refer to the relational development between the supervisor and supervisee. The supervisory contract outlines and clearly explains expectations for both the supervisee and supervisor. Specifically, when considering the supervisory contract, the supervisor must inform the supervisee about the evaluation criteria, supervision goals and expectations, and the limits of confidentiality. The supervisory structure rests on the foundation of power sharing within the supervisory relationship, as the supervisor strives to empower the supervisee to exercise determination and self-control.

Holloway (1994) combined the supervisor’s tasks, also referred to as the “how” of supervision, and supervisee’s functions, or the “what” of supervision, to facilitate a collaborative growth process. The supervisor’s tasks include: (a) monitoring and evaluating, (b) instructing and advising, (c) modeling, (d) consulting, and (e) supporting
and sharing. The supervisee’s functions are: professional role development, emotional awareness, counseling skills, case conceptualization, and self-evaluation of strengths and weaknesses to facilitate client progress.

According to Holloway (1994), an effective supervisor is able to fulfill many tasks within the supervisory relationship. Through monitoring and evaluating, the supervisor conducts both formative and summative evaluations to allow the supervisee to remain current on his or her progress. A supervisor instructs and advises a supervisee when his or her experience may aid in the supervisee’s development. The supervisor’s advising will decline as the supervisee progresses in experience. A supervisor models behavior when working with supervisees, sometimes via role-playing. Through consulting, the supervisor facilitates collaborative communication with the supervisee to process clients’ needs. The supervisor practices the tasks of supporting and sharing by balancing encouraging and challenging comments with the supervisee, while sharing his or her perceptions about the supervisee’s actions, emotions, and thoughts.

The supervisee’s functions are equally important in the task-function combinations of supervision (Holloway, 1994). One of the supervisee’s functions, professional role development, is explained as the supervisee’s ability to effectively facilitate growth for clients while upholding ethical boundaries and mandates. The supervisee’s emotional awareness is considered individually, for the supervisee, and within relationships. This means that the supervisee is aware of his or her emotions and how they interact with others’ emotions within a relationship. The supervisee can then
better understand the impact of his or her emotions on the clients and manage them to promote client growth.

Counseling skills refer to the supervisee’s ability to communicate effectively with clients, display empathy, and appropriately implement a myriad of counseling techniques. A supervisee’s ability to case conceptualize depends on his or her understanding of the client’s history and presenting problems to form a diagnosis and create a treatment plan. Self-evaluation of the supervisee allows for reflection on strengths and weaknesses to facilitate client progress. And in the current investigation, it may be that the supervisee’s acquisition of functions requires additional time or resources within supervision when considering clients with eating disorders.

**Bernard’s Discrimination Model.** Bernard (1979) created a model that focuses on two aspects of the supervisory relationship: role and function. According to Bernard and Goodyear (2009, p. 52), the supervisor roles of teacher, counselor, and consultant, are used to facilitate the growth of the supervisee in three areas: intervention (previously referred to as process), conceptualization, and personalization. The role of teacher is directive and used to educate and inform supervisees. In the role of counselor, the supervisor attempts to help a supervisee become more reflective about issues related to intervention, conceptualization, and personalization. The consultant role of the supervisor is intended for collaboration with supervisees. The supervisor uses the roles of teacher, counselor, and consultant to address three areas of focus for supervisees. The supervisor addresses the focus of intervention, originally referred by Bernard (1979) as process, when she assesses how the supervisee communicates with clients (e.g., reflection
of clients’ emotions; reframe of a situation). The supervisor uses the focus of conceptualization to evaluate supervisees’ ability to provide rationale for their facilitation of therapy based on a client’s presentation. Personalization is how a supervisee presents oneself in the therapeutic relationship.

Bernard’s (Bernard & Goodyear, 2009) Discrimination Model may be especially helpful for supervisees who work with clients with eating disorders because their unique needs within supervision are considered throughout the process. The supervisee’s unique needs determine the supervisor’s role and facilitation of skills. For example, if the supervisee presents with frustration around a client’s secrecy about eating patterns, the supervisor may use his or her role as counselor to facilitate personalization skills to aid the supervisee in better understanding the meaning behind this frustration and how to prevent this feeling from limiting the growth of the therapeutic relationship. In response to this example, the supervisee’s frustration may never be processed if the supervisor remained rigid in his or her stance as teacher, rather than counselor. The role of teacher may be used, for example, when teaching a supervisee how to uphold the safety of clients by conducting a thorough suicidal assessment. The role of consultant may be used when the supervisee is further along in his or her identity development as a counselor and may be brainstorming additional ways to work with a client when progress is stagnant.

Bernard suggested that the roles of teacher, counselor, and consultant be tailored to meet supervisees’ unique needs, yet complete exclusion of any of these roles in supervision was not recommended. Supervisees may require these roles from the supervisor at some point during the supervisory process. In the current study about supervisory experiences
with clients with eating disorders, participants might identify roles noted by Bernard (1979) and Bernard and Goodyear (2009) as helpful in supervision.

**Constructionist supervisory approaches.** For constructionist supervisory approaches, a collaborative relationship between the supervisor and supervisee is crucial (Bernard & Goodyear, 2009; Gray & Smith, 2009). Within this supervisory relationship, the strengths of the supervisee are stressed, instead of deficits. The use of constructionist approaches in supervision, where multiple truths and perspectives are upheld, may be helpful in supervisors’ understandings and openness to their supervisees’ work with clients. However, this may also prove to be challenging for a novice supervisee who is uncertain how to uphold ethical practices in areas such as confidentiality or dual relationships. The current researcher’s investigation may uncover times when it was helpful to use this approach in supervision.

Anderson (2002) and Edwards and Chen (1999) supported constructionist approaches to supervision when emphasizing the importance of collaboration within supervision. Anderson described this approach as a collaborative community, whereas Edwards and Chen referred to the method as Wu-wei. Anderson’s and Edwards and Chen’s perspectives stressed the importance of a cooperative supervisory relationship. Within Anderson’s collaborative community, connection and collaboration within the supervisory relationship lead to the construction of the supervisees’ counselor identity through a co-creation and sharing of knowledge, in addition to intentional reflection. Through reflective dialogue, the supervisee grows in understanding of self and others, which aids in counselor identity development. Edwards and Chen’s Wu-wei method is a
postmodern supervisory approach, where the supervisor and supervisee share knowledge and power within the supervisory relationship. The supervisor admits to not having the answers to all of the supervisee’s questions and does not assume that he or she (supervisor) has all of the skills to work effectively with clients. The supervisee, alongside the supervisor, takes ownership of one’s development and effectiveness in working with clients. The person of the supervisee is valued, and this supervisee takes time to reflect on how his or her unique personal characteristics may be used to facilitate a working alliance with clients. The method rests on the notion of collaboration and co-construction of meaning and solutions with supervisees. Edwards and Chen suggested that this type of supervision may be referred to as “covision and cocreated vision” (p. 353). This covision allows the supervisor to share responsibility for facilitating therapeutic meaning and direction with the supervisee. This strength-based standpoint in supervision may enhance supervisees’ feelings of capability in working with clients.

To explore constructionist approaches to supervision, Murphy and Wright (2005) investigated power dynamics in the supervisory relationship by interviewing 11 supervisees (3 men and 8 women) who were members in the Commission on Accreditation of Marriage and Family Therapy Educational Training Program. The researchers used a grounded theory methodology to create a theory about power within supervisory relationships. Murphy and Wright’s results expanded on the purpose of collaborative supervision as an empowering process for the supervisee. Their theory explained that power is not held by the supervisor alone within this relationship, but rather shared to allow for an empowering developmental experience for the supervisee.
In their research, Murphy and Wright (2005) posed questions to supervisees including, but not limited to, the following:

How does power in the supervisory relationship help [or] hinder you in your training? Do you feel you have power during the supervision session? Do you believe a supervisor has power with you as a supervisee? When you think of power, what do you think of? (p. 285)

Their results revealed positive uses of power by the supervisor: (a) the supervisor discussing power in supervision; (b) the supervisor providing viewpoints through disclosure of ideas, feedback, and summative and formative evaluations; (c) the supervisor empowering supervisees by allowing them freedom to take ownership of their therapeutic techniques with clients and affirming them when they felt doubtful and anxious about their professional development or uncertain about choices they made with clients; (d) the supervisor providing a secure base, including the maintenance of supervisees’ confidentiality, to support supervisees in trying out new techniques with clients; (e) the supervisor facilitating a collaborative exchange of opinions about the therapeutic processes; and (f) the supervisor informing supervisees about expected responsibilities with clients. Essentially, the participants felt safe under the instruction of a supervisor, yet wanted to use this time to better understand themselves as supervisees by having the opportunity to try out different techniques and ways of being in session with their clients. For example, with regard to safety, one supervisee stated, We knew with our supervisor what the boundaries were, and then because we knew, we felt safe to do and to talk about different things, we knew he was going
to keep us safe, but it was also that he wasn’t going to abuse his power. (Murphy & Wright, 2005, p. 288)

Their research supports the notion that a safe foundation contributes to collaborative and empowering supervisory relationships.

Further supporting the notion of a secure base to facilitate constructionist supervisory approaches, Pistole and Watkins (1995) addressed the importance of safety in supervision in order to facilitate a collaborative working supervisory alliance. Pistole and Watkins described the necessary secure base to allow supervisees the freedom to develop individually and feel empowered to process their efforts with clients. Knowing they have appropriate support to ensure the safety of clients, supervisees can use supervision to grow more fully in counselor identity development. This process allows the supervisor to facilitate the supervisee’s development from close monitoring and instruction to increased independence to the final goal of a collaborative supervisory relationship.

Two types of constructionist approaches to supervision are solution-focused supervision (Molnar & de Shazer, 1987) and narrative supervision (Parry & Doan, 1994). Both approaches stress a collaborative working relationship between the supervisor and supervisee to help improve the supervisees’ counseling (Bernard & Goodyear, 2009; Juhnke, 1996; Selekman, 1995). According to Selekman, solution-focused supervision stresses both supervisees’ and clients’ strengths. In supervision, the supervisor focuses on what is working for the supervisee in session with clients. The supervisee then uses his or her strengths as a counselor to help clients reach their goals. Narrative supervision uses a “storying” approach to support supervisees in recreating their professional story as
counselors (Parry & Doan, 1994). The supervisees then use their newly created story of themselves as counselors and work as co-editors in forming alternative stories to replace the clients’ problem-saturated stories.

The supervisor who implements solution-focused techniques with supervisees focuses on establishing a collaborative relationship in which supervisees are able to realize their strengths to become the counselors they wish to be. The supervisor uses techniques such as: (a) finding exceptions to supervisees’ presenting problems in their work with clients; (b) recognizing past successes with clients; (c) becoming more aware of unrecognized resilience and coping; (d) using the miracle question to envision future success and competence; (e) using scaling questions to envision progress in steps, rather than through absolute evaluation via either success or failure; (f) complimenting the supervisee for the purpose of support and encouragement; and (g) facilitating questions about supervisees’ progress for the purpose of motivation (Gray & Smith, 2009). The use of solution-focused supervision may be especially helpful when counseling clients with eating disorders to shift the focus from the complexity and challenge of the work to areas where the supervisee is having success with clients.

Through narrative approaches to supervision, the supervisor listens to the supervisee’s retelling of the client’s story and together they work on understanding how the supervisee experiences this story. In collaboration, the supervisor and supervisee reflect on the influences of the story, including, but not limited to, individual differences and aspects related to gender, religion, culture, and power (Gray & Smith, 2009). From this reflection, the supervisor and supervisee may converse about differences pertaining
to experiences, values, beliefs, and biases and how these may impact the supervisee’s ability to co-edit the client’s story with the client in session. The supervisor may utilize the following techniques with supervisees: (a) collaborative reflection on the details of the client’s story the supervisee presents in session, specifically why they are meaningful for the supervisee to discuss; (b) challenge of supervisees’ perspectives or opinions of “stuck” or “helpless” clients by teaching them to facilitate an externalization of the problem; (c) education about the definition of externalization, known as seeing the problem separate from the client, to shift supervisees’ perspective away from the client as the problem; (d) utilization of unique outcome questions to predict different client results; (e) use of questions about how others may evaluate the supervisee to enable the supervisee to see improvement in his or her professional identity; and (f) practice using a metaphor for the supervisee’s emerging professional identity to enable the supervisee to focus on future progress (Gray & Smith, 2009). For example, a supervisee may create a metaphor of a runner to have courage and strength to keep moving forward despite obstacles in their work with clients. In conclusion, these constructionist approaches to supervision, including solution-focused and narrative envisioning and “storying” of future experiences, may be illuminated through the current research.

**Broadening and Narrowing Supervisory Practices for Empowerment**

The current investigation explored the supervisory experiences of supervisees who work with clients with eating disorders. Practices of broadening and narrowing for empowerment have been identified in some supervisees’ descriptions of their experiences (Frederickson, 2001; Gazzola & Theriault, 2007; Worthen & McNeill, 1996). Regardless
of supervision models, some of the techniques for broadening are evident; however, there may also be times when narrowing of the supervisory conversation may be helpful, especially when considering the importance of a safe foundation. According to Frederickson (2001), when supervisors facilitate a larger perspective or multiple ways of responding to clients, they have helped the supervisee broaden his or her perspective and facilitated development and, when the supervisor controls the supervisee’s actions, a narrowing effect on the supervisee’s perspective occurs. Frederickson coined the terms broadening and narrowing to describe particular supervisory practices used to facilitate supervisees’ development. A study by Gazzola and Theriault (2007) and another investigation by Worthen and McNeill (1996) used these terms to describe outcomes in their research.

According to Frederickson (2001), broadening enables positive thoughts and feelings about supervisees’ processes in relationship to their supervisors and clients. These positive thoughts and feelings often lead to flexibility and creativity of supervisees within both supervisory and counseling sessions. Gazzola and Theriault (2007) further explained broadening procedures as providing a supervisee with opportunities to take initiative in their work with clients. Broadening procedures are facilitated within a “nurturing, compassionate, supportive, non-judgmental, and respectful” environment by a supervisor who exhibits “interest, enthusiasm, positive energy, creativ[ity], sense of humor, availab[ility], flexib[ility], and open[ness] to differences” (p. 196). Within this environment, the supervisors are intentional about validating their supervisees’ perspectives and providing development, through “promot[ing] autonomy, modeling,
constructive feedback, and challeng[ing] supervisee to go beyond [his or her] comfort zone” (p. 196).

Frederickson (2001) stated that narrowing processes tend to constrain the supervisees’ actions and decisions, as the supervisor holds the control and guides the supervisee with regard to using specific procedures with clients. These narrowing processes may be considered negative when they limit the supervisee’s freedom to engage in his or her own professional development, and instead encourage imitation of the supervisor’s style and directives. Specific narrowing behaviors demonstrated by supervisors were “being inflexible, providing inadequate feedback; contributing to dysfunctional relational dynamics; and showing a lack of sensitivity” (Gazzola & Theriault, 2007, p. 195). Inflexibility was predominantly aligned with theoretical orientation. For example, a supervisor may push a counselor to use Reality Therapy approaches, when Cognitive Therapy approaches may resonate more for a particular supervisee with a specific client. Inadequate feedback was another example of narrowing when it is identified as vague, not concrete or practical enough, or lacking a positive perspective. For example, a supervisor may fail to be specific or suggest an unbalanced perspective of negative and positive comments in recommendations to a supervisee. Dysfunctional relational dynamics were defined by insufficient respect, ambiguous boundaries, and limited allowance of supervisees’ perspectives. Insensitivity was aligned with criticism, judgment, and enforcement of rigid counseling procedures with supervisees. However, narrowing processes, for example, may be beneficial to ensure ethical and safety standards for confidentiality, consent, and suicidal assessments.
Allowing the supervisee to find his or her own way in these particular situations may create unnecessary risk for clients.

Using the terms of broadening and narrowing to describe supervisory processes, Gazzola and Theriault (2007) researched supervisory experiences to tease out factors contributing to supervision effectiveness. Gazzola and Theriault asked 10 supervisees, enrolled in a Canadian counseling master’s degree program (one male and nine females), using semi-structured interviews, about positive and negative aspects of their supervisors. Gazzola and Theriault examined these positive and negative aspects more specifically through the supervisory alliance. They found that a close working alliance was created through appropriate use of broadening and narrowing processes. Gazzola and Theriault concluded that supervisees rated a balance between broadening and narrowing processes most positively, where more flexibility was aligned with therapeutic approaches, and more rigid processes applied to safety and ethical concerns. Therefore, both broadening and narrowing processes may be helpful for supervisees in supervision because effective supervision requires attention to balance (Gazzola & Theriault, 2007; Worthen & McNeill, 1996).

Within supervisory discussions, this balance of broadening and narrowing processes first pertains to devoting attention to the needs of both clients and supervisees. Then, within the supervisory relationship, the supervisor must be intentional about moderating support with challenge, and supervisee independence with dependence. A balance of support with challenge, and supervisee independence with dependence is essential, though this distribution is dependent on the supervisee’s needs. For each
supervisee, the supervisor analyzes the supervisee’s professional needs, aligns support and challenge with the supervisee’s developmental stage, and offers more instruction and support anytime the supervisee works with unfamiliar clientele. For the supervisor to master these tasks, he or she must spend time reflecting on the needs of both the clients and supervisees (Dixon, 2009; Scaife, 2010). The supervisor’s ability to appropriately balance broadening and narrowing processes with supervisees may impact their (supervisees’) experiences as they work with clients with eating disorders. The participants in the current investigation may refer to these approaches within their descriptions of their supervisory experiences.

Supervisory Relationship

According to Bernard and Goodyear (2009), the relationship between the counselor supervisor and counselor supervisee

Is evaluative and hierarchical, 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 he, she, or they see, and serving as a gatekeeper for those who are to enter a particular profession. (p. 7)

According to Bernard and Goodyear, this relationship may be either effective or ineffective in providing a safe place to balance the supervisory needs of the supervisee, while ensuring safety and ethical standards for the client or clients. The hierarchical nature of this relationship differs depending on the supervisors’ approach to supervision. For example, as mentioned previously, supervisors who demonstrate constructionist
approaches would share a collaborative relationship with their supervisees (Gray & Smith, 2009).

The supervisory relationship is an important component in the facilitation of supervisee development (Gazzola & Theriault, 2007; Orlinsky et al., 2001; Worthen & McNeill, 1996). Within this relationship, Winters (1994) stated that gender was a crucial factor to consider, as both the supervisor and supervisee carry gender-related beliefs and values. For example, Winters stated that relational needs may be a priority for females, yet they may not be as important for males who may be more independent. Winters believed that feminist theory might be helpful in supervision, where the supervisor shares power with the supervisee, allowing for intrapersonal and interpersonal needs to be met. This collaborative stance in supervisory relationships aligns with constructionist approaches (Gray & Smith, 2009).

Orlinsky et al. (2001) supported the importance of creating a strong supervisory relationship. From their quantitative survey of 4,923 therapists in a myriad of international locations, supervision was the second most important factor in their professional development, while actually practicing therapy with clients was first. An exception was reported among therapists who had been practicing for less than 18 months. For these participants, supervision was most crucial for their professional development. Within the realm of supervision, these therapists believed that the supervisory relationship was much more salient than other aspects of their educational process.
Worthen and McNeill (1996) also focused on the importance of a strong supervisory relationship to facilitate more positive experiences in supervision. They conducted a phenomenological investigation of eight advanced level trainees (four women and four men) on their descriptions of a “good supervisory experience” (p. 25). Themes about a “good supervisory experience” emerged from the open-ended prompt, “Please describe for me as completely, clearly, concretely as you can, an experience during this semester when you felt you received good psychotherapy supervision” (p. 26). Worthen and McNeill discovered that a supervisor who “conveyed an attitude that manifested empathy, a nonjudgmental stance toward them, a sense of validation or affirmation, and encouragement to explore and experiment” constituted a “good supervisory experience” (p. 29). Supervisors’ support allowed supervisees to safely explore alternative ways of being with clients to facilitate progress. Supervisory tasks must be performed within a strong supervisory relationship for the experience of supervision to be helpful in facilitating supervisee growth (Orlinsky et al. 2001; Worthen & McNeill, 1996).

**Multiculturalism.** Supervisees reported more positive supervisory experiences when supervisors initiated conversation around cultural variables including ethnicity, gender, and sexual orientation (Gatmon et al., 2001). After Gatmon et al.’s (2001) sample of 289 predoctoral psychology interns completed surveys, correlational analyses revealed significant positive correlations between the supervisory relationship and quality of discussions about all three cultural variables. In their conclusions, it was noted that supervisors seldom initiated discussions about these variables despite the fact
that supervisees felt the discussions often enhanced relationships with their supervisors and sometimes led to more positive experiences in supervision. Of all three cultural variables, supervisors were least likely to bring their supervisees’ sexual orientation into the conversation. Gatmon et al. suggested that supervisors may not be initiating these conversations because they lack the confidence to discuss these; consequently, Gatmon et al. called for more advanced multicultural training for supervisors.

**Significance of gender.** Gender considerations within supervisory relationships may also impact supervisees’ experiences in supervision. According to Doughty and Leddick (2007), gender, described as psychological traits commonly connected with males and females, impacts the manner in which supervisors relate to their supervisees. Although not based in research, their view was that both male and female supervisors provide more direction to female supervisees and more often critically respond to female supervisees’ emotional disclosures. Doughty and Leddick proposed that when more instruction was given to female supervisees, opportunities for collaboration and empowerment diminished. Further, the authors suggested that supervisors’ critical responses to female supervisees’ expression of emotions may be linked to the “overemotional” female gender stereotype in comparison to men who are seen as being more logical (p. 22). Doughty and Leddick called for a more diverse perspective on the decision-making processes in supervision by referencing the moral development theories of Gilligan (1982) and Kohlberg (Bernstein et al., 2006). While relational caring was the goal in Gilligan’s developmental theory, Bernstein et al. (2006) stated that Kohlberg emphasized an individual’s movement toward justice and rights.
Gilligan’s moral development emphasized growth and care in connection with others. Bernstein et al. described moral decision making, according to Kohlberg’s model, as progressing toward autonomous decision making for individuals within a community. According to Bernstein et al., these theories commonly stand in opposition to one another. Gilligan’s theory represents the feminine voice and Kohlberg illustrates the masculine voice. Doughty and Leddick suggested that both relational caring and justice are important for decision-making in supervision and advocated for androgynous voices in supervision. Doughty and Leddick also suggested that education in supervision, regarding gender bias, might prevent these biases from limiting both counseling and supervisory relationships.

Granello’s (2003) research was consistent with Doughty and Leddick’s (2007) conceptual framework about gender differences in the supervisory relationship, while also introducing influence strategies in the supervisory relationship. To better understand the impact of gender on the relationship, Granello conducted a content analysis of audiotapes of 42 supervisory dyad sessions. These dyads were comprised of supervisees enrolled in a master’s practicum or internship class with their off-site credentialed supervisors. These dyads included: 5 male supervisor-male supervisee pairs, 20 female supervisor-female supervisee pairs, 8 male supervisor-female supervisee pairs, and 9 female supervisor-male supervisee pairs. The supervisors’ gender was associated with the supervisory relationship and resulted in four findings: (a) male and female supervisors were affirming of female supervisees’ comments, (b) male and female supervisors asked male supervisees their perspective twice as often as female supervisees, (c) male
supervisees asserted themselves three times more often than female supervisees, and (d) female supervisees were more complementary to their male and female supervisors than their male supervisee counterparts. Therefore, male supervisees were probed and voiced their opinions more often than female supervisees with both male and female supervisors. And compliments were given more often by female supervisees to both male and female supervisors. Granello stated that female supervisees tended to use more indirect and passive forms of communication with their supervisors in contrast to their more direct and active male supervisee colleagues.

The current investigation interviewed only female supervisees to illuminate their experiences and what they, as females, have found helpful in supervision while working with clients with eating disorders. The current investigation may support and oppose some of the findings from Granello’s (2003) research about supervisory experiences of females.

Summary of Chapter I

Counselors who work with clients with eating disorders are attempting to meet the goals of clients who present with a complex set of symptoms (Escobar-Koch et al., 2010; Franko & Keel, 2006; Milos et al., 2003; Warren et al., 2009). Clients present with distortions about their body size and shape and often refuse to eat food or feel unable to control the amount of food they consume (APA, 2013). According to Warren et al. (2009), clients with eating disorders also frequently present with comorbidity and suicidal ideation. Physiologically, their myriad of health complications may lead to death in the most severe cases (NEDA, 2011; The Renfrew Center Foundation for Eating Disorders,
When facilitating a decrease of symptoms in their clients with eating disorders, mental health providers may present the following feelings: (a) anxiety and worry (Costin, 2009; Franko & Rolfe, 1996; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Satir et al., 2009; Zerbe, 2008), (b) anger (Hamburg & Herzog, 1990; Satir et al., 2009; Zerbe, 2008), (c) boredom (Hamburg & Herzog, 1990; Satir et al., 2009; Zerbe, 2008), (d) despair (Delucia-Waack, 1999; Hamburg & Herzog, 1990), (e) exhaustion and guilt (Hamburg & Herzog, 1990), and (f) helplessness (Delucia-Waack, 1999; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Satir et al., 2009). Counselors’ feelings, coupled with behaviors and thoughts, may negatively impact clients’ progress in counseling (Bunnell, 2009; Delucia-Waack, 1999; Franko & Rolfe, 1996; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999). Further complicating counselors’ work with clients diagnosed with eating disorders are sociocultural factors associated with the thin ideal for female physique in the United States (Bordo, 1993; Costin, 2009; Hesse-Biber et al., 2006; Maine & Kelly, 2005; Mensinger et al., 2007; Tylka, 2004; Wolf, 1994).

Supervision is one tool used to aid counselors in their work with clients (Bernard & Goodyear, 2009). In this literature review, supervision was represented through diverse models which all carry a common theme of consideration of the unique needs of both supervisees and their clients. Supervision models discussed included a developmental model (Stoltenberg, 2005), a Systems Approach to Supervision (Holloway, 1987, 1995), a social role model (Bernard, 1979), and constructionist models (Edwards & Chen, 1999; Gazzola & Theriault, 2007; Gray & Smith, 2009; Molnar & de
According to Bernard (1979), Holloway (1994) and Stoltenberg (2005), the focus of supervision is on supervisees and the manner in which supervisors facilitate their (supervisees’) professional growth. Constructionist approaches focus on collaborative supervisory relationships where a balance of support and challenge empowers supervisees (Edwards & Chen, 1999; Gazzola & Theriault, 2007; Gray & Smith, 2009; Molnar & de Shazer, 1987; Murphy & Wright, 2005; Orlinsky et al., 2001; Parry & Doan, 1994; Worthen & McNeill, 1996). Within the supervisory relationship, attention to multicultural issues and gender identity are also important to facilitate a strong connection, and supervisors should be intentional about addressing these topics with their supervisees (Doughty & Leddick, 2007; Gatmon et al., 2001; Granello, 2003).

Supervision is suggested as one resource available for counselors in managing unhelpful feelings, behaviors, and thoughts in response to their clients with eating disorders (Delucia-Waack, 1999; Dixon, 2009; Gorman-Ezell, 2009; Hamburg & Herzog, 1990; Hayes et al., 2011; Franko & Rolfe, 1996; Zerbe, 2008). However, the literature available on the topic of supervision for counselors who work with clients with eating disorders is limited and requires further investigation to illuminate supervisory experiences when working with clients with eating disorders (Costin, 2009; Delucia-Waack, 1999; Hamburg & Herzog, 1990; Zerbe, 2008). Therefore, supervision for counselors who work with clients with eating disorders was investigated to better understand the supervisees’ experiences and potentially helpful aspects of the process. To achieve this, the current study explored the following research questions: “What are
the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?” In the remainder of the dissertation, Chapter 2 describes the methodology used for the current study, Chapter 3 presents the study’s results, and Chapter 4 includes a discussion of the results, limitations of the study, recommendations for further research, and implications from the study’s results for both supervision and the training of future counselors in Counselor Education and Supervision programs.
CHAPTER II

METHODOLOGY

The purpose of this study was to increase understanding of supervisory experiences for counselor supervisees working with clients with eating disorders and the meanings supervisees make of these experiences. It was thought that the study might also reveal helpful approaches in the supervision of counselor supervisees who work with clients with eating disorders. When referring to helpful approaches in supervision, the term “helpful” referred to anything that supported the counselor supervisee in her work with clients with eating disorders. These understandings could then be used to revise approaches in supervision to be more helpful to supervisors and supervisees.

Research Questions for a Phenomenological Approach

Moustakas (1994) stated that the phenomenological approach was “rooted in [research] questions that give a direction and focus to meaning, and in themes that sustain an inquiry, awaken further interest and concern, and account for our passionate involvement with whatever is being experienced” (p. 59). According to Moustakas, every word in the research question must be intentionally chosen “in such a way that the primary words appear immediately, capture [the researcher’s] attention, and guide and direct . . . the phenomenological process of seeing, reflecting, and knowing” (p. 59) to illuminate the meaning of the experience. Creswell (2007) and Moustakas (1994) suggested that the research questions are created from two broad general questions: “What have you experienced in terms of the phenomenon? [How do] contexts or situations typically influence or affect your experiences of the phenomenon?” (Creswell,
Moustakas added an additional focus by questioning participants’ meanings of their experiences of the phenomenon. These broad questions pave the way for an open-ended interview during which participants may disclose their descriptions of the phenomenon.

According to Moustakas (1994), participants’ disclosure of the phenomenon is broken up into textural and structural descriptions. Therefore, the research questions must address both the textural and structural descriptions of the phenomenon. For the textural description, Moustakas stated that the participants describe “what” they experienced, referring to participants’ raw behaviors, feelings, and thoughts about their experiences. According to Creswell (2007) and Moustakas (1994), the textural description is the participant’s account of her experiences with the phenomenon. For example, in the current study, this may be exemplified through a supervisee’s description of her supervisory experiences, including case conceptualization, or watching and assessing her counseling tapes with the supervisor.

In comparison, the structural description represents “how” participants experienced supervision or the participants’ meanings behind their description of their experiences. According to Moustakas (1994), the structural description is a narrative which portrays the “underlying dynamics of the experience, the themes that account for ‘how’ feelings and thoughts are connected” to the phenomenon (p. 135). For example, if the participant stated that case conceptualization was helpful for the textural description, the structural description would illuminate “how” it was helpful or “how” the supervisory approach was meaningful. For example, the supervisee may think the teaching element
of case conceptualization aided her in better understanding clients’ presenting symptoms. With this understanding, the supervisee may have been less anxious with her clients, may have been more responsive to her clients in sessions, and may have felt more positive about her counseling work. In the case of the current study, these underlying feelings and thoughts may not have been stated directly by the supervisees, but may have been evident in their direct quotes.

The current study explored the following research questions to capture the textural and structural descriptions of the phenomenon: “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?”

**Phenomenology as Qualitative Inquiry**

Phenomenology was chosen as the method of qualitative inquiry for two purposes: (a) there was no evidence of research about supervisory experiences of counselor supervisees when working with clients diagnosed with eating disorders in the literature, and (b) the research questions sought to explore the “lived experiences” of participants in supervision while working with clients diagnosed with eating disorders (Goes, 2013, para. 3). Phenomenology “best fits research problems that are unstructured, and for which there is little or no research or evidence in the literature” (Goes, 2013, para. 2). No research on the topic of supervisory experiences of counselors working with clients diagnosed with eating disorders had been conducted at the time of the study. Instead, theoretical writings, rather than research, explored the topic of supervisory
experiences for supervisees working with clients diagnosed with eating disorders.

Second, Goes (2013) wrote, “phenomenology involves gathering lived experiences of individuals, and if these experiences are unique and largely unstudied, then a phenomenological study can generate thick descriptions of great value for understanding a problem that has not been well studied” (para. 3). The researcher hoped to capture the “voices” of the supervisees about their shared experiences in supervision while working with clients diagnosed with eating disorders (Creswell, 2007, p. 37). These results could then provide structure for future research about the supervisory experiences of counselor supervisees when working with clients diagnosed with eating disorders.

Phenomenology literally means the study of that which appears. It is “a return to things just as they are given, removed from everyday routines and biases, from what we are told is true in nature and the natural world of everyday living” (Moustakas, 1994, p. 58). Though the researcher remained aware of how her presence impacted the interviews, through phenomenological research, the researcher sought to illuminate the participants’ natural and spontaneous descriptions of their experiences as opposed to her exclusive interpretation of the participants’ experiences (Merriam, 2002). According to Polkinghorne (1989), experiences are defined as a compilation of events and created relationships of meaning that evolve from a person’s interaction with his or her environment. “Reality is not ‘out there’ in an objective or detached sense but it is inextricably tied to one’s consciousness of it” (Schram, 2006, p. 99). Through the phenomenological research approach, the researcher sought to capture a description of the participants’ subjective perception of reality to better understand the phenomenon.
According to Moustakas, the phenomenon can only be understood more fully by understanding people’s descriptions of their experiences of or with the phenomenon.

According to Schram (2006), the essence of the phenomenon is illuminated through intuition and reflection on the participants’ experiences. The participants’ descriptions of their experiences, rather than the researcher’s experience with the phenomenon, were the nucleus of this research. The researcher captured participants’ voices about their experiences through interviews. Throughout the investigation, the researcher remained cognizant about how the participants’ descriptions of their supervisory experiences were impacted by the person of the participant, other people engaged with the participant, the context of the participant, the person of the researcher, and the lens through which the researcher captured the participants’ experiences in her analysis. Therefore, intersubjectivity was created in the communication between these parties and impacted the meaning of the participants’ experiences in supervision. Through bracketing of the researcher’s biases about supervisory experiences, transferability of data with a similar population of participants was possible (Lincoln & Guba, 1986).

Moustakas’ Psychological or Transcendental Phenomenological Approach (1994) provided the most appropriate data analysis for this phenomenological investigation for two reasons. First, this phenomenological data analysis approach was constructivist in nature by highlighting similarities among participants in their description of what and how they experienced the phenomenon, and it also accepted participants’ differing perspectives to illustrate the phenomenon (Hatch, 2002). By capturing the
multiple perspectives of the participants and accepting their descriptions as all contributing to the essence of the phenomenon, all “voices” were given attention (Creswell, 2007, p. 37). Second, the researcher sought to better understand the essence of the phenomenon through the participants’ descriptions of “what” they experienced in addition to “how” they experienced this. “What” participants experienced is called the textural description of the phenomenon, and “how” the participants experienced the phenomenon is the structural description of the phenomenon. This structural description of a phenomenon is built into Moustakas’ data analysis. Moustakas’ transcendental methodological approach incorporates data analysis modified by Stevick (1971), Colaizzi (1973), and Keen (1975), and entails: (a) the epoché, (b) phenomenological reduction to illuminate the textural description, (c) imaginative variation to report the structural description, (d) composite textural and structural descriptions to report all of the participants’ experiences, and (e) synthesis of the composite textural and structural descriptions to reveal the phenomenon under investigation.

**Epoché**

Moustakas’ (1994) phenomenological approach is transcendental because it seeks to capture participants’ descriptions of the investigated phenomenon as if it is newly introduced for the first time. To meet the goals of this approach, the researcher engaged in the process of epoché throughout the entire research process, from the time of preparation for data collection though the analysis and description of the results. Epoché meant that the researcher suspended her biases, judgment, and presuppositions about the
experience through reflexivity and bracketing to enable her to see the experience through
the participants’ recollections.

**Reflexivity**

Reflexivity is defined as the vigilant reflective self-examination of ideas, discussion, and analysis of experiences throughout the entire research process (Davies & Dodd, 2002; Hesse-Biber & Leavy, 2006). By engaging in intentional reflection on self as the researcher, she decreased her influence on the data collection and analysis. The researcher kept a journal of her research process where she recorded feelings and thoughts about her perceptions of biases before and after each interview (Ortlipp, 2008). Before an interview, the researcher used the research journal to record reflections about her feelings and thoughts regarding potential biases and their influence on her when asking interview questions of participants. After an interview, the researcher continued reflection of feelings and thoughts about biases present during and after the interview in the research journal. For example, the researcher asked herself if she asked more clarifying questions when she received an unexpected response from a participant. In her research journal, the researcher (a) recognized more of her biases, (b) thought about the potential impact of these biases on her ability to facilitate nonjudgmental questioning in interviews and to create the descriptive themes and individual and composite descriptions, (c) reconsidered created descriptive themes and individual and composite descriptions, and (d) then considered how to reduce biases in subsequent interviews to prevent them from impacting future interactions with participants or questions posed. For example, the researcher realized that she thought that counselor supervisees working
with clients with eating disorders may feel anxious about their clients’ presentations of suicidal ideation or health status. Participants did not report anxiety surrounding these presentations. The researcher also requested help from peer reviewers to challenge the possible impact of her biases on her data collection and analysis. Peer reviewers’ feedback was also reflected on in the research journal. The process of peer review, examples of peer reviewers’ feedback, and how it aided the researcher in her recognition of biases will be discussed in greater detail later in this chapter.

The research journal enabled her to be more intentional about the processes of reflexivity. Through this intentionality, a trusting relationship between the researcher and participants was possible. The researcher used her professional counseling knowledge to grow in empathy, sensitivity, respect, connection, and openness with her participants by not making assumptions about the participants’ experiences and remaining curious about their reported experiences. The researcher was intentional about avoiding judgment about the participants’ experiences during data collection and analysis. The researcher sought to conduct the investigation in a way that upheld rigor through reflexivity and treated participants in a respectful manner, by remaining open to being informed by the research participants (Howe & Moses, 1999; Lincoln & Denzin, 2000).

**Bracketing**

The researcher avoided imposing her own “understanding and construction on the data” (Ahern, 1999, p. 407) through the technique of “bracketing.” The researcher bracketed her biases by: (a) deciphering her biases, (b) remaining aware of how they may have impacted the research process, and (c) setting them aside. For example, the
The researcher realized a bias regarding frustration she thought counselor supervisees would disclose. The researcher thought that counselor supervisees might feel frustrated if clients presented in a pre-contemplative stage of change or if the establishment of the therapeutic relationship was difficult. Some participants talked about frustration regarding their work with clients diagnosed with eating disorders, but these reasons were not disclosed. The researcher was aware that she asked about additional situations when participants may have felt frustrated and none were provided. Had the researcher not had this bias, she may not have asked this question. Regardless of her biases, she practiced open-ended questioning throughout the interviews and was intentional about not using leading questions to arrive at the responses she expected. Open-ended questions began with the words, “What…” or “How…” and were asked to elicit a lengthy and descriptive response versus a close-ended question that typically results in a single word answer. Leading questions seek to get a response that is expected. An example of a leading question may be, “How were your experiences working with clients diagnosed with eating disorders stressful?” Instead, the researcher was intentional about asking participants, “Tell me how you felt when working with clients diagnosed with eating disorders.”

The specific bracketing processes the researcher used to grow more aware of her feelings and thoughts, keep them in check, and limit them from inhibiting the research processes and outcomes were: member checking, peer review, and reflection in a research journal. For example, through member checking, the researcher (a) emailed participants textural and structural descriptions linked with their transcripts, (b) asked participants if
she fully captured their experiences and checked for accuracy, and (c) edited these descriptions until inconsistencies were removed and additional information was incorporated to capture the participants’ experiences of the phenomenon. The researcher asked peer reviewers to also check for biases in her created textural and structural descriptions and then incorporated the peer reviewers’ feedback as applicable. Peer reviewers helped the researcher reduce the impact of her biases, presuppositions, and judgment on the data collection and analysis. Last, the researcher used the research journal to reflect on participants’ and peer reviewers’ feedback, grow in awareness of her biases, and prevent them from impacting the descriptive themes and individual and composite descriptions. Specifically, as the primary instrument in the investigation, the researcher sought to reveal how her preconceptions about the phenomenon under investigation might impact the questions she asked of participants and her ability to capture their experiences of or with the phenomenon in the individual and composite descriptions (Lincoln & Guba, 1985). By setting these aside, she instead reported the participants’ disclosures about their experiences.

According to Ahern (1999), bracketing personal feelings and preconceptions is more productive than attempting the impossible task of elimination. The researcher was aware that she could never remove her biases from her understanding of the participants’ experiences of the phenomenon entirely, yet she could be aware of them and how they might impact her ability to see the phenomenon as the participants intended (Rubin & Rubin, 2005). The researcher’s demographics and life experiences limited objectivity, yet they facilitated connection around shared practice, purpose, and meaning. Through
bracketing, the researcher-participants’ relationships helped to maintain reciprocal caring, trust, and respect (Howe & Moses, 1999).

**Personal Reflections of the Researcher**

I, the researcher in this study, acknowledge that I am not an impartial observer, but have experienced the roles of counselor, (both under supervision and independently licensed) who worked with clients with eating disorders, and supervisor-in-training with supervisees working with clients diagnosed with eating disorders. From my experiences in these roles, I have formulated my own beliefs and assumptions about the resource of supervision for female counselors who work with female clients diagnosed with eating disorders.

Supervision may be used as a resource to appropriately process counselors’ feelings as related to their counseling work and clients. Pearson (2001) advised that the immediate needs (e.g., crisis situations) of the supervisee or supervisor topics (e.g., ethical conflicts and client well-being) are the highest priorities. However, after these concerns are addressed, time for counselors to explore themselves and their feelings and thoughts about the counseling process is necessary in supervision (Pearson, 2004). For supervision to be effective for counselors who work with clients with eating disorders, I believe counselors’ feelings and thoughts about their work need to be addressed in supervision. I further believe that a foundation for the counselors’ disclosure of feelings and thoughts about their work is facilitated through a collaborative supervisory relationship.
In the role of supervisor-in-training, I have been intentional about establishing an open, supportive, and collaborative relationship with my supervisees and understand the challenges of supervisors. In supervision, I have made efforts to appropriately balance attention to the client and the counselor in the therapeutic relationship. Depending on the nature of the relationship, there have been times when the client or counselor needed more attention in the supervisory relationship, and I have sought to balance these needs in supervision. When supervisees expressed tiredness or stress about the counseling process, I taught them about the importance of self-care. However, I have been uncertain about how helpful this education was for them. As a supervisor-in-training, I learned how to facilitate the process more effectively, and I am biased in my beliefs that ongoing supervision or consultation for supervisors may be necessary to appropriately meet the expectations of these challenges.

For the purposes of the current investigation, I reflected on my beliefs about the role of supervisor throughout the investigation and sought to suspend these beliefs while listening to supervisees’ descriptions about their experiences with their supervisors. This reflection and suspension of my beliefs was done through member checking, peer review, and a research journal. Through member checking, I was able to ask participants if I accurately and completely created individual and composite descriptions based on their disclosures in interviews and then correct when it was inaccurate or incomplete. For example, a participant corrected me regarding intense emotions reported. The participant stated that she did not realize the inflammatory language she had used in the interview and did not intend to report her experience in that manner. This description linked with
the participant’s experience was corrected until she believed I had captured her disclosures accurately. In peer review, peers challenged my created individual descriptions and whether they were able to see how the descriptions evolved from the transcript of the participant’s disclosures about her experiences. The peer reviewers asked me questions to ponder, and some of these questions are provided in the peer review section in this chapter. In a research journal, I (a) reflected on both participants’ and peer reviewers’ feedback, (b) recorded my feelings and thoughts about biases, (c) considered the potential impact of my biases on my ability to facilitate interviews and create individual and composite descriptions, (d) reconsidered the created individual and composite descriptions, and (e) thought about my questioning and clarification from participants in subsequent interviews. I was intentional about listening openly to the participants’ experiences of supervision, withholding judgment about their reports of their supervisors’ work in order to uncover the participants’ descriptions of their supervisory experiences.

The following is a list of assumptions formulated from my experiences as a counselor (under supervision and independently licensed), a supervisor-in-training, and a researcher immersed in the study of supervision of counselors working with clients with eating disorders:

1. Clients with eating disorders are often situated in the pre-contemplative stage of change (Bloomgarden, 2009; Prochaska & DiClemente, 1986).
2. Counselors working with clients with eating disorders may be challenged because of the lack of trust in the therapeutic relationship stemming from clients’ mistrust with themselves and their bodies.

3. Counselors’ feelings of anxiety, anger, boredom, despair, exhaustion, guilt, and worry may increase when working with clients diagnosed with eating disorders.

4. Counselors’ relationships to their own body, weight, and food may be altered by their work with clients with eating disorders.

5. Supervisees may not be open with their supervisors about their struggles with clients with eating disorders.

6. Facilitation of effective supervision is dependent on the strength of the supervisory relationship.

7. Effective supervisors may tailor supervision to support supervisees’ strengths and lessen their weaknesses.

8. Effective supervisors may focus on supervisees’ holistic development by encouraging them (supervisees) to engage in self-care and professional development.

I acknowledged these assumptions at the onset of the investigation and reflected on them in a research journal throughout the data collection and analyses to help prevent my biases from influencing the outcomes of the phenomenological investigation. I also gave both participants and peer reviewers opportunities to challenge my assumptions through the processes of member check and peer review, and these are discussed later in the
chapter. Moustakas (1994) stated that a researcher’s results will never be completely free of bias. However, through intentional reflexivity and bracketing, the results will hopefully be improved.

Participant Selection

After the Kent State University Institutional Review Board approved this study (see Appendix A), the researcher used purposeful sampling to select participants who met specific criteria to yield information rich data (Kisely & Kendall, 2011). This study sought to better understand the supervisory experiences of counselor supervisees who work with clients with eating disorders, so specific criteria were used to choose participants for the study.

Inclusion criteria for participants were specified as a current or previous (within the last two years) female supervisee: (a) who attained a master’s degree in counseling and counselor license through her professional board; and (b) was currently or previously (within the last two years) working under supervision of a state licensed supervisor, with clients diagnosed with anorexia nervosa, bulimia nervosa, binge eating disorder, or other specified feeding or eating disorder (OSFED), according to the DSM-V (APA, 2013). Prior to 2013, the DSM-IV-TR (APA, 2000) referred to binge eating disorder as eating disorder not otherwise specified (NOS). In the DSM-V (APA, 2013), OSFED replaced eating disorder NOS as a diagnosis for an eating or feeding disorder that represents impairment, but does not meet criteria for anorexia nervosa, bulimia nervosa, or binge eating disorder. Diary memory recall for autobiographical information declines to 79% accuracy after 31 months; therefore, supervisory experiences were defined as taking place
within the last two years (Koriat, Goldsmith, & Pansky, 2000). And female supervisees were chosen because females outnumber males in the specialty of eating disorders (Barbarich, 2002).

The researcher chose online directory resources as an initial way to solicit participants for this study, EdReferral (2013), Google Searches, and Psychology Today (2013), in addition to requesting participation from counselor supervisees in the region whom she was able to discover via colleagues and Internet searches. EdReferral was chosen as one recruitment resource because it advertises itself as a comprehensive online directory for eating disorder treatment in the United States. Second, the researcher recruited participants via Psychology Today online directory because she was able to search for counselor supervisees who specialized in the treatment of clients with eating disorders.

The researcher started the participant selection process by first telephoning the directors of eating disorder treatment centers and private practitioners who advertised on EdReferral or Psychology Today websites, or who were discovered via Google searches, to inquire about counselor supervisees working with clients with eating disorders (see Appendix B). They were asked about their willingness to post a flyer (see Appendix C) with a brief description of the study and contact information in their break rooms, and their openness to having the researcher present her proposed investigation at a staff meeting. The researcher sent Director/Private Practitioner Recruitment Letters to receptive directors and private practitioners describing the study in detail (see Appendix D) via email, and then potential participants at treatment centers or private practices
contacted the researcher via telephone or email. The researcher then referenced inclusion criteria to find appropriate candidates, after potential participants at treatment centers or private practices expressed an interest in involvement in the study, and telephoned potential participants about their interest (see Appendix E). While considering Creswell’s (2007) recommendations for participant selection, the researcher used purposeful sampling to select five participants who met specific eligibility requirements to participate in the study. The potential participants were sent a Participant Informed Consent Form (see Appendix F) and an Audiotape Consent Form (see Appendix G) and a Demographic Questionnaire (see Appendix H) via postal service with an enclosed return envelope or email for individuals who had the ability to sign and scan the documents.

The researcher used Creswell’s (2007) recommendations and her ability to attain saturation point as she conducted the interviews to determine a large enough sample size. Though phenomenological qualitative samples vary in size, Creswell recommended approximately five to seven participants. Of those who volunteered, the researcher selected an initial minimum of five supervisees, who met inclusion criteria. Saturation was reached after five participants were interviewed. According to Hesse-Biber et al. (2006), saturation point is when interviewees are no longer presenting new information to the researcher and redundancy in their disclosure is occurring.

**Data Collection**

Kvale (1996) presented clear steps to guide the research process. The researcher utilized Kvale’s steps to organize the data collection by designing the purpose of the investigation and steps in data collection prior to interviewing, transcribing, analyzing,
verifying, and reporting the final data interpretation. The process of data collection was not mutually exclusive from the analysis, as interviewing, transcribing, analyzing, and verifying happened concurrently. According to Hesse-Biber and Leavy (2006), “the great strength of methods such as in-depth interviewing is that you can engage simultaneously in the processes of data collection and analysis. The two processes inform each other” (p. 142). Therefore, the researcher practiced this simultaneous data collection and analysis because the processes of collection and analysis influence each other. For the steps of interviewing, transcribing, analyzing, verifying (via member checking and peer review), and reporting the final data interpretations, the researcher created a Flow Chart for Phenomenological Data Collection and Analysis Procedures (see Appendix I) to detail her procedures, including approximate time frame.

According to Kvale (1996), the initial step of designing the purpose of the investigation highlights guiding research questions for interviews. Through the literature review, the researcher identified the purpose of the investigation to better understand the supervisory experiences of counselor supervisees working with clients with eating disorders in terms of what and how they experienced supervision. The guiding research questions were descriptive and aligned with a phenomenological study: “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?”
A timeline for the data collection and analysis procedures was established, and it was outlined on the flowchart (see Appendix I). The timeline summary entailed (a) two rounds of interviews, ranging in duration of 50-90 minutes each, per participant; and (b) member checking interviews for the purpose of providing the participants with an opportunity to provide feedback in response to the researcher’s created themes following all interviews. Data collection occurred over four and a half months.

**Interviews**

Two interviews were held with each participant. The semi-structured interview process allowed for both the researcher and participants to contribute to the process of data collection through the researcher’s use of broad open-ended research questions. These questions allowed the diversity of the participants’ experiences to surface based on how much they disclosed or what they brought forth as new topics for consideration. The interview process was improved by establishing rapport with the participants, by starting with less personal questions, and by providing participants with time to reflect on the textural and structural descriptions of their supervisory experiences (Clarke, 2006; Moustakas, 1994). Once rapport had begun to be established, participants were able to take more ownership of the process of sharing their experiences. Throughout the process, the researcher was inquisitive to help participants understand that they were the “experts” of their stories and to allow for their descriptions of their experiences to surface (Hesse-Biber & Leavy, 2006, p. 128). From this relationship, the researcher hoped the semi-structured interview questions would give participants enough space and time to
describe the textural and structural descriptions of their supervisory experiences in a manner aligned with a phenomenological investigation (Moustakas, 1994).

According to Guion, Diehl, and McDonald (2011), the three main components of semi-structured interviews are: the facesheet (see Appendix J), the interview guide (see Appendix K), and the research journal about the interview process. Prior to this semi-structured interview process, the researcher received signed informed consent forms from participants. For the interview process, the researcher first used a facesheet to document the time, date, location, and unique environmental factors that impacted the interview process. Second, she used an interview guide for the interviews, detailing questions for exploration (Weiss, 1994). The researcher honed this interview guide through a practice interview by requesting help from a female colleague who previously worked with clients with eating disorders under supervision. Through this practice interview, the researcher explored the interviewee’s understanding of the questions, edited questions for clarification purposes, and added additional questions based on her feedback. She improved the interview protocol through this practice interview by editing any closed or leading questions and remembering the intent of the investigation, while continuing to bracket her biases about participants’ perspectives on topics (Smith, 2006, p. 61). The researcher kept Smith’s advice in her mind,

Remember you are trying, as far as possible, to allow the participant to tell you what it is like to live in their personal world. You are not trying to find out what they think about your views of their personal world. (p. 61)
Interview questions on the interview guide were given to each participant in advance of the first interview to prepare them for the interview process. The interview guide was then used with participants to provide questions for semi-structured interviews, while allowing participants to have freedom with regard to their responses about the specific experiences of and with the phenomenon. Therefore, the interview guide was not followed rigidly, in order to allow the participants’ unique voices to relay their supervisory experiences, but it assisted the researcher in identifying open-ended questions to ask the participants. The researcher used the interview guide in subsequent interviews to address questions not covered from the initial interview or areas needing further clarification about previous responses to questions. She also recorded observations about how participants’ body language and facial expressions aligned with particular topics. After each interview, the researcher used a research journal to reflect on the interview process (Ortlipp, 2008). Through journaling, she grew more aware of her biases about the phenomenon and this allowed for the illumination of the participants’ experiences of and with the phenomenon, rather than her own.

Rounds of interviews were conducted until: (a) participant consistency in the textural and structural descriptions was attained, meaning saturation point was reached as participants disclosed redundant information instead of new information; (b) participants verified the descriptions of their experiences of the phenomenon via member checking; and (c) peer reviewers presented no new feedback.
The Researcher as the Instrument

Throughout the interview process, the researcher was intentional about using herself to facilitate the participants’ disclosure of their experiences by actively listening, upholding eye contact, presenting markers and probes (Hesse-Biber & Leavy, 2006), paraphrasing, and reflecting (Guion et al., 2011; Rubin & Rubin, 2005). Markers were simple phrases such as, “Could you please expand upon the topic that you spoke of earlier?” or “Tell me more about your feelings within the situation that you previously mentioned.” Probes included such phrases as, “Mmmm” or “Right,” which suggested that the researcher desired the participant to expand upon what she disclosed. The researcher paraphrased participants’ responses to reassure the participants that she was listening. For example, simple phrases could be, “I heard you saying how helpful your supervisor was in teaching you ways to determine when self-disclosure might be appropriate.” Paraphrasing helped reassure the participant that her message was received accurately and encouraged her (the participant) to engage more fully in the interview process. By paying attention to participants’ tone and emotional content of their disclosure, the researcher was able to more accurately reflect back their emotions. These responses strengthened her understanding of the participants’ statements. According to Hesse-Biber and Leavy (2006), these techniques of active listening are important in phenomenological studies to capture the richness and depth of each participant’s experience.
Preparation for the First Interview

For each interview, participants received an email and telephone voicemail message confirming the date and location of the interview (see Appendix L). Though the participants chose the location (e.g., their office or the library) for the first interview and those following, the researcher encouraged the participants to choose a private location to uphold their confidentiality as a participant in the study. All interviews took place in person. The researcher sent each participant the textural and structural descriptions prior to the onset of the second interview.

Second Interviews

The researcher began every second interview by member checking: (a) asking each participant a specific set of member checking questions about the textural and structural descriptions, and (b) offering each participant an opportunity to add information to her (the participant’s) description of the phenomenon that she may have neglected from the previous interview (Lincoln & Guba, 1985). Since this occurred at the onset of the second interview, these questions are represented in the interview guide (see Appendix K). After the researcher edited the descriptions, she sent an email to the participant displaying revisions (see Appendix M) and gave the participant another opportunity to converse over the telephone should the participant desire additional edits (see Appendix N). This process of member checking, which contributed to the increased trustworthiness of the study, is discussed in greater depth in a latter part of this chapter.

The questions posed in the second interview were questions left unanswered from the previous interview and included follow-up questions based on the analysis of the
prior interview to insure that the participants fully disclosed their descriptions of their supervisory experiences. Also, in both interviews, the researcher reiterated the purpose of the investigation, asking the participants to describe their experience of supervision while working with female clients diagnosed with eating disorders. This gave participants an opportunity to expand on their initial disclosure and possibly delve into new areas that were not discussed in the beginning of the interview process.

**Imaginative Variation**

According to Lin (2013), “imaginative variation is a procedure used to reveal possible meanings through utilizing imagination, varying frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions” (p. 472). The researcher asked these variation questions in both interviews with participants, and then reflected on their responses to these questions in data analysis to reveal the structural descriptive themes and individual and composite structural descriptions. By using this process during interviews with participants and then reflecting on participants’ responses in the data analysis, the research was able to capture underlying and precipitating factors that account for what is being experienced; in other words the ‘how’ that speaks to conditions that illuminate the ‘what’ of the experience. How did the experience of the phenomenon come to be what it is? (Moustakas, 1994, p. 98)

According to Moustakas (1994), the researcher uses the procedure of imaginative variation to uncover meanings and beliefs connected to participants’ experiences, which
are ultimately organized into structural descriptive themes. The researcher facilitated imaginative variation by asking the participants questions about alternative experiences to “what” the participants described as their experiences to more fully capture the meaning and beliefs connected to their actual experiences. For example, the researcher asked participants to consider how their experiences would have been different if they had not experienced educational discussions about working with clients diagnosed with eating disorders. This enabled them to reflect on how their competencies as counselors increased after having these educational discussions. Therefore, these variation questions allowed the participants to explore additional meanings and beliefs about their actual experiences and these contributed to the researcher’s analysis of their responses and creation of the structural descriptive themes and structural descriptions.

**Data Transcription**

The researcher audio recorded and transcribed all interviews, to ensure the accuracy of the participants’ verbalizations. The transcription of each interview audio recording was completed within one week of the interview to ensure that the material was fresh in the researcher’s mind. When transcribing, she utilized “denaturalized” transcription methods by leaving out extra background noises (e.g., doors shutting, wind, outside conversations; Mero-Jaffe, 2011). To help ensure the participants’ confidentiality was upheld, pseudonyms were used for the participants’ names, their supervisors’ names, and practice locations throughout the transcriptions. Within a week after the interview was conducted, and prior to the next round of interviews, the process of transcription and
analysis was completed. The transcribed data were stored on a password protected external hard drive.

**Data Analysis**

The data were organized and analyzed through Moustakas’ (1994) modified analysis methods; that is, modified from Stevick (1971), Colaizzi (1973), and Keen (1975) procedures. Moustakas’ Transcendental (1994) analysis was a systematic method that continued the process of epoché. As stated previously, the process of epoché began prior to data collection and continued throughout data collection, analysis, and results. Epoché meant that the researcher suspended her judgment about the experience to enable her to see the experience through the participants’ recollections. The goal of the transcendental phenomenological analysis was reduction of the phenomenon under investigation to expose the participants’ perspectives of their experiences with the phenomenon. This process of phenomenological reduction gradually “stripped” the researcher’s preconceived notions of the experience to allow her to get in “touch with what is actually before [her], with the thing itself, the essential nature of the phenomenon” (Moustakas, 1994, p. 91). For phenomenological reduction, the researcher began the process by immediately transcribing the interview. After the interview for each participant was transcribed, the researcher highlighted significant statements. A statement was significant if it described the participants’ experiences and related to the research questions. The researcher then began the process of horizontalization. Through the process of horizontalization, she identified and assigned equal value to all significant statements. All significant statements were then kept and labeled as meaning units or
“invariant constituents” if they met three criteria: (a) related to the participants’ experiences and the research questions, (b) could be linked with other significant statements and ultimately labeled a theme, and (c) were repeated and overlapped with other significant statements throughout the transcript. These meaning units, also known as “invariant constituents,” were then organized or clustered into themes. These themes were used as a guideline for the individual textural description for each participant. The researcher then identified similarities from the individual textural descriptions pertinent for all participants to create the composite textural description across all participants. For the next step, she identified structural themes, individual structural descriptions, and the composite structural description by reflecting on participants’ responses to variation questions in interviews through the process of imaginative variation. Imaginative variation was a process she engaged in by asking variation questions of participants in interviews and then used participants’ responses to consider all meanings possible for the participants’ disclosed experiences in the data analysis. The researcher remained open to diverse perspectives about meanings, created textural and structural descriptive themes and textural and structural descriptions for each individual participant, and revealed the composite for all participants. For the last step, she illuminated the textural-structural synthesis by cross-analyzing the composite textural and structural descriptions. The textural-structural synthesis was then used to describe the phenomenon under investigation for all participants.
Transcendental Phenomenological Reduction

The researcher sought to capture the participants’ experiences of supervision as if perceived for the first time. This process entailed a stripping away of the researcher’s preconceptions about the experience by beginning the process of epoché and continuing this process of epoché throughout the analysis. By peeling back the layers of the researcher’s beliefs and biases about the phenomenon, the researcher was able to capture the essence of the phenomenon through the participants’ disclosures. This process entailed detailed steps. The first step was to identify significant statements and assign equal value to all statements, also known as horizontalization.

Identification of significant statements and labeling of meaning units. After an interview was transcribed, the researcher read through the transcription of the interview to “highlight significant statements, sentences, or quotes that [provided] an understanding of how the participants experienced the phenomenon” (Creswell, 2007, p. 61) of the supervision of counselor supervisees who work with clients with eating disorders. As instructed by Patton (2002), for the first reading of the data, she labeled each significant statement, sentence, or quote and chose to color code similar and different ideas. Next, according to Moustakas (1994), she assessed and kept those significant statements that: (a) related to the experience of the phenomenon under investigation and research questions, (b) could be labeled and combined with other significant statements, and (c) repeated and overlapped with other significant statements. If the significant statement did not meet these criteria, it was set to the side for the time. According to Moustakas, significant statements that meet these criteria are then labeled
meaning units or “invariant constituents,” as they are unchanging and part of the essence of the phenomenon (pp. 120-121). All meaning units were recorded verbatim from the transcripts.

**Grouping of meaning units into textural descriptive themes.** Once the meaning units, also known as “invariant constituents,” were identified, similar units were grouped together in a separate document to create textural descriptive themes from this raw data based on multiple reviews of the transcripts (Moustakas, 1994; Patton, 2002). The researcher pieced together the meaning units into groups several times until all meaning units were represented in a group. She returned to the transcripts and read through them several more times to remember the context of the meaning unit, to make certain it fit appropriately within a particular group (Hycner, 1999). After groups of meaning units were formed, the researcher created a name for each textural descriptive theme to represent these groups of meaning units (Groenewald, 2004; Moustakas, 1994). Following the second interview, she returned to the established textural descriptive themes, from the first interview, to decipher if meaning units from the second interview fit within a previously established theme. When meaning units failed to fit within a textural descriptive theme, a new theme was created. The researcher sorted and resorted these meaning units from each interview into textural descriptive themes until all meaning units were represented (Groenewald, 2004). The textural descriptive themes contributed to an initial and general understanding of the counselor supervisees’ experiences of supervision when working with clients diagnosed with eating disorders.
and provided a foundation for the individual and composite textural descriptions, and
textural-structural synthesis.

Creating Textural and Structural Descriptions: Individual, Composite, and
Textural-Structural Synthesis

Following the first interview, the researcher began to create textural and structural
descriptions to capture the phenomenon of supervisory experiences for each participant.
The researcher used the textural descriptive themes, created from the groups of meaning
units from a participant’s first interview, and structural descriptive themes, developed
through the process of imaginative variation, to illustrate the holistic textural and
structural descriptions of the individual participant’s experiences. The textural
description illustrated “what” the participant experienced, while the structural description
displayed “how” they experienced supervision or the participant’s meanings behind her
description of her experiences. According to Moustakas (1994), the structural description
is a narrative that portrays the “underlying dynamics of the experience, the themes and
qualities that account for ‘how’ feelings and thoughts are connected” to the phenomenon
(p. 135). The researcher illuminated the structural description, or “how” the participants’
meanings and beliefs were connected to their experiences, by exploring: (a) the person of
the participant, (b) other people engaged with the participant, and (c) and the context of
the participant (i.e., the eating disorder treatment centers). The researcher added to these
individual textural and structural descriptions after each interview was conducted to
create final textural and structural descriptions for each participant. Once the final round
of interviews was complete, the researcher reviewed all individual textural and structural
descriptions for each participant. The researcher then analyzed these individual textural and structural descriptions for similarities among all participants in the study. By capturing the similarities between the textural and structural descriptions of the participants, the researcher was then able to create composite textural and structural descriptions that were relevant for all supervisees who worked with clients with eating disorders. For the final step, the researcher combined these composite textural and structural descriptions to form a textural-structural synthesis of the phenomena under investigation. Through the process of member checking, the researcher noted textural and structural descriptions that did not appear to fit with the illumination of the phenomenon for all participants and these were excluded from the final synthesis of the textural and structural descriptions for all participants (Moustakas, 1994). All descriptions for participants were stored after the completion of the study in electronic files maintained on a password protected flash memory data storage device for use in future publications.

**Trustworthiness**

A necessary aspect of all research is trustworthiness. In qualitative research, trustworthiness ensures the final data analysis and conclusions are based on thick descriptions and are “fully supported” by data. The researcher relied on Lincoln and Guba’s (1985) standards including: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability to ensure the trustworthiness of her study.
Credibility

According to Lincoln and Guba (1985), credibility is when the researcher is able to accurately capture the participants’ perceptions about the phenomenon. The researcher sought to make certain that her findings described the phenomenon that she intended to investigate (Shenton, 2004). Following Lincoln and Guba’s directives, the researcher made certain that the data resulting from the investigation were credible through “prolonged engagement” (p. 301), member checking (p. 314), peer review (p. 308), and negative case analysis (p. 309).

**Prolonged engagement.** Through prolonged engagement, the researcher spent a substantial amount of time growing more familiar with the supervisory practices and with the work of counselor supervisees who specialize in working with clients diagnosed with eating disorders, by researching previous literature and spending a lengthy amount of time with participants. The researcher grew more knowledgeable about this line of inquiry by reading scholarly theoretical and research articles. The researcher spent time (two interviews in total, lasting approximately 60 minutes in length) with the participants building rapport and eliciting disclosures about their supervisory experiences. This gave participants time to express their perspectives about their supervisory experiences.

**Member checking.** To increase the credibility of the investigation of the participants’ descriptions of their supervisory experiences, the researcher engaged in the practices of member checking (Lincoln & Guba, 1985). Per Lincoln and Guba’s methods, the researcher engaged in the process of member checking by asking
participants to provide feedback about the individual textural and structural descriptions after each round of interviews. The researcher also requested participants’ feedback regarding their highlighted contributions to the composite textural and structural descriptions for all participants and the textural-structural synthesis. Again, after both interviews were complete, member checking was an opportunity for participants to correct and add clarity to the researcher’s textural and structural descriptions, the composite textural and structural descriptions, and the textural-structural synthesis. To engage in member checking successfully, the researcher continued to focus on establishing rapport with the participants. This enhanced an open and honest relationship with them and enabled participants to disagree with the researcher should she incorrectly capture their experiences.

Through the member check for their individual descriptions, the participants were given an opportunity to: (a) clarify any inaccuracies about the researcher’s textural and structural descriptions, and (b) provide greater detail about their experiences of supervision while working with clients with eating disorders. To achieve this, the researcher: (a) created textural and structural descriptions for all interviews for each participant, (b) emailed participants the textural and structural descriptions aligned with their interview, and (c) proceeded with the member checking process at the onset of the following interview. In order to member check, the researcher (d) emailed participants their final textural and structural descriptions, and (e) arranged an individual telephone conversation approximately a week later to discuss their feedback (see Appendix M). After all textural and structural descriptions were compiled, the researcher (f) created
composite textural and structural descriptions from the individual textural and structural descriptions for all participants, (g) created the textural-structural synthesis, and (h) emailed composite descriptions and the textural-structural synthesis to all participants with their highlighted contributions approximately one week prior to the member checking process. If the participants were uncertain about the accuracy of the description or had additional feedback to offer, the researcher (i) scheduled a telephone conversation with the participant.

For further clarification, the researcher has provided an illustration. For example, the researcher created textural and structural descriptions for the first interview and then completed a member check with the participant at the onset of the second interview. After the second interview, the researcher emailed the final textural and structural descriptions to the participant and requested an individual telephone conversation to complete the member check for the second interview. Then, the researcher created the composite textural and structural descriptions from the individual textural and structural descriptions for all participants with participants’ contributions highlighted, created the textural-structural synthesis with participants’ contributions highlighted, and then emailed these composite descriptions and textural-structural synthesis and requested feedback about accuracies or descriptions requiring more depth. If the participant was uncertain about the composite textural and structural descriptions or textural-structural synthesis, and had additional feedback to offer, the researcher scheduled an individual telephone conversation with the participant. The researcher then edited the individual descriptions, composite descriptions, and textural-structural synthesis to include the
participants’ feedback to ensure that she accurately and fully relayed the participants’ experiences of supervision.

Peer review. Through peer review, the researcher’s peers gave her an opportunity to revisit the textural and structural descriptions from the interviews and “correct [her] prejudices or set them aside and hear ‘what the text [said] to [her]’” (Moustakas, 1994, p. 10). For peer review, the researcher requested participation from two peers in the field of counseling who were familiar with qualitative research as a result of having taken coursework in graduate school (Lincoln & Guba, 1985). For each round of interviews, the researcher requested that the peer reviewers read (a) one complete transcription for one interview, and (b) the individual textural and structural descriptions for the same transcription. These data were sent to the peer reviewer via email and then discussed over the telephone. Based on Patton’s (2002) suggestion, the researcher asked the peer reviewers to keep in mind the following: (a) “Did you understand how the textural and structural descriptions were created based on the transcription?” and (b) “Was the text of the transcript accurately situated within the descriptions, or is additional information necessary to capture the participants’ comprehensive experience?” The peer reviewers inquired about the researcher’s descriptions, often pertaining to meanings reported in the structural descriptions. One peer reviewer provided an example regarding discomfort in supervisory relationships:

I wondered the extent to which the supervisee felt discomfort with the first supervisor was primarily related to the fact that as she discussed . . . she was new and experiencing everything in a fresh way . . . increased self-doubt, etc., and
brought this with her into the interaction versus the supervisor’s gender and
personality and approach she took with her . . . just something I’m thinking about.
A peer reviewer also challenged the researcher’s understanding of trust within the
supervisory relationships.

Interestingly though, the trust came from very different contexts . . . with [the
first] supervisor, I trusted her because I respected her knowledge and with the
second supervisor, the trust was more layered I think, including factors within the
client where she appeared to trust herself more.

Questions from peer reviewers allowed the researcher time to ponder the meanings of the
supervisory experiences. As she deemed applicable, the researcher incorporated the peer
reviewers’ feedback and edited the individual descriptions of the interviews reviewed.
These edits altered the individual textural and structural descriptions and the composite
textural and structural descriptions. The researcher then also applied their
recommendations, as seemed appropriate, to all other descriptions they did not read. As
an illustration, a peer reviewer may have noted a bias in the researcher’s description of
the supervisory relationship. The researcher would not only edit this bias in the
description of the one interview where it was noticed, but she would also search for any
biases about the supervisory relationship written in a description from other interviews.

Negative case analysis. To further increase the investigation’s credibility, the
researcher utilized negative case analysis. Negative case analysis means that the
researcher took her created textural and structural descriptive themes and attempted to
find inconsistencies within these themes when she compared them to the transcripts. A
negative case is an emerging inconsistency that conflicts with the researcher’s textural and structural descriptive themes. If a negative case was discovered, the researcher questioned the validity of her textural and structural descriptive themes and made attempts to edit the descriptive themes to incorporate this inconsistency or create another descriptive theme. An example of an emerging inconsistency that required a textural descriptive theme was “modeling by the supervisor.” Initially, this textural descriptive theme was incorporated into the theme “specialized education for working with clients diagnosed with eating disorders.” However, when the researcher returned to the transcripts, she saw that “modeling by the supervisor” had reoccurring support throughout the transcript evidenced by significant statements. Ultimately, this initial theme “specialized education for working with clients diagnosed with eating disorders” was changed to “educational discussions about working with clients diagnosed with eating disorders” because the significant statements highlighted less of the specialization and more discussion in their educational experiences of supervision. The researcher checked these created textural and structural descriptive themes, represented in descriptions, with participants through the member checking process and peer reviewers to gain confidence in her accuracy of descriptive themes.

**Transferability**

Transferability means that the results of the research may successfully be applied to similar populations (Lincoln & Guba, 1986). The researcher documented a detailed description of the investigation’s processes, including: (a) the time frame with the length and amount of interviews conducted over a period of months, (b) the purposeful sampling
of demographics, (c) the researcher’s influence as the instrument for the study, and (d) the dissertation committee advisors’ constant instruction for the researcher and the process. The researcher practiced transparency of sampling for participants, data collection, and analysis by documenting her methodology and rationale for decisions (Rubin & Rubin, 2005). The researcher provided this comprehensive description of the processes and data collection and analysis to increase both the transferability and trustworthiness of the study (Lincoln & Guba, 1985).

**Dependability**

The researcher sought dependability to increase the trustworthiness of the study (Creswell, 2007; Lincoln & Guba, 1985). Dependability means that the research study could be replicated if other researchers used the same methodological procedures (Sin, 2010). To improve dependability, the researcher clearly described procedures used in data collection and analysis in order to create thick textural and structural descriptions of the phenomenon through member checking and peer review. The researcher clearly outlined the methodology to enable another researcher to replicate the study in the future.

**Confirmability**

Confirmability refers to the quality of the research findings and how accurately the researcher captured the participants’ descriptions of the phenomenon, excluding her bias or her notions about the phenomenon. To increase confirmability and the trustworthiness of the study, the researcher utilized the techniques of bracketing and reflexivity in her research journal to ensure the findings were aligned with the experiences and perspectives of the participants, rather than her personal biases (Shenton,
For qualitative research, trustworthiness is enabled throughout the process by broadening of the definition of rigor through the techniques of bracketing and reflexivity. Ahern (1999) described bracketing and reflexivity as collaborative processes, “One [the researcher] must be reflexive in order to bracket, and both activities require time to reflect, an environment of support, and reflective skill” (p. 410). The researcher was committed to these techniques before, during, and after her research process and recorded them in the research journal.

**Assumptions**

The researcher assumed that her participants would answer honestly in the face-to-face interviews and telephone conversations. To increase this assurance, the researcher explained to the participants verbally, and written in the informed consent, that anonymity and confidentiality would be upheld throughout the research process and in presentations of the study by the researcher.

**Summary of Chapter II**

The researcher’s aim in Chapter 2 was to clarify the phenomenological method of qualitative inquiry used for the current investigation of the supervisory experiences of counselor supervisees who work with clients with eating disorders. Epoché was achieved through the process of bracketing to illuminate and set aside the researcher’s preconceived notions about the experience under investigation. The researcher addressed phenomenology, the researcher’s personal reflections, as well as sampling procedures, data collection and analysis, and procedures for supporting the trustworthiness of the data. Chapter 3 presents the results of this phenomenological investigation about the
supervisory experiences of counselor supervisees who work with clients with eating disorders.
CHAPTER III
RESULTS

Phenomenological inquiry seeks to understand the meaning of an experience through investigation and analysis. According to Moustakas (1990, p. 175), this process is a matter of:

engaging in [a] scientific search through methods and processes aimed at discovery; a way of self-inquiry and dialogue with others aimed at finding the underlying meanings of important human experiences. . . . This requires a passionate, disciplined commitment to remain with a question intensely and continuously until it is illuminated or answered. . . . Through exploratory open-ended inquiry, self-directed search, and immersion in active experience, one is able to get inside the question, become one with it, and thus achieve understanding of it.

The phenomenon under investigation in this research was counselor supervisees’ experiences of supervision when working with clients diagnosed with an eating disorder. The research questions for the study were: “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?” This chapter presents the results of phenomenological research into the supervisory experiences of counselor supervisees working with clients diagnosed with an eating disorder. The
results from Moustakas’ transcendental phenomenological approach incorporate data analysis modified by Stevick (1971), Colaizzi (1973), and Keen (1975).

The purposes of this chapter are to: (a) describe the five participants’ demographics, (b) present textural descriptive themes created from meaning units or “invariant constituents” and structural descriptive themes from the process of imaginative variation, (c) present individual textural and structural descriptions for each participant, (d) reveal composite textural and structural descriptions for the collective whole of participants, and (e) report the textural-structural synthesis for all participants. A thread linking this entire process shows each of the steps being connected with one another.

**Demographics**

All participants were given pseudonyms to help protect confidentiality and no names of practice sites or names of supervisors were revealed. All participants’ supervisors are referred to as female and given female pronouns throughout the quotes to help uphold confidentiality. The female gender as a reference for supervisors was chosen because females outnumber males in the specialty of eating disorders (Barbarich, 2002).

Five participants were selected for the study because they had an interest in the research topic about the supervision of counselor supervisees who work with clients diagnosed with an eating disorder. Of those who volunteered, the researcher selected participants who met inclusion criteria and remained open to adding participants until the saturation point of presenting descriptive themes was attained. According to Hesse-Biber et al. (2006), saturation point is when interviewees are no longer presenting new information to the researcher and redundancy in their disclosure is occurring. All
participants were engaged in the research, as evidenced by their timely scheduling of
interviews, correspondence between interviews via telephone and email, and time
commitment to the interview process. Each participant was interviewed twice and all 10
interviews were conducted in supervisees’ office settings. Participants identified
themselves as Caucasian and ranged from 26–37 years of age. The number of
supervisors for each participant varied: one supervisee worked with one supervisor,
whereas four supervisees worked with two supervisors. The participants’ time spent in
supervision with one supervisor, while working with clients diagnosed with an eating
disorder, varied between 3 weeks to 14 months. For this time in supervision, supervisees
reported one hour a week of individual supervision and one hour a week of group
supervision. These participants worked with an average of 2 to 24 clients diagnosed with
an eating disorder each week.

Four participants at the time of the study were licensed as counselors still working
under supervision and one had been licensed as an independent counselor for four months
at the time of the study. The participant who was independently licensed had previously
worked under supervision for 23 months and experienced her last supervision four
months prior to the study. While working under supervision, all supervisees were
credentialled with their state board as a supervisee working with a supervisor who was
independently licensed and credentialled with the state board as a supervisor. All five
participants worked at specialized eating disorder treatment centers while counseling
under supervision, and each participant worked with clients in different levels of
treatment. These levels of treatment included: partial hospitalization, intensive
outpatient, and outpatient. Sometimes participants simultaneously worked with clients in more than one level of treatment. For example, one participant worked with clients enrolled in partial hospitalization, intensive outpatient, and outpatient at the same time. All participants served clients with the following diagnoses according to the *DSM-V* (APA, 2013): Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge-Eating, and Other Specified Feeding and Eating Disorder (OSFED).

**Textural and Structural Descriptive Themes of Supervisory Experiences When Working With Clients Diagnosed With an Eating Disorder**

From the participants’ transcripts, descriptive themes to represent the textural and structural experiences of the phenomenon surfaced. From significant statements, clustered meaning units or “invariant constituents” were used to illuminate “what” the participants experienced in supervision, that is, the textural descriptive themes. Then during data analysis, the researcher considered different perspectives for “how” the participants experienced supervision to create structural descriptive themes. The structural descriptive themes displayed the underlying dynamics or participants’ meanings or beliefs about the experience. This general overview of textural and structural descriptive themes is the first step in Moustakas’ (1994) transcendental phenomenological data analysis followed by more specific disclosures about experiences from individual participants. The purpose of this general overview is to provide a look at the foundation or broad textural and structural descriptive themes from the study prior to reporting more specific individual textural and structural descriptions, composite textural and structural descriptions, and the textural-structural synthesis.
Textural Descriptive Themes of Supervision

The following themes from the individual textural descriptions surfaced from “what” the participants disclosed as their experiences in supervision. Textural descriptive themes of supervision included: (a) time in supervision, (b) educational discussions about working with clients diagnosed with eating disorders, (c) modeling by the supervisor, and (d) individual and group supervision.

Time in supervision. Supervisees reported that supervision was held weekly. Supervisees reported experiences of one hour for individual supervision and one hour for group supervision weekly. All supervisees in the study reported receiving the same amount of time each week in supervision.

Educational discussions about working with clients diagnosed with eating disorders. Supervisees discussed these topics in their interviews: (a) specialized instruction for working with clients diagnosed with eating disorders for the first year of supervision, and (b) reaction papers about topics related to weekly counseling experiences.

Specialized instruction for working with clients diagnosed with eating disorders. Supervisees discussed specialized instruction taught in supervision for working with clients with eating disorders. Supervisees reported that instruction provided them with an array of possible approaches to utilize. All supervisees stated that the instruction aided them in creating treatment approaches with specific clients to reduce symptoms of eating disorder diagnoses.
For example, Britney and Daisy talked at length about the specialized curriculum taught in supervision. The curriculum provided supervisees with possible procedures when working with specific clients diagnosed with eating disorders. Britney remarked about how helpful it was to collaborate with her supervisor on treatment plans to address the symptoms aligned with the diagnosis, in addition to comorbidity. Britney also spoke about how helpful it was to have readings on Dialectical Behavioral Therapy to help regulate and manage emotions of clients diagnosed with eating disorders; Cognitive Behavioral Therapy for working with clients with eating disorders; the Maudsley approach for adolescents diagnosed with eating disorders and their guardians; Interpersonal Therapy for working specifically with clients diagnosed with Binge-Eating Disorder; and genetics and neurobiology information as related to clients’ eating disorder diagnoses. Daisy commented about learning therapeutic procedures, boundary setting with personal concerns and clients, and “centering” communication (Interview 1). She stated that she was introduced to Gestalt therapeutic procedures, which she found to be a helpful approach at times when working with clients with eating disorder diagnoses.

**Reaction papers related to weekly counseling experiences.** All supervisees were assigned reaction papers related to their weekly counseling experiences. Some of these supervisees believed this to be helpful in providing structure and topics for instruction in the supervisory sessions while also promoting reflection about their experiences as counselor supervisees and their work with clients. Through these assigned weekly reflection papers, supervisees realized the importance of regularly practicing reflection
around their experiences as a counselor supervisee working with clients. They may not have regularly practiced reflection unless assigned weekly reflection papers.

**Modeling by the supervisor.** Daisy and Christina described ways in which their supervisors modeled counseling approaches and ways of being with clients in supervision. Specifically, Daisy and Christina talked at length about the ways that their supervisors modeled supervisory “centering” experiences. Daisy described her supervisor’s “good tone of voice . . . very calming,” and her supervisor’s facilitation of breathing exercises as helping with “centering” (Interview 1). From her supervisor’s instruction, Daisy learned to use “centering” procedures in supervision and then to reduce her nervousness during counseling. With reduced nervousness, Daisy was able to continue focusing on her clients. She then used this modeling of “centering” to reduce her clients’ discomfort during therapeutic sessions. Daisy also talked about her supervisor modeling Gestalt procedures, which she then used in sessions with her clients. Christina recalled that her supervisor shared observations about her (supervisor’s) limitations and this normalized Christina’s growth within their professional community. Regardless of independent licensure, Christina learned that both supervisees and supervisors grow in their counseling skills over the lifetime of a career.

Supervisors’ modeling of procedures in supervision aided supervisees in their understanding of ways to work with clients. These demonstrations enabled supervisees to empathize with how clients experienced counseling while also growing in their understanding of the implementation of different approaches.
Individual and group supervision. All five participants received weekly individual and group supervision that lasted for an hour. The main differences between individual supervision and group supervision were: (a) the supervisors’ ability to tailor the discussion to more specifically meet the supervisee’s needs in individual supervision, and (b) the supervisor and supervisees offering feedback on client cases in group supervision. Among the participants, commonalities in individual and group supervision included: (a) case consultation, feedback, and instruction and modeling of alternative treatment procedures; and (b) discussion about the impact of counseling work on supervisees’ feelings and thoughts.

In individual supervision, supervisees talked about their cases one-on-one with their supervisors. When compared to group supervision, supervisees received more specific instruction (e.g., possible therapeutic approaches) and support tailored to their unique needs in individual supervision. Specific examples included more instruction of therapeutic procedures and increased focus on reducing the supervisee’s nervousness (e.g., supervisor’s facilitation of “centering” exercises). The supervisors addressed the conceptualization of the supervisees’ client cases as well as their feelings and thoughts in response to clients. Although what was covered in individual supervision was similar for all of the supervisees, the amount of time spent on the different topics varied. Regarding group supervision, the supervisees spoke about hearing the perspective of their supervisor and other group supervisees while making case presentations. In group supervision, supervisees received feedback from multiple sources on how to proceed with clients and then were able to apply this feedback to their counseling sessions.
Similar to other supervisees, Ellen shared that discussion of cases was helpful to her in that she could listen to her supervisor and other supervisees in group supervision. She learned about alternative therapeutic approaches and received ideas about procedures to use with her clients. Ellen then stated that role-playing enabled her to practice skills she was interested in using with clients. Daisy discussed her ability to understand herself better after engaging in Gestalt activities in both individual and group supervision. Daisy stated that, through this process, her supervisor made her aware of her tendency to interrupt others in the group setting, encouraged her to share her feelings, and helped her see where she held those feelings within her body. Daisy realized that, after her supervisor’s questioning in both individual and group sessions, she was afraid of not being heard by other members so she would interrupt others to make sure that she had an opportunity to speak.

Supervisees also stressed the importance of individual and group supervision discussions. Christina disclosed that after a group supervisory discussion she felt supported by members when her silent feelings and thoughts were normalized. Although Christina chose to keep her feelings and thoughts to herself about her work related worries, she realized, through this discussion, that she could identify with other group supervisees’ disclosures about their work with clients. Listening to and identifying with their disclosures normalized her feelings and thoughts.

While Christina gleaned support through listening, specifically in group supervision discussions, Frankie benefited from sharing, even when she didn’t feel entirely comfortable with her expression of feelings in the group supervisory session.
Frankie reported that her supervisor supported her disclosures by validating and encouraging her to share feelings and thoughts in both individual and group supervision discussions. Frankie benefited from support in supervision, stating, “I [didn’t] have to compartmentalize and [was] able to show up as myself” (Interview 2).

Through group discussions, Ellen realized the importance of upholding healthy and realistic perceptions of her own body and this assisted her in maintaining self-care and continued professional growth. Ellen mentioned that one drawback about group supervision was the lack of cohesion among members. Ellen believed that discussions were limited by members’ inability to share more with each other in groups (i.e., efforts pertaining to their counseling or feelings and thoughts in response to clients). The strength of the supervisory relationship, in both individual and group supervision, was influential in determining the helpfulness of the discussion.

All supervisees reported that individual and group supervision, occurring weekly for one hour each, were valuable experiences. Supervisees were able to get feedback on their approaches with clients through the use of case conceptualization and presentation. They were also able to discuss the professional impact of their work on their feelings and thoughts and gather support from their supervisor and other supervisees in group supervision. However, all five supervisees reported that feedback and support were regulated by the supervisees’: (a) willingness to openly share information pertaining to their counseling work in individual and group supervision, and (b) perceptions of their supervisory relationships during individual and group supervision.
Structural Descriptive Themes of Supervision

The structural descriptive themes of supervision explained “how” the majority of participants understood their supervisory experiences. The structural descriptive themes explained the underlying dynamics or the participants’ meanings or beliefs about their experiences. To capture structural descriptive themes, the researcher considered “how” the meaning of participants’ reported disclosures was impacted by: the person of the participant, other people engaged with the participant, and the context of the participant. Structural descriptive themes also surfaced from the process of imaginative variation when the researcher asked questions of participants to attain these variations in data collection and considered diverse perspectives about “how” the participants may have felt and thought about “what” they experienced in supervision in the data analysis. Structural descriptive themes of supervision included feelings and thoughts about: (a) competencies as a counselor; (b) population of clients diagnosed with eating disorders; (c) resources offered at specialized eating disorder treatment centers; (d) behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders; and (e) supervisory relationships.

Competencies as a counselor. Britney and Christina reported worries about their professional competency in general when working as a new counselor. Their “worries” or concerns were exacerbated by “high expectations” for themselves and by their perceptions of their employers’ “high expectations.” These supervisees stated that they “worried” about not working “effectively” with clients, and they often had “high expectations” for themselves in the profession of counseling and desired to be viewed as
“skilled” and “professional” (Britney, Interview 1; Christina, Interview 2). This apprehension may be normal when working as a new counselor. These concerns may have led to supervisees desiring more instruction from their supervisors and feeling unsatisfied about their supervisory experiences when their supervisor didn’t provide this instruction.

**Population of clients diagnosed with eating disorders.** The population of clients diagnosed with eating disorders shaped supervisees’ supervisory experiences. The majority of supervisees stated that comorbidity was common with clients diagnosed with an eating disorder (e.g., Depression, Bipolar Disorder, and Obsessive Compulsive Disorder). Supervisors responded to supervisees’ reports of challenges addressing comorbidity in clients with instruction about possible approaches for general and specific clients diagnosed with eating disorders. All supervisees reported benefitting from instruction pertaining to a variety of possible therapeutic approaches specific to counseling clients diagnosed with eating disorders. Supervisees found this supervision to be helpful, especially when they first began working with clients diagnosed with these disorders. With supervisory instruction targeted toward working specifically with clients diagnosed with eating disorders, supervisees felt more confident in their work with this population. Instruction in supervision specific for working with clients with eating disorder diagnoses may support supervisees who feel anxious about their ability to work with clients when supervisees are in the early stages of development as a counselor or when they are working with a new population for the first time. In this early stage of development, the supervisee may desire and benefit from more instruction in supervision
about possible approaches to utilize with particular clients. Instruction in supervision may facilitate increased confidence in working with their client population.

**Resources offered at specialized eating disorder treatment centers.** All supervisees worked with their clients at specialized eating disorder treatment centers that offered varying levels of care and additional resources to meet client needs. These specialized treatment centers offered additional resources, including: (a) support groups for family and friends of clients with eating disorder diagnoses, (b) dietetic instruction for clients, (c) psychiatric services, and (d) medical support. The additional resources may have met client needs while also providing supervisees with assurance that their clients were being treated holistically. These additional resources allowed for supervisees to work alongside others on a treatment team. The treatment team worked together in helping clients and may have allowed supervisees to feel supported in working with clients. On a treatment team, supervisees could consult with others about their work and felt positive about united efforts in working with clients. This may have impacted their experiences with supervision in that supervisees may have felt more confident about helping clients meet their goals.

**Behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders.** Supervision may aid supervisees in managing their professional behavior, feelings, and thoughts specifically with regard to the impact on their counseling efforts. While all five supervisees, Britney, Christina, Daisy, Ellen and Frankie, went to their supervisors for instruction and support regarding behaviors, feelings, and thoughts, Britney, Christina, Daisy, and Ellen admitted that they did not reveal everything to their
supervisor. Situations when supervisees did not fully disclose included: (a) supervisees’ concerns about appropriate modeling of eating, and (b) supervisees’ desires for support while working with a challenging client. Only Frankie reported complete disclosure to her supervisor about the impact of her work on her behaviors, feelings, and thoughts. The supervisees’ ability to be honest with their supervisors may have impacted their ability to meet their supervisory goals. It would be understandable that supervisees would report more positive feelings and thoughts about supervision if their goals were met.

Supervisees’ concerns about appropriate modeling of eating. Some supervisees shared meals with clients in individual sessions or in group counseling sessions. Concerns about modeling surfaced for some of these supervisees, as they asked themselves if they were eating enough when with clients. They wondered what clients were thinking about their (supervisees’) eating patterns and food choices. Christina asked herself, “Am I eating enough?” “Are they looking at me and thinking ‘[She’s] not eating enough’?” “What do they think?” “Are they judging me?” “Am I eating too fast?” “Do the clients notice that I pretty much bring the same thing to eat [each day]?” “Am I going to finish everything?” (Interview 2). Christina talked about conferring with her supervisor for suggestions regarding the appropriate amount and types of food to bring to meal counseling group sessions with clients in order to reduce her concerns about appropriate modeling. Christina may have thought that supervision was a helpful resource when her supervisor offered her suggestions about her modeling in meal groups with clients.
Supervisees’ desires for support while working with a challenging client.

Britney shared with her supervisor a situation concerning the professional impact of her work on her behaviors, feelings, and thoughts. Britney sought support from her supervisor to help her with a client. She reported that she felt positive about her supervisory experiences because her supervisor taught her to be firm, set boundaries, and utilize DBT to help her client with emotional regulation. Britney disclosed that her supervisor encouraged her to not take her client’s inappropriate behavior toward her personally. She recalled her supervisor stating,

“It’s part of this disorder, and that’s why she’s doing it. It has nothing to do with you. You know that’s part of the diagnosis.” And then she [my supervisor] would give me tips . . . [on] what maybe she did in a session that she saw was beneficial, and then I could try and do it. So, it was really, really helpful. . . . She [my supervisor], would say, “It’s her disorder, and her disorder is offending you, rather than her, the person. You are at battle with her disorder, not her. So don’t take it personally.” (Britney, Interview 1)

After supervisees requested support, they reported positive feelings and thoughts about supervision when their supervisors aided them in managing the impact of their work on their behaviors, feelings, and thoughts in response to clients. These practices included: (a) normalizing supervisees’ behaviors, feelings, and thoughts in response to their clients; (b) teaching the importance of upholding strong boundaries with clients; and (c) encouraging the practice of self-care.
Normalizing supervisees’ behaviors, feelings and thoughts in response to their clients. Britney explained that she sometimes felt bad about her “countertransference” experiences (i.e., behaviors, feelings, and thoughts in response to clients), but stated that her supervisor was helpful through encouragement and normalization (Interview 1). It seemed that because of her supervisor’s normalization of her behaviors, feelings, and thoughts, Britney’s concerns decreased, and she continued to focus on her clients.

Britney disclosed thoughts about the process.

A lot of times I would feel guilty if I was having countertransference [i.e., behaviors, feelings, and thoughts in response to clients]. So that would be difficult to talk about. But it helped hearing how [my] supervisor reacted [to her clients in behaviors, feelings, and thoughts] . . . and also to hear the other clinicians share similar experiences [in group supervision] was helpful. [One supervisor encouraged] me to process [with her] what it was about and what I was feeling [in supervision sessions]. (Britney, Interview 1)

Teaching the importance of upholding strong boundaries with clients. Both Britney’s and Daisy’s supervisors stressed the importance of establishing boundaries with clients diagnosed with eating disorders. Because of these boundaries, both Britney and Daisy were clear about expectations for clients, and they may have felt more certain about how to proceed with clients. This increased certainty may have allowed them to feel more confident about their decisions. Britney stated that she had grown in supervision and realized that all counselors experience countertransference. Her supervisor aided her in establishing minimal expectations with clients and that allowed
her to focus on clients who were willing to make changes necessary to reduce symptoms of the eating disorder diagnosis.

[My supervisor] could be difficult to work with at times, but I really grew . . . as a [counselor] because she was that way. She would challenge me with some clients . . . and taught me limits with what I was willing [to tolerate in counseling from clients]. I learned to say, “I’m not going to see you [referring to the client], because you need more care than I can give you. So, if you are continuing to binge seven times a day, and you’re not trying any of the things we talk about, that is not outpatient level [care] appropriate. It’s not ethical for me to see you. It’s not helpful for me to see you.” She [my supervisor] was really good at helping me say, “That is great progress, and you need more than what I can give you.” And that I think is the only way you can [avoid] burn out in this field, if you know your limits. If you are like, “I really, really care about you, but I’m not going to take you.” (Daisy, Interview 1)

Daisy’s first supervisor aided her in establishing boundaries with her clients by teaching her to not work with clients who continued to present with severe symptoms (e.g., unable to eat food with “minimal, reasonable interference;” Interview 1). Daisy’s supervisor explained that these clients needed more care than Daisy would be able to provide in an outpatient counseling setting and Daisy was taught to provide clients with a referral for alternative care. Because of this supervisory focus on establishing boundaries, Daisy may have felt assured that she was working with clients who were capable of progressing in outpatient counseling.
Encouraging the practice of self-care. Britney’s, Frankie’s, Ellen’s, and Daisy’s supervisors all advised their supervisees to use self-care practices to reduce the impact of their counseling work on their own behaviors, feelings, and thoughts. Britney also talked about how her supervisor stressed self-care in response to a personal situation.

[I was] dealing with a lot in my personal life and trying to make sure it didn’t affect my work. My supervisor [encouraged me to] take care of [my]self and understand that [I am] human. My supervisor . . . gave me tips on how to manage all of that and balance. “You’re human. Just because you are a [counselor] doesn’t mean that you can’t grieve. It’s okay if you need time off. It’s okay if you feel this way, for whatever amount of time that would be. We all know this from our education, but everyone grieves differently. It’s a different process, and a different time span for everybody.” And she basically said that there are going to be times where you are going to be triggered because of a client that you have. She said, “It’s okay to talk about personal life stuff too [in supervision]. (Britney, Interview 1)

Another supervisee, Frankie, talked with her supervisor about her interest in counseling clients with body image disturbance and how she could relate to their struggles. She stated, “There’s a sense of desperation about losing weight [for clients]. I can relate to their desire to lose weight and understand all of that weight stigma that is attached” (Frankie, Interview 2). When impacted by her work with clients, Frankie responded by upholding self-care (e.g., dressing in clothing that enabled her to feel more
comfortable or setting boundaries between her professional and personal life). Frankie’s supervisor encouraged her maintenance of self-care.

In contrast to the other supervisees, Ellen discussed how her supervisory education about nutrition encouraged her to maintain self-care when working with clients diagnosed with eating disorders. She believed this education reinforced the importance of moderation in eating, regardless of whether the foods were labeled as whole or processed.

Daisy talked about the importance of preventing her personal concerns from interfering with her work with clients. Daisy spoke of “noise” in life that sometimes distracted her (Interview 1; Interview 2). Daisy reported that her supervisor stressed the importance of self-care and to talk about this “noise” in supervision in order to prevent it from interfering with her focus on clients. Daisy believed this supervisory focus was helpful in aiding her efforts with clients.

Some supervisees also reported situations where their own behaviors, feelings, and thoughts were not revealed to their supervisors. These supervisees disclosed a couple of examples of experiences that were kept private such as: uneasiness about a supervisor’s perceptions of a supervisee presenting with any behaviors commonly aligned with the diagnosis of an eating disorder; and uncertainty about supervisors’, colleagues’, and clients’ perceptions of a supervisee’s competencies. This inability to be honest about their feelings in response to their work with clients may have limited an opportunity for supervisees to experience supervision as a helpful resource.
Supervisory relationships. For all five participants, the supervisory relationship was important to their supervision experience. If the supervisee described the relationship as positive, the supervisory experience was viewed more favorably. The supervisory relationships were described based on the following attributes: (a) comfortable, (b) supportive, and (c) trustworthy.

Comfortable. Supervisees described their supervisory relationships as both comfortable and uncomfortable. Although the word comfort more often aligned with a helpful experience, discomfort in one circumstance challenged a supervisee to grow by stretching her outside of her comfort zone. Supervisees also noted discomfort in other situations. Frankie reported discomfort within the supervisory relationship when her supervisor assumed the responsibilities of a “boss” (Interview 1; Interview 2). Two supervisees disclosed discomfort with a supervisor who was male. A comfortable supervisory relationship enabled a helpful experience as evidenced by descriptions of “competency of supervisor” (Christina, Interview 2; Daisy, Interview 2) and “empathic” communication processes (Christina, Interview 2).

Level of comfort did not necessarily define the helpfulness of the supervision, as both comfort and discomfort were aligned with helpfulness in the situation where Britney was challenged to grow. “Discomfort” in a supervisory relationship, however, was deemed unhelpful in two circumstances. In the first instance, the supervisor also fulfilled the responsibilities of “boss,” and the supervisee described “discomfort” because of responsibilities associated with the two roles (Frankie, Interview 1; Interview 2). In the second instance, two supervisees described “discomfort” with male supervisors because
of their doubt about a male sharing some of their perceptions pertaining to body image
dissatisfaction and eating disorders (Britney, Interview 1; Interview 2; Christina,
Interview 2). As a result, these supervisees shared less with their male supervisors.

Frankie supported the notion of unhelpful discomfort when describing a
supervisor who was also her boss.

I think whether it’s my previous experiences or just the nature of most work
environments, you want a little more distance from a boss emotionally. The boss
makes a lot of decisions, financial decisions, promotion[al] decisions, and if they
have more intimate information about you, it could change the outcome of your
career . . . when you are processing countertransference and things . . . you’re
vulnerable. And you need that support . . . from your supervisor . . . [and] you
might be fearful about disclosing that information with the person who’s also your
boss. (Frankie, Interview 1)

A comfortable relationship was aligned with growth in supervision, although
discomfort was also linked to progress for three supervisees. For example, when a
supervisee was pushed out of her comfort zone, she may have been able to realize more
about herself as a counselor. Britney spoke to this topic directly by describing her
relationship as uncomfortable, yet helpful. It may have pushed her to grow in her
understanding of herself as a counselor.

I would get annoyed or uncomfortable when my supervisor used the Gestalt . . .
supervision on me. I thought, “Oh my gosh, I’m not your client. What are you
doing?” But like I said, looking back, it was helpful . . . but it wasn’t somewhere
I wanted to go, at times, when I need[ed] to. She [my supervisor] would make us do empty chair towards other parts of ourselves or a client [with whom we] are having countertransference. She [my supervisor] would make me identify what I was feeling, and she would totally call me out on my body language. (Britney, Interview 1)

Christina and Ellen used the word comfortable to describe their supervisory relationships by talking about communication processes. Christina described her supervisor as empathic because she listened with a “comforting and warm” presence (Interview 1). Similar to Christina, Ellen described her supervisor as empathic with a supportive and open mind.

Supportive. Four supervisees, Christina, Ellen, Frankie, and Daisy, stated that supervision was helpful when aligned with a supportive supervisory relationship. The supervisees deemed their relationships with their supervisors as supportive for the following reasons: (a) the supervisor’s understanding and assurance of help after the supervisee disclosed a need; (b) the supervisor’s listening skills; and (c) the supervisor’s instruction and modeling of therapeutic procedures, and assistance with establishing boundaries with clients, “centering,” and self-reflection.

Christina defined supervision as supportive because of her supervisor’s assurances that she would help Christina after her disclosure about challenges at work. Christina’s supervisor reassured her.

Every person in this program has had a point in time where, if they can’t handle the things that are going on, we, as a team, come together and help [them] with
that and help [them] get through that. What do you need? (Christina, Interview 1)

Christina also stated that her supervisory relationship was supportive in that her supervisor frequently asked about her welfare at work and commended her counseling efforts with clients.

Ellen and Frankie believed that their supervisory relationships were supportive because of their supervisors’ listening skills. Ellen stated, “She’s [my supervisor’s] a good listener. She doesn’t interrupt me. She’s a really good listener” (Interview 1). Similar to Ellen, Frankie disclosed, “I really feel that she’s good at listening to me. In validating my concerns, she is very no-nonsense” (Interview 1).

Daisy discussed the support she felt in one supervisory relationship. Daisy explained instruction and modeling of therapeutic procedures (e.g., Gestalt procedures), establishment of boundaries with clients, “centering” communication, and self-reflection contributed to her feelings that the supervisory relationship was supportive. After instruction and modeling, Daisy stated that her confidence using the Gestalt approach in counseling with clients had increased. With regard to establishing boundaries, Daisy reported being challenged by her supervisor to realize that she was working too much in sessions with clients rather than facilitating the client’s role in her process of change. Daisy learned that she needed to encourage clients to take more responsibility for their growth. In response to this realization, she learned to establish healthy boundaries with clients by setting minimal expectations for clients (e.g., ability to schedule and keep appointments). Daisy’s supervisor also taught her communication for the purposes of
“centering” and encouraged her to self-reflect to aid her in professional growth. Through the self-reflection, she was able to grow in awareness of her strengths and weaknesses as a counselor and make changes to improve her counseling skills.

**Trustworthy.** Trustworthiness was another attribute used to describe supervisory relationships. Supervisees described their supervisory relationships as trustworthy when they were able to believe in the competency of their supervisor and when they were able to be vulnerable and share aspects of their work with a supervisor.

Britney and Daisy spoke about trust as an attribute of their supervisory relationships. This trust allowed these supervisees to be more vulnerable in supervision and helped them to benefit from supervision. Britney described her trust in her supervisor.

I trusted [my supervisor]. I trusted that she knew what she was doing and that [her supervisory exercises] were going to be beneficial. I didn’t question it . . . and with growing and changing, you have to be vulnerable, and uncomfortable, and [then accept this discomfort]. We make our clients do it, so why shouldn’t we as well? (Britney, Interview 1)

Daisy described a similar trust in her supervisor because of respect for her as a well-known professional in the field in addition to her supervisor’s validating and supportive approach.
Individual Textural and Structural Descriptions for Supervisory Experiences When Working With Clients Diagnosed With an Eating Disorder

According to Moustakas (1994), phenomenological research seeks to identify the essence of an experience by identifying the textural and structural descriptions. The textural descriptions illustrate the raw behaviors, feelings, and thoughts about participants’ experiences, also referred to as “what” is experienced. The structural descriptions display the underlying dynamics or participants’ meanings or beliefs of the experience, representing “how” the feelings and thoughts are connected to the phenomenon. Thus, the structural description illuminates what shaped the participants’ experience overall. For example, in the current study, the textural description may be exemplified through a supervisee’s description of her supervisory experiences, including case conceptualization or watching and assessing her counseling tapes with the supervisor. In comparison, the following example illustrates the structural description. If the participant stated that case conceptualization was helpful as part of her textural description, the structural description would illuminate “how” it was helpful or “how” it was meaningful. For example, the supervisee may think that the teaching element of case conceptualization aided her in better understanding clients’ presenting symptoms. With this understanding, the supervisee may have been less anxious with her clients, may have been more responsive to her clients in sessions, and may have felt positive about her counseling work. In the current study, these feelings and thoughts may not have been stated directly by supervisees, but may have been supported indirectly through their statements.
Individual Textural Descriptions of Supervision

After each interview, the researcher constructed individual textural descriptions for each participant from the meaning units also known as “invariant constituents” (Moustakas, 1994) found within the participants’ transcribed interviews. The textural description sought to answer the research question, “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” In this description, the researcher used verbatim statements from the transcribed interviews to represent “what” the participants experienced in supervision. The individual textural descriptions for each participant are presented below.

Britney’s textural description. The textural description of Britney’s Supervisory experiences presented “what” she experienced in supervision. Britney described her experiences of individual supervision with two different supervisors as well as her experiences of group supervision with one of her individual supervisors. Key components of her supervisory experiences surfaced from interviews with the researcher. Britney’s descriptions of her first individual supervisory experiences were similar to those that she experienced in group supervision because they were both facilitated by the same person.

When describing her experiences of individual supervision with her first supervisor, Britney reported the process to be “structured,” as evidenced by meeting once a week and having a clear focus for the process, including instruction in response to specific clients diagnosed with eating disorders, specialized curriculum surrounding possible treatment approaches with particular clients, and reaction papers about
professional experiences (Interview 1). Britney’s preferences for structure in supervision were increased by her doubts of professional competence in general as a new counselor and when working with clients diagnosed with eating disorders. Britney shared her thoughts about her doubts.

So, that first year, being a new clinician, working with a totally new population, a very difficult population at that, [I found myself] constantly questioning [my] competency. Talking about this was difficult because I had this notion that because I was out of graduate school, I was supposed to know [how to work with clients]. I had high expectations for myself and was worried that this job and company that just hired me out of graduate school also had them [expectations] for me. (Britney, Interview 1)

Britney stated that the focus of this “structured” supervision helped her alleviate concerns about competency (Interview 1).

Britney stated that her supervisor relayed her extensive experience working with clients diagnosed with eating disorders by (a) sharing a specialized curriculum about possible approaches for working with these clients, and (b) assigning weekly reaction papers focusing on Britney’s counseling experiences. Britney described this specialized curriculum as reading and learning about: different comorbid diagnoses (e.g., Obsessive Compulsive Disorder and Depression), and diverse treatment approaches for working with clients diagnosed with eating disorders (e.g., Dialectical Behavioral Therapy [DBT] and Acceptance and Commitment Therapy [ACT]). Britney shared her initial thoughts and feelings about her supervisor’s instruction.
“I’m done with school. I’m over it. I don’t want to do it anymore. Like why do we have to do this?” But it was really helpful and I did enjoy it in the long-run. I liked the structure of it. (Britney, Interview 1)

One reason Britney found this specialized training to be helpful was because it allowed her to address the complex symptoms of her clients diagnosed with eating disorders, including comorbidity. Britney stated that comorbidity, the simultaneous presence of two chronic conditions, is common with clients diagnosed with an eating disorder. With this training being part of her supervision, Britney felt more competent in her ability to work with clients.

Through specialized curriculum that her supervisor designed, and assignment of reaction papers, Britney had additional learning opportunities and occasions to become more proficient working with clients diagnosed with eating disorders. Britney noted, “[The reaction papers were aligned] with a theme around eating disorders, what we saw in our personal life, as related to my counseling work, or stuff that was happening at work with another staff member or within our caseload” (Interview 1). The purpose of the papers was to reflect on some of her professional experiences in order that they might be discussed in individual supervision.

Britney’s supervisor used Gestalt therapeutic approaches so that Britney could view these as possibilities in her work with clients, and might better understand herself as a clinician and her clients’ possible experiences with these therapeutic approaches. Britney then used this increased understanding to aid her in working with clients because she was more skilled with using the procedure and could also more fully empathize with
the client’s experience. Britney stated that some of the experiences she had in supervision were challenging. She disclosed her feelings and thoughts about her supervisor’s use of Gestalt approaches with her in supervision. Britney referred to the impact of these experiences using plural pronouns because both she, in individual supervision, and her peers, in group supervision, participated in the activities.

She [Britney’s supervisor] would make us do empty chair towards other parts of ourselves or a client we [were] having countertransference with. She would make us identify what we were feeling, and she would . . . call us out on our body language. If I [had] a bad day, she knew. She would . . . call me out on it and make me sit with it and explain what I was feeling and where [I was feeling this emotion in my body]. It was very uncomfortable. I often thought, “Oh, my gosh! I’m not your [her supervisor’s] client. What are you doing?” (Interview 1)

Britney stated that even though she had this reservation, she trusted her supervisor. Britney described her perceived trust in her supervisor that led to her acceptance of her supervisor’s challenges; “With growing and changing, you have to be vulnerable, be uncomfortable, and sit with [these feelings]. We [challenge] our clients to do it, so why shouldn’t we” (Interview 1)?

Britney also discussed her work with another supervisor in individual supervision and described it as less instructional especially in comparison to her first supervisory experience. Britney’s supervisor shared similar professional experiences with her while supporting Britney in finding her own answers to questions regarding client cases. Britney also cited examples of her supervisor guiding her in response to frustration about
insurance companies’ refusal to authorize clients’ care. Britney elaborated on these feelings in the following disclosure.

[My supervisor] has a lot of experience with [insurance companies] as well, so [my supervisor] just kind of helps walk me through [the] ways she handled it in the past. And then she also kind of helps me process what’s really going on or why I’m having certain emotional reactions to that issue . . . because I do. I wouldn’t say [I] get emotionally attached to the clients or anything. I mean I have boundaries, but I do have [some feelings of] responsibility when I’m not able to get the insurance company to authorize their treatment. [I think], “Oh no! Now what? [The clients] really needed that treatment.” I definitely feel for them. . . .

For lack of words, it’s frustrating. (Interview 1)

In this example, Britney’s supervisor offered her suggestions about managing her interactions with the insurance companies, based on the supervisor’s similar experiences. Britney’s supervisor also helped Britney process through her feelings and thoughts in response to her dealings with insurance companies.

Britney’s group supervisory experience, led by the first supervisor described in this section, included up to eight supervisees at a time for one hour per week. Britney reported that group supervision included education applicable to particular clients with whom she worked. Many of these topics were similar to those covered in individual supervision (e.g., DBT and Gestalt Therapeutic approaches). Britney stated that education on a variety of treatment modalities helped her to meet the needs of her clients. Britney also reported feelings of openness and trust in this group after she was able to
move past her feelings of intimidation about other group members’ credentials (e.g., Doctor of Medicine [M.D.] or Doctor of Philosophy [Ph.D.]).

Britney disclosed differences in her supervisory relationships. Her relationship with one supervisor was “connective and egalitarian” (Interview 1). Britney disclosed that all of the following attributes and actions contributed to the connective and egalitarian characteristics of the relationship. Britney stated that she and her supervisor had similar personalities, and she felt comfortable talking about her feelings and thoughts in response to clients. Britney added that this supervisor supported her by “normalizing her feelings” and “encouraging self-care practices” (Interview 1). Britney explained that her supervisor provided instruction about how to separate her professional and personal domains to take better care of herself. At the same time, her supervisor normalized this difficulty of separating one’s professional and personal domains by stating that “counselors are human,” and the professional and personal domains sometimes collide (Interview 2). An example of a collision may be when a counselor’s personal life (e.g., sleep deprivation or the birth of a child) makes it difficult to be fully present with clients’ concerns. Britney explained that she felt emotionally distant in her relationship with her second supervisor. Though personality differences exist for all individuals, regardless of gender, Britney attributed some of the emotional distance she felt in the relationship to his gender. She added that she doubted that men, those working with clients diagnosed with eating disorders, would understand the female perspective.
Christina’s textural description. Christina’s textural description presented “what” she experienced in supervision. She experienced individual supervision with two different supervisors and experienced group supervision with one of her individual supervisors. Because one of her individual supervisory experiences was for only three weeks, she stated that she could not provide an adequate description of this period of time. Therefore, Christina’s textural and structural descriptions are based on individual and group supervision experiences with the same supervisor. All individual and group supervision experiences occurred once a week for one hour each.

Christina reported that her individual supervision sessions had a flexible agenda; she brought her concerns to the sessions and spent a lot of time on case conceptualization. She reported that her individual supervisor encouraged reflection around her work with clients and noted that her supervisor normalized her behaviors, feelings, and thoughts concerning her inexperience working with clients. These supervisory discussions helped to ease Christina’s feelings and thoughts about her competency and limited work experience with this population in general and with regard to specific clients. Christina was initially hesitant to share her perceived lack of experience or ask for help because she desired her supervisor to view her as a competent professional. Christina stated that, when she finally did reveal her feelings and thoughts to her supervisor, her professional growth and limitations were normalized. She found out that both supervisees and supervisors are growing, and both have things to learn regarding their work with clients. Christina’s supervisor shared some of her professional limitations and Christina stated
that this was helpful because she realized that she was not alone with her behaviors, feelings, and thoughts.

Christina spoke about her individual supervisor facilitating supervision by teaching her about possible therapeutic approaches (e.g., DBT and ACT) for working with clients with eating disorders and suggested different therapeutic approaches to utilize with “challenging” clients (Interview 1). To support and encourage her use of diverse approaches, Christina’s supervisor shared worksheets and handouts for her to use in sessions with clients. Christina stated that her supervisor’s teaching of a specialized curriculum provided a foundation for understanding possible ways of working with specific clients and clients in general.

Christina stated that the assignment of weekly reaction papers in supervision was something she found to be helpful at the beginning of her supervisory experience because they provided structure and facilitated her reflections on herself, her clients, and her therapeutic relationships with her clients. Christina stated that she found it unfortunate that her supervisor eventually discontinued assigning these reaction papers. Christina described the reaction papers.

[Reaction papers were about] writing where I was [professionally] and what I needed help with. It would be just writing out your experience that week... anything [I was] wanting to bring to supervision to work on. [These reaction papers] gave the [supervision] session more structure, and I think for me, writing can be really helpful just to get things out, [such as feelings or thoughts] that I
wouldn’t necessarily think about when I’m just talking with someone [supervisor in supervision]. (Interview 1)

In group supervision, Christina reported the following activities: case conceptualization, instruction about possible therapeutic approaches with clients diagnosed with eating disorders, and normalization of pressures in working with these clients. Case conceptualization gave Christina an opportunity to see how other supervisees were working with their clients, while also receiving feedback and support concerning alternative approaches with her individual cases. She reported that instruction about working with clients in her caseload and in general was helpful because it increased her understanding of the diagnoses and provided her with possible approaches for this specific population (e.g., education pertaining to DBT and neuroscience research associated with eating disorders). Christina explained how group supervisory discussions allowed her to normalize some of the pressures she felt when working with clients diagnosed with eating disorders. Christina stated that group members discussed how common it was to have feelings and thoughts (i.e., concerns) in response to clients diagnosed with eating disorders. Her supervisor also encouraged her to grow in connection with the other supervisees through sharing. Christina stated that her supervisor challenged her by saying, “When you do present that way, like you don’t need help from anyone, it can come off like cold or aloof” (Interview 1). Although Christina noted that she didn’t often share her feelings and thoughts in group supervision, she stated that she felt supported by the other group supervisees’ disclosures.
During the interview, Christina disclosed behaviors, feelings, and thoughts that surfaced about her own body in response to working with clients, yet she was hesitant to reveal these in individual or group supervision. Christina shared that her occasional dissatisfaction with her own body image sometimes aided her in relating to clients’ concerns. Christina explained that she was fearful about being perceived in her workplace as being “unhealthy” (Interview 1).

I think there is definitely a culture of, “You can’t work here if you have an eating disorder or if you have had a history of an eating disorder recently. You need to be in recovery.” I do not have a history of an eating disorder, but certainly have thoughts of my own body image or wanting to stay fit or lose weight. And so I think I would be hesitant to talk about that, just because I would be afraid people would suspect something that wasn’t there. . . . I have thought about that before, and I don’t think I would talk about that. I think, I don’t know, I can’t speak for everyone, but for me, kind of like I said before, it’s that fear of being “flagged” or being pulled into someone’s office and saying, “We think you have a problem.” (Interview 1)

Although Christina was hesitant initially, during supervision, she eventually elaborated on her behaviors, feelings, and thoughts about her relationship with food. Later in the supervision process, Christina explained that she reached out to her supervisor for instruction and support regarding these behaviors, feelings, and thoughts in response to her work with clients. Christina’s supervisor facilitated these discussions by providing her with non-judgmental listening to talk about her concerns. With regard to
food in general, Christina stated that she talked with her supervisor regarding her worries about food items she should bring to meal group sessions, the lack of diversity in her food choices, and questions about the appropriate amounts of food to eat at these meals. Pertaining to Christina’s behaviors with food, the supervisor used nonjudgmental and curious questioning and reflection to facilitate mindfulness (being present in the moment) about Christina’s eating pace and ability to finish food items she brought to meal groups where she monitored clients’ food intake and eating patterns. Christina relied on her supervisor for support in response to her concerns to ensure that she was modeling appropriately with her clients. Supervision provided her with a comfortable space to process and consider her behaviors, feelings, and thoughts in response to her work with clients.

Christina’s supervisor provided instruction to calm Christina’s concerns about her behaviors with food and enabled her to navigate her position as a counselor in meal group sessions in a more confident manner. Christina incorporated her supervisor’s suggestions, for example, by bringing a small to medium amount of food to a meal group to avoid a situation where she may be too full to finish her meal. When Christina expressed concerns about mindfulness in her facilitation of meal groups with clients, Christina’s supervisor normalized her feelings and reassured her that this lack of mindfulness was a reality for counselors who were responsible for monitoring clients’ intake of food in meal groups. Her supervisor stated that all counselors had a limited ability to uphold mindfulness in meal groups because they were multi-tasking and this made it difficult to be present in the moment.
Throughout both individual and group supervision, Christina reported a positive relationship with her supervisor despite her initial reluctance to share some of her behaviors, feelings, and thoughts in response to her work with clients. Christina stated that her supervisory relationship was a positive one because her supervisor validated her counseling efforts, assured her that she was not alone with her challenges, and reiterated that help, in the form of supervision, would always be available as a resource. Christina explained that her supervisor listened in an understanding manner, displayed empathy and competency, and provided examples from the supervisor’s own experiences.

Christina provided examples of some of the helpful and supportive questions her supervisor posed, “How are you doing with everything?” “Is there anything that we can do?” “How are you feeling about all of the changes in the job?” “How is the process going?” “Are there any changes you would make?” (Interview 1). Christina stated that her supervisor empathized with her when she verbalized concerns (e.g., clients’ hesitancy to commit to counseling), as she said, “This is a lot to deal with. If you need support, let us know. We work as a team” (Interview 2). Christina also stated that she felt comfortable because of her supervisor’s competency and level of experience.

Christina disclosed that she believed that her positive relationship with her supervisor may have been aided by the fact that her supervisor was a female, stating that she would feel less comfortable speaking with a male supervisor. Christina reported her perception of working with a male versus a female supervisor.

We [clinicians] should definitely do it [have discussions about our feelings and thoughts in response to clients’ disclosure about their body disturbance and
symptoms related to their diagnoses]. However, I don’t know if a male supervisor would [understand] it. My female supervisor addressed it pretty directly and was receptive. Maybe they [males] wouldn’t be able to relate to a woman’s experience of dealing with body image and the messages from the media, messages even from family members growing up, or people or friends, because it is different for them. It definitely comes up for them [males], obviously, but the majority of my clients are female, so I think their [males’] take on it is a little bit different personally than ours. I think that they [males] can definitely empathize [with issues related to body image], and they can definitely have the education about it, and everything, but it’s just, I think it’s different when you experience it yourself. (Interview 2)

**Daisy’s textural description.** Daisy’s textural description of supervision or “what” she experienced in supervision was composed from three experiences: individual supervision with two different supervisors, and group supervision with one of her individual supervisors. She reported a focus on learning more about possible therapeutic approaches and about herself as a counselor during her first individual supervisory experience and her group supervisory experience, which was led by her first individual supervisor. Through these supervision experiences, Daisy built a foundation to enable her to work with clients diagnosed with eating disorders. Daisy described the supervisor of her second individual supervisory experience as less instructional. Daisy stated that she preferred an instructional style and thus found this second supervisory experience less
helpful than her previous supervisory experiences. All supervision experiences met weekly for one hour.

During Daisy’s first individual supervisory experience, Daisy explained that she was “molded, shaped, and taught how to be a [counselor]” by her supervisor (Interview 1). Here, Daisy learned more about: (a) possible therapeutic procedures to use with clients, (b) reflective listening, (c) self-reflection, (d) boundary setting with clients, and (e) general self-care. With regard to learning about therapeutic approaches, Daisy reported that she spent a great deal of time learning about DBT and Gestalt therapeutic approaches to possibly use when facilitating individual and group counseling sessions. Daisy reported that her supervisor taught her about these approaches by modeling procedures of each approach with her in supervision. Especially with Gestalt therapy, Daisy stated that she learned through experiencing the “here-and-now” in supervision (Interview 1; Interview 2). A hypothetical example of this could be a supervisor modeling an empty chair technique with one of the supervisee’s descriptions of a client or a problematic aspect of self (e.g., a tendency to interrupt or a desire to control counseling sessions). The supervisor would encourage and facilitate dialogue between the empty chair and the supervisee to increase awareness of the supervisee’s behaviors, feelings, and thoughts. This awareness might then be used in supervision to increase Daisy’s understanding of her counselor identity. Counselor identity could be referred to as the supervisee’s understanding of her profession according to: “(a) counselor tasks and services provided; (b) counselor training and credentials; (c) wellness and developmental focus” (Mellin, Hunt, & Nichols, 2011, p. 143).
Daisy stated that learning more about reflective listening and self-reflection allowed her to better focus on counseling processes and to understand herself more fully. During individual supervision, Daisy reported that her supervisor taught her more about being a reflective listener with her clients and how to respond to clients with statements such as, “I am so hurting that you are hurting” or “That makes me really upset that you would say that” (Interview 2). In addition to reflective listening, Daisy’s supervisor also encouraged self-reflection by asking questions of her such as, “What’s going on with you when this is happening?” and “Why are you responding this way?” (Interview 2). Daisy cited another example of self-reflection when talking about some clients and experiencing heightened emotions. She recalled her supervisor asking her to identify her emotions in that moment and to talk about her behaviors, feelings, and thoughts in response to clients. Daisy stated that her supervisor facilitated this self-reflection through processing Daisy’s feelings and thoughts with her in the moment. Daisy believed that self-reflection was needed to become a better counselor.

Daisy’s supervisor taught her to set boundaries with clients through the creation of criteria for outpatient counseling. Daisy disclosed some behaviors, feelings, and thoughts with her supervisor to elicit support. She spoke about how she felt “exhausted” at times working with clients diagnosed with eating disorders especially if a client did not seem appropriate for outpatient counseling (e.g., needed a higher level of care; Interview 1). To help Daisy determine whether or not a client was appropriate for outpatient counseling, her supervisor taught her to set a minimum expectation or criteria for clients to stay in an outpatient level of care: (a) be able to take food with “minimal, reasonable
interference;” (b) be able to show up to appointments; (c) and be able to use supports (family, friends, professional resources) when needed (Interview 1). Establishing outpatient criteria reduced the number of clients in outpatient counseling, allowing Daisy to focus on clients who were prepared to make changes.

Daisy disclosed that her supervisor also taught self-care practices to manage her personal and professional concerns. Daisy described her personal and professional concerns as “noise” (Interview 1; Interview 2). This “noise” was negative self-talk about distorted perspectives of her body and food. Daisy explained that this “noise” made it difficult to focus on her clients. A hypothetical example may include a counselor having had experiences similar to those of a client, resulting in the counselor having behaviors, feelings, or thoughts in response to the client’s disclosure (e.g., thoughts about weight or excessive exercise after eating). When the counselor is faced with these behaviors, feelings, or thoughts, she may reach out to her supervisor for assistance with the client’s disclosure that was similar to her own experiences. Daisy was able to challenge this “noise” through processing it with her supervisor. Daisy explained processing as talking about the “noise” in order to grow in awareness and acceptance of it first, and then ultimately releasing it. Daisy did not provide more specifics about processing beyond this description. By releasing the “noise” in supervision, Daisy was able to counsel clients with a clearer mind, giving them more of her attention.

Daisy noted that her first individual supervisor modeled and taught her “centering” communication as a possible approach to use with clients and also a self-care practice (Interview 1). This communication provided Daisy with time to “center” herself
(i.e., ground herself) and was also considered a self-care practice when it decreased her “noise” that impacted her ability to be present with clients. Daisy further explained “centering” communication as including an intentional tone and dialogue used to relax and calm a person. Daisy stated that this procedure helped her regulate her emotions and enabled her to think more clearly. Daisy remembered her supervisor’s words on one occasion when she felt uneasy, and the image of her supervisor’s presence and the memory of the words and tone of voice that she used reduced Daisy’s concern. Daisy’s supervisor said, “Your job right now is to just listen to me and breathe. Just listen to my voice.” Daisy described this experience:

She had a really good tone of voice . . . very soothing . . . kind of calming. I always felt like when I got really anxious about clients or when I got really nervous about things, she had a very calming voice. . . . [My supervisor] used that in a lot of other therapeutic ways with clients, very, very calming, centering, like, “We’re not going to get anxious right now.” [V]ery, very impacting . . . I felt very safe with her. She was also a woman that, when she walked in the room, she acted like she knew what she was doing. (Interview 1)

Throughout this supervision, as explained in the last statement quoted above, Daisy reported that she viewed her supervisor as competent. While working under her supervision, Daisy’s perception of her supervisor’s competency reduced Daisy’s worries about her own competency and allowed for her to feel more comfortable working as a counselor.
Daisy’s first individual supervisor also served as her supervisor for group supervision. In group supervision, Daisy reported receiving additional education through the use of case presentations where she was provided an opportunity to give and receive feedback with other group supervisees regarding specific client cases. Daisy stated that Gestalt activities conducted in the group setting were helpful, especially in addressing her tendency to interrupt clients in the counseling environment. Daisy recalled a time when her supervisor stopped her when she was interrupting during a group supervision session and asked, “What’s going on right now?” and then encouraged her to say what she was thinking and feeling to other group supervisees, while making eye contact and telling them where she experienced her feelings in her body as a way to promote mindfulness (Interview 1). Daisy stated that she realized that her interruptions showed that she was neither listening, nor present. Daisy ultimately grew in awareness of her concerns about other group supervisees and clients not hearing or listening to her.

In comparison to Daisy’s first individual supervisory experience, she reported that her second individual supervisory experience was less instructional. Daisy reported that her second supervisor was less experienced as a supervisor in comparison to her first supervisor. Daisy may have needed less instruction from this second supervisor because she had already experienced supervision (although she missed the increased instruction from her first supervisory experience). Daisy’s second supervisor, aware of her previous supervision, may have been giving Daisy an opportunity to take on more initiative and to make decisions regarding her counseling practice.
In summary, Daisy reported that her first supervisor for both individual and group supervision was instructional and supportive. From this supervisor, Daisy grew in understanding of herself as a counselor through self-reflection and realized the importance of “centering” as a self-care practice to challenge professional concerns or “noise.” Daisy implemented these self-care practices to prevent distraction and uphold her focus on clients’ disclosures. Daisy also grew professionally when she learned more about how to practice reflective listening with clients and more about creating outpatient counseling criteria for clients. Daisy mentioned that she trusted the processes that were facilitated by her first supervisor and believed that they helped her grow and evolve into a more effective counselor. With her second supervisor, Daisy reported less of an instructional process but viewed supervisory consultation as helping her make decisions regarding her counseling practice.

**Ellen’s textural description.** The textural description illuminated “what” Ellen experienced in supervision. Ellen discussed experiences in individual supervision and in two separate group supervisions. She reported that the supervisor of her individual supervision also facilitated one of her group supervision experiences.

Ellen disclosed that she had individual supervision for one hour each week and, with regard to instruction, she reported that the supervision provided less instruction than she would have preferred. Ellen stated that the areas where she needed assistance usually determined her supervisory agenda. Ellen mentioned,

I do appreciate that [my supervisor] is laid back and does let me take the lead in the agenda, and at the same time though, I wonder if there are things that she
should or could be teaching me that she’s not. I’m not sure what they could be. (Interview 1)

Although Ellen wondered if her supervisor could be teaching her more, she reported that her supervisor facilitated educational activities and modeled empathy and non-judgment. More specifically, Ellen’s supervisor focused on case presentations. Ellen explained that through case presentations she received feedback about how to proceed with specific clients and clients in general.

Ellen shared that the same supervisor who facilitated her individual supervision experiences also ran one of her supervision groups. This group met weekly for one hour. Ellen shared that, within the group supervision experience, case presentation was helpful and consisted of sharing clients’ demographics, behaviors, treatment planning, progress toward treatment goals, concerns and transition plans to life after the termination of counseling services. In response to case presentations, the supervisor and fellow group supervisees offered suggestions about the supervisee’s facilitation of counseling. Ellen stated that this process allowed her to learn about different therapeutic approaches, watch or demonstrate different approaches, and talk about the helpfulness of the different approaches when working with clients. Ellen disclosed her perceptions of the group supervision and case presentation.

The case consulting [presentation] we do primarily is helpful. It’s helpful for me to hear what the other supervisees are dealing with, working on, and what approaches they are taking. And I also get their feedback on my cases, which is helpful. Whenever we do a role-play, I find those helpful. (Interview 1)
Ellen disclosed that through this group supervision, she realized the importance of upholding healthy and realistic perceptions about her own body as a way to maintain professional growth. She also noted that, “I work with people [clients] everyday whose lives are almost ruined because of the over-importance [of body image]” (Interview 2). Ellen’s supervisor encouraged the supervisees to consider their feelings and thoughts about their own bodies and their clients’ presentations of “over-evaluation and the obsessive piece” about their bodies (Interview 2). Ellen stated that her group supervisor aided her and other group supervisees by teaching them how to create a separation between clients’ “over-evaluation” and obsessiveness and the supervisees’ feelings and thoughts. The supervisor commented on supervisees’ negative self-talk about body image in response to clients’ negative presentations about body image. Then, the supervisor taught and modeled replacement of supervisees’ negative self-talk with positive and more realistic dialogue about body image. Ellen reported that, through these conversations with other group members in supervision about clients who obsess about their bodies, she learned to use supervision to create positive self-talk about her own body to maintain holistic health. An emphasis on positive self-talk and maintenance of holistic health allowed Ellen to dispute any negativity about her own body and continue her focus on her clients’ presentation of body disturbance and treatment progress. This supervisory intervention prevented Ellen from allowing her clients’ comments to impact her own feelings and thoughts about her body and aided her in remaining focused on her clients’ concerns during counseling sessions.
Another discussion that evolved within this group supervision focused on eating with clients in group counseling meal sessions. The purpose of these group counseling meal sessions was to encourage clients diagnosed with Anorexia Nervosa and Bulimia Nervosa to follow their meal plans by finishing all the food that they brought. Ellen talked with other group supervisees and her supervisor about the pressure she felt to finish her meals, even when she was full. Ellen stated that she knew the expectation for clients was to finish their meals, and also wanted to model healthy eating behaviors for her clients by eating enough and finishing the food she brought to group. Ellen stated that her supervisor alleviated her fear of not being able to finish her meal by suggesting that she not bring too much food to group counseling meal sessions. Ellen reported that modeling a healthy relationship with food to the clients could be challenging at times, but other group supervisees and her supervisor reassured her that she was not alone with this challenge. Ellen disclosed that the other group supervisees and her supervisor reported similar uneasiness, which normalized her behaviors, feelings, and thoughts regarding modeling healthy eating.

In this group supervision, led by the same supervisor who facilitated Ellen’s individual supervision experience, Ellen explained that her supervisor taught about nutrition and the value of eating in a balanced manner for both the general population and for clients diagnosed with eating disorders. Ellen’s original belief about moderation of all foods was reinforced in group supervision. She stated, “This [notion of moderation of all foods] has helped me in my life outside of [my profession] and opposes society in the discussion about whole foods or processed foods” (Interview 2). Ellen used her
supervisor’s educational information from group supervision to teach clients about the importance of not labeling foods and eating in moderation.

Although Ellen reported that, overall, this group supervision experience with the same supervisor who facilitated her individual supervision was positive, she thought conversations were limited by the other group supervisees’ inability or unwillingness to share more information. She was hopeful that, in time, other supervisees would be able to share more information in relation to their work.

Ellen had another group supervision experience before the individual and group supervision discussed above, and she mentioned that a different supervisor facilitated this experience. This group supervision consisted of no more than six supervisees at any given time and met weekly for one hour. Ellen spoke about this first group supervisory experience as an educational process focusing on specific client cases. It began with less instruction, but became more instructional when the supervisor facilitated organized activities (e.g., teaching and modeling of possible therapeutic procedures).

This group supervisor taught her about the components of eating disorders (e.g., neurobiology) and different approaches (e.g., Cognitive Behavioral Therapy [CBT] and DBT) for working with clients with these diagnoses. Ellen’s supervisor also asked her to write weekly reaction papers that were reflection papers on aspects of her work. Her supervisor used these papers to facilitate instruction on various issues, such as challenges with clients and the perceived impact of clients on supervisee’s behaviors, feelings, or thoughts.
Ellen reported feeling “challenged” by this group supervisor (Interview 1; Interview 2). She remembered an experience when her supervisor asked her what she feared about a specific therapeutic relationship. Ellen responded that she was afraid about possibly hurting the client’s feelings or offending her client. Her supervisor responded bluntly and directly about her desire for Ellen to resolve these feelings and thoughts. Ellen reported that this “blunt and direct nature” was helpful at times (Interview 1). Although Ellen mentioned that she respected her supervisor as being an intelligent and professional role model, she did not feel completely comfortable with her strong personality.

Ellen reported differences between the supervisory relationships. She disclosed a connection with the supervisor who facilitated her individual supervisory experience and her second group experience, and stated that it was an egalitarian relationship. Ellen described how this supervisor demonstrated support, empathy, and non-judgmental listening skills. Ellen reported that she preferred her relationship with her individual supervisor to her relationship with her first group supervisor. With her first group supervisor, Ellen stated that she often felt uncomfortable, where she felt more like a client or a student in a hierarchical relationship.

Frankie’s textural description. The textural description illuminated “what” Frankie experienced in supervision. Frankie discussed experiences in individual supervision and two separate group supervisions. She reported that the supervisor, who facilitated her individual supervision, also facilitated one of her group supervision experiences. All of these supervision experiences met once weekly for one hour. Prior to
any of the supervisory experiences, Frankie worked in a community agency setting with people who were struggling with symptoms of eating disorders or who were in recovery. Through these experiences prior to receiving her master’s degree in counseling, Frankie gained an increased awareness of some struggles faced by individuals diagnosed with eating disorders. As a counselor, Frankie grew even more aware of the complexity of these diagnoses as she began working with outpatient counseling clients. Also, as a counselor, Frankie learned, with the help of her supervisor, to address the symptoms of the eating disorder and comorbid diagnoses (e.g., Depression or Obsessive Compulsive Disorder) by designing comprehensive treatment approaches.

The focus in Frankie’s first group supervisory experience was instructional around specific clients’ needs. When experiencing her group supervisor’s teaching, Frankie reported engagement with: (a) a curriculum of reading and education to address specific clients’ needs to be discussed weekly in supervision, focusing on the neurobiological processes of eating disorders, DBT approaches, and physiological responses to weight restriction and restoration; and (b) reaction papers on topics related to her work (e.g., counseling work with specific clients diagnosed with eating disorders) that prompted discussion in supervision sessions. Frankie also reported that this supervisor provided space for the supervisees to discuss their behaviors, feelings, and thoughts by first facilitating trust and relationship building through group exercises. Frankie reported that trust was a foundation in this group, and this enabled her to share honestly about challenges in her work and express her “uncomfortable” feelings (Interview 2). Frankie stated that she didn’t hesitate to express her feelings and thoughts
because “[In supervision], it [was] about my experience [as a counselor], not the client’s” (Interview 2). Frankie shared her behaviors, feelings, and thoughts in group supervision because of her preference for support and encouragement. After this sharing, Frankie was better able to focus on her clients’ concerns in session. However, despite her supervisor’s efforts to create a foundation of trust, Frankie reported that the group lacked cohesion, especially in the beginning when everyone was new.

Frankie reported that her first group supervisor’s style was organized. Frankie stated that her supervisor consulted with her, provided an opportunity to discuss her counseling work with clients, and helped her determine appropriate plans. Frankie’s supervisor addressed the challenges that Frankie was having with clients (for example, safety concerns and the clients’ presentations of medical conditions that might require a higher level of care) by educating Frankie about various ethical considerations. These instructional emphases taught her safety and ethical guidelines for working with clients. Frankie also described her supervisor as a person who modeled advocacy for counselors in a multi-licensed mental health environment by standing against the implementation of practices that were in conflict with the code of ethics for counselors. This emphasis on ethics gave Frankie a strong foundation for working with clients. Frankie’s supervisor listened to her disclosures about working with clients and gave her opportunities to reflect. She reported that it was helpful to have a supervisor who “validat[ed]” her work, and gave her an opportunity “to process through [her] own doubts, [her] own questioning to know that [she] was on the right track [with regard to treatment processes with her clients]” (Interview 2).
Frankie disclosed that the same individual who facilitated her individual supervisory experience was also responsible for her second group supervisory experience. Similar to her first group supervisory experience, Frankie’s second group experience had “questionable” cohesion, in that she reported limited connection among members (Interview 2). Despite this “questionable” cohesion, Frankie stated that her supervisor validated her feelings and thoughts. Frankie reported that, in one group supervision discussion, she was not entirely comfortable with her expression of feelings, yet she still shared her feelings and thoughts anyway. Frankie indicated that this conversation was important to her, and she stated that she went “straight to emotional lines,” meaning that Frankie shared her feelings immediately when she began to engage in this group discussion (Interview 2). Frankie stated that her supervisor validated her feelings and thoughts and assured her that supervision was the appropriate place for this expression. Her supervisor’s words normalized Frankie’s feelings and thoughts within the group environment, regardless of the lack of support she perceived from the other group supervisees.

With regard to Frankie’s supervisory relationships, she reported her experiences with her first group supervisor to be somewhat uncomfortable because her supervisor also carried out some responsibilities more commonly aligned with those of an employer or a “boss” (e.g., promotional decisions, salary changes, and caseload assignments; Interview 1; Interview 2). Frankie stated that she worried about the effect of her disclosures on her professional career but, ultimately, she continued to share her feelings and thoughts because her desire for support outweighed her concern about the effects of her sharing.
Regarding the relationship with her individual supervisor who also facilitated one of her group supervision experiences, Frankie stated that she felt more comfortable sharing with her individually, but once again experienced some uneasiness in the group setting. Similar to her first group experience, she moved past her concerns of vulnerability to receive feedback she knew that she needed to be more successful in working with clients diagnosed with eating disorders.

**Individual Structural Descriptions of Supervision**

The structural description referred to “how” the supervisee connected her thoughts and feelings to the textural description of supervision. The structural descriptions display the underlying dynamics or participants’ meanings or beliefs of the experience, representing “how” the feelings and thoughts are connected to the phenomenon. The structural description was created through the process of imaginative variation. Imaginative variation was a process included in both data collection and data analysis. During the interview process for data collection, the researcher asked variation questions to capture the meaning. Similar to Bevan’s (2014) recommendations for phenomenological interviewing, the researcher used “active listening and a reflexive approach” to generate these variation questions (p. 142). According to Bevan, variation questions are aimed at guiding the participants to hypothesize about how their experience would have been different if aspects of the experience had been altered to clarify the meanings and beliefs about their actual experiences. Examples of questions the researcher posed were: (a) “How might your supervisory experience have been different if you had been limited to individual supervision and not had supplementary group
supervision?” and (b) “How might your supervisory experience have been different if you worked in a different treatment setting (e.g., private practice instead of a specialized eating disorder treatment center)?” The researcher considered alternative experiences for the participants through imaginative variation in data analysis and this allowed her to understand the meanings and beliefs about their actual experiences more fully (Bevan, 2014). The individual structural descriptions were enhanced with the help of two peer reviewers who had taken qualitative research courses and through notes in a research journal. Notes about possible structural descriptive themes of each participant’s experience were constructed after considering these variations which then led to individual structural descriptions.

**Britney’s structural description.** Britney’s structural description revealed her meanings and beliefs about her supervisory experiences or “how” she connected her feelings and thoughts to her supervisory experiences. Structural descriptive themes that emerged from her supervisory experiences included feelings and thoughts about: (a) competencies as a counselor and meeting the professional expectations of her employers and self, (b) the population of clients diagnosed with eating disorders, (c) resources offered at a specialized eating disorder treatment centers, (d) responses to clients diagnosed with eating disorders, and (e) supervisory relationships. Britney described her experiences of individual supervision with two different supervisors as well as her experiences of group supervision with one of her individual supervisors.

Britney reported worrying about her professional competency in general when working as a new counselor. These worries were exacerbated by her reported high
standards for herself and by her perception of her employer’s expectations. This suggested that Britney had a desire to feel confident about her ability to perform her tasks well, put pressure on herself by holding to high standards, and desired a supervisor’s confirmation that she was doing a good job. Britney’s concerns may have also contributed to her desire for more instruction from her supervisor.

The population of clients diagnosed with eating disorders also shaped Britney’s supervisory experiences. Britney stated that comorbidity was common with the clients she met who were diagnosed with an eating disorder. Because of these complexities, Britney benefited from the instruction sometimes offered in supervision, especially when she first began working with clients diagnosed with these disorders. This instruction may have explained Britney’s reported preference for her supervisor instructing and providing a foundation for working with specific clients and clients in general.

Britney spoke about additional resources offered to clients at the specialized eating disorder treatment center where she worked. This specialized treatment center offered varying levels of care for clients determined from their assessment of presenting symptoms. Some additional resources included: support groups, medical support, dietetic, and psychiatric services. These additional resources may have provided Britney with assurance that the client was being treated holistically, and this may have impacted her experiences in supervision. Because she felt confident that her clients were being treated holistically and getting their needs met, she may have needed less support in supervision than a counselor working without these complimentary resources.

Britney reported her responses to some clients diagnosed with eating disorders.
It’s a normal thing when you see these clients. You’re [i.e., your behaviors, feelings, and thoughts are] going to be triggered by it. Obviously, we don’t have eating disorders, but certain things are going to be brought up within ourselves. We’re going to have some self-esteem or body image stuff come up. It’s very normal. But also a lot of awareness then once we go out into the real world. It’s interesting in interacting with people in our personal lives how much you see disordered eating . . . how much you hear “fat talk” [i.e., discussion about body dissatisfaction] . . . what you see in the media and being advertised about the ideal body and that we all need to be perfect, engaging in exercise regimens and diets. I wasn’t really aware of all that before I started working here. (Interview 1)

Britney’s awareness of how society impacted the prevalence of eating disorders increased her understanding of the complexity of the diagnoses and how difficult it may be, in her work with clients, to counter these distorted messages about bodies. Britney used both individual and group supervision as an outlet to effectively address her feelings and thoughts, and she used supervision as a resource during times when she was “triggered” to engage in “fat talk” about herself (Interview 1). Britney’s supervisor supported and provided feedback to Britney allowing her to move forward with these clients. By discussing her feelings and thoughts in supervision, she prevented them from interfering with her counseling work and upheld her focus on clients’ concerns. And it was understandable that she was able to report positive experiences in supervision.

Britney cited an example when her supervisor’s words helped her manage her feelings of inadequacy. Britney stated that her supervisor challenged her to not take the
client’s actions and words personally and to see the client’s actions and words as stimulated by the eating disorder, rather than as a personal attack from the client. Britney recalled her supervisor’s advice:

It has nothing to do with you. You know that [the client’s presentation] is part of the diagnosis. Her disorder is offending you, rather than her, the person. You’re at battle with her eating disorder, not her. So, don’t take it personally. (Interview 1)

Britney grew through narrative supervision that encouraged her to separate the client from the disorder through the process of externalization, which, in narrative therapy, means that the person is not the problem, but rather the symptoms of the disorders are the problem (Carey & Russell, 2004; White & Epston, 1990). By learning how the eating disorder is an entity apart from the client, she was able to grow in her acceptance and understanding of the person sometimes hidden behind the symptoms of the eating disorder. Britney was able to speak of positive and helpful experiences in supervision because she shared her concerns about clients with her supervisor. Had she not reached out to her supervisor regarding specific clients, she may have not reported such positive and helpful experiences.

Within Britney’s supervisory relationships, she reported her first supervisor guided and directed her in her work to reduce her competency worries and her second supervisor facilitated connection and comfort through “normalizing her feelings” and “encouraging self-care practices” (Interview 1). Britney found her first supervisor’s instruction to be helpful because it reduced her worries about her competency to work
with clients presenting with eating disorder diagnoses. In the early stages of her development as a supervisee, Britney may have benefited from and preferred more instruction as a way to manage her anxiety when working with clients for the first time and when working with a new population.

Christina’s structural description. “How” Christina experienced supervision or “how” she connected her thoughts and feelings to her supervisory experiences was shaped predominantly by her feelings and thoughts about: (a) competencies as a counselor; (b) resources offered at a specialized eating disorder treatment center; (c) behaviors, feelings, and thoughts about her own body and her relationship to food in response to clients diagnosed with eating disorders; and (d) supervisory relationships. Christina’s structural descriptions are based on individual and group supervision experiences with the same supervisor.

After Christina had been in supervision for a while and felt more confident about herself as a counselor working with clients diagnosed with eating disorders, she disclosed her feelings and thoughts about her perceived competency to her supervisor. Christina stated that, initially, she was cautious about revealing her doubts about her competency and lack of work experience because she was concerned that she wouldn’t be perceived as an effective counselor. This concern about disclosure and her supervisor’s perceptions may suggest that Christina, being a new counselor, was uncertain of her abilities and desired her supervisor’s validation to insure her that she was proficient in her work. These concerns about her competency may have also led to her desiring more instruction from her supervisor, especially in the early stages of supervision.
Christina stated that additional resources for clients at the specialized treatment center where she worked were helpful. Christina disclosed that she felt assured that her clients were getting their needs met and were being treated holistically with the inclusion of these resources. This also may have allowed her to see that her counseling work was just one aspect of clients’ treatment plans. According to Christina, these additional resources included varying levels of care for clients: partial hospitalization, intensive outpatient, and outpatient. Dietetic services offered meal planning for clients, and psychiatric services were available for assessment and prescription of psychotropic medications. Medical support monitored clients’ presenting health issues. Because Christina consulted with other professionals attending to her clients’ care, Christina may have required less support from her supervisor in comparison to another supervisee working at a location without these resources and professional community.

Other factors that influenced Christina’s experiences of supervision were her feelings and thoughts about her own body and her relationship to food and how these surfaced at times in response to her work with clients diagnosed with eating disorders. Christina shared her experience of weight fluctuations throughout her life and how these experiences aided her in identifying with clients diagnosed with eating disorders. However, Christina was cautious about sharing feelings and thoughts pertaining to her own body because of her workplace environment and client perceptions. Christina stated that she worried that her colleagues would think that she wasn’t healthy enough to work with this population of clients if, at times, she was concerned about her own body and weight. Initially, these concerns may suggest that Christina felt pressure as a counselor to
have a healthy perception of her body, and this may have impacted her disclosures. These concerns may have limited her ability to use supervision as a resource to disclose and process her feelings and thoughts in response to clients, in order to prevent the feelings and thoughts from interfering with her work with clients, and to enable her to focus more fully on client concerns. Christina may not have felt her supervisory experiences were as helpful when compared to a supervisee who was forthright about feelings and thoughts pertaining to her body image. A hypothetical example may be a supervisee talking about her concerns with regard to weight gain and how she may feel at times when clients discuss stress related to weight fluctuations. The supervisor could facilitate discussion about the supervisee’s feelings to enable her to arrive at some peace and closure about her changes in weight. This discussion may enable the supervisee to focus on the client’s concerns when counseling, rather than on her own discomfort.

With regard to Christina’s relationship with food in response to her work with clients, she expressed concerns about modeling appropriately during counseling meal group sessions. Christina wanted to make certain that she related to food in a healthy way, and she also wanted clients to perceive her as an appropriate model. These disclosed concerns may suggest that Christina was in a process of learning what a healthy relationship with food was for her as well as for her clients. Christina was conscious of wanting to model for clients a healthy way of relating to food. Christina reported that she asked her supervisor for instruction and support in this area, and her supervisor helped her by discussing her concerns and by providing her with non-judgmental listening and a comfortable space to express her thoughts and feelings. The supervisor validated her and
gave her an opportunity to attain resolution through acceptance of her relationship with food, or changing her way of relating to food. Additionally, she learned from her supervisor how to behave and model appropriately when eating with clients in counseling meal group sessions through increased intentional mindfulness (being present in the moment), followed by enhanced awareness of her eating patterns and potential behavioral changes. Through an emphasis on mindfulness, awareness, and potential behavioral change in supervision, Christina learned to be intentional about paying attention to her hunger and eating a diverse range of foods with clients during counseling meal group sessions. Through this process, Christina’s supervisor also aided her in feeling more confident in her ability to resolve concerns in supervision, and to have an increased ability to redirect her focus toward her clients and their treatment progress. Because Christina was able to share these concerns with her supervisor, she may have felt her supervisory experiences with regard to these disclosures to have been helpful and positive.

Christina explained that she felt supported by her supervisor who facilitated both individual and group supervision. Christina focused on the fact that her supervisor validated her and offered her help. This may have further supported Christina’s desire to receive affirmation about her work due to her uncertainty about her effectiveness with clients. Christina may have felt comfortable asking for help from her supervisor because of her perception of her supervisor’s level of competency. Christina described her supervisor’s competency.
I know [that] she’s a very competent counselor. She has a lot of experience, so I would never really question anything that she would tell me. And I know that from other people’s report[s], her report of her experiences in the field, and from seeing her in groups and working with clients. I see that she does good work with [clients] and is passionate about what she does. (Interview 1)

Christina believed that male supervisors would not fully understand and be able to empathize with clients presenting with eating disorder diagnoses and body dissatisfaction. This statement about male supervisors may suggest that Christina wouldn’t have felt as open in supervision with a male supervisor. She may not have been as comfortable with a male supervisor and might not have reached out for as much support as she did with her female supervisor.

**Daisy’s structural description.** Structural descriptive themes influencing “how” Daisy experienced supervision or “how” she connected her thoughts and feelings to her supervisory experiences included feelings and thoughts about: (a) the population clients diagnosed with eating disorders; (b) resources offered at a specialized eating disorder treatment center; (c) behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders; and (d) supervisory relationships. Daisy reported three experiences in supervision: individual supervision with two different supervisors, and group supervision with one of her individual supervisors.

Daisy stated that her supervisory experiences were impacted by the population of clients diagnosed with eating disorders. Daisy spoke about the severity of her clients’ diagnoses and what the work required of her at times, such as when a client was not ready
for outpatient counseling and she needed to refer the client to a higher level of care. Daisy’s first supervisor aided her in establishing minimal expectations with her clients by teaching her to not work with clients who continued to present with severe symptoms (e.g., unable to eat food with “minimal, reasonable interference”). Daisy’s supervisor explained that these clients needed more care than she would be able to provide in an outpatient counseling setting. Daisy shared that her supervisor encouraged her to say to clients, “That is great progress, and you need more than what I can give you. I really, really care about you, but I’m not going to [continue working with] you” (Interview 1). Daisy then assisted clients in locating a more appropriate higher level of care to address the severity of their presenting symptoms. Daisy reported this supervisory experience to be positive because it helped her understand her limitations as a counselor when working with this population in the outpatient counseling setting. And it was also important for Daisy to understand the criteria that a client must meet to have a chance for success at this level of outpatient care.

Daisy may have felt supported by the varying levels of care and additional resources offered at the specialized eating disorder treatment center where she worked. She was able to refer clients within the treatment center should they need a higher level of care beyond outpatient counseling and also offer additional resources of support to aid the clients and their significant others. Daisy spoke of support groups offered to clients and their families and friends. She also mentioned clients’ opportunities for dietetic meal planning, psychiatric services for medication management, and medical support. These additional resources may have provided her with assurance that the clients were being
treated holistically and getting their needs met through this comprehensive treatment. By working alongside other professionals working with the same clients, she also had opportunities for consultation and support, and this may have led to less of a need for consultation and support in supervision.

Daisy reported her behaviors, feelings, and thoughts in response to her clients and explained how these impacted her supervisory experiences. Daisy described her concerns in response to clients as “noise.” This “noise” was Daisy’s negative self-talk about distorted perspectives of her body and food. Daisy explained that at times this “noise” made it difficult to focus on her clients. Daisy explained that she desired support from her supervisor to manage the “noise.” With the help of her supervisor, Daisy grew in understanding of herself as a counselor through self-reflection and realized the importance of “centering” communication, and she viewed these as self-care practices to challenge the “noise.” Daisy implemented these self-care practices to prevent distraction and uphold her focus on clients’ disclosures. She reported her supervisor’s responses of support and education of self-care practices as helpful and positive.

Through processing these professional and personal concerns in response to clients, Daisy was able to release her feelings and thoughts aligned with these concerns enough to uphold her focus and attention on the client’s treatment progress. When Daisy’s supervisor modeled and taught “centering” communication as one possible self-care practice, Daisy was given an opportunity to ground herself through positive self-talk. In part, as a result of her supervisor’s modeling and teaching, Daisy grew to understand and accept and manage her feelings and thoughts in response to clients’
disclosures about their body image or relationship with food. Because of her supervisor’s modeling and instruction on helpful self-care practices, Daisy was able to maintain personal health and reported positive experiences in supervision.

Daisy spoke of her relationships with her supervisors as impacting her supervisory experiences. She discussed the support she felt in two supervisory experiences and explained that both supervisors were supportive, yet in different ways.

Daisy described how her first supervisor displayed characteristics of “guidance,” “education,” “validation,” “trust,” “respect,” and “support” (Interview 1; Interview 2). Daisy felt “led, mentored, and taught” by instruction (Interview 1). Daisy also felt validated by her supervisor when her supervisor would affirm her with positive feedback. Daisy preferred to work with an experienced supervisor who was certain of her own counseling abilities and skills and was able to model these for her. Daisy stated that she respected her supervisor as a competent professional. Daisy disclosed that she sought out supervision with this particular supervisor because she was a leader in the field and known in the community as someone who worked with clients with eating disorder diagnoses. Daisy’s decision to pursue a leader in the field for supervision may suggest that it was important for her to feel confident about the qualifications of a supervisor in order to trust the process of supervision. With her first supervisor, Daisy did not question the processes, but rather felt trust and certainty that she was growing as a counselor with her supervisor’s assistance. One possible explanation for why Daisy refrained from questioning her supervisor may be that she did not want to interrupt the supervisory curriculum where new therapeutic approaches were introduced. Daisy stated that she
wanted her supervisor to determine the supervisory curriculum because she believed her supervisor would be more certain about skills necessary for a supervisee to learn. This educational agenda included instruction in the following areas: (a) possible therapeutic procedures (e.g., Gestalt therapeutic approaches), (b) boundary setting with clients, (c) “centering” communication as one possible self-care practice, (d) reflective listening, and (e) self-reflection. Through supervision, Daisy may have realized that these procedures were helpful processes in her growth as a counselor.

Daisy described how her second supervisor provided less instruction and relied more on consultation in supervision. Daisy stated that she thought of this supervisor as less experienced in comparison to her first supervisor. As a result, Daisy questioned her supervisor’s facilitation of supervision. Daisy was nearing the end of her time as a supervisee when she began working with this second supervisor and may have needed less educative support, even if she desired more, than with her first supervisor with whom she worked immediately after graduate school. Her second supervisor may have provided less instruction because the supervisor may have thought that Daisy required less instruction and more consultation from a supervisor as she had become more advanced in her development as a counselor. So, although Daisy may have preferred a continued amount of instruction as she moved into her second individual supervisory experience, her second supervisor’s consultative role may have been more appropriate for Daisy’s stage of development as a counselor.
Ellen’s structural description. “How” Ellen experienced supervision or “how” she connected her thoughts and feelings to her experiences was shaped predominantly by feelings and thoughts about: (a) the population of clients diagnosed with eating disorders; (b) resources offered at a specialized eating disorder treatment center; (c) behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders; and (d) supervisory relationships. Ellen discussed experiences in individual supervision and in two separate group supervisions. She reported that the supervisor of her individual supervision also facilitated one of her group supervision experiences.

The population of clients diagnosed with eating disorders shaped Ellen’s supervisory experiences. Since Ellen was working with this population of clients for the first time, she worried about what she needed to learn to work effectively with clientele who often presented with comorbid diagnoses (e.g., Depression and Obsessive Compulsive Disorder). Case presentations in group supervision, with the same supervisor who facilitated her individual supervision, aided her in determining how to proceed with clients generally and in response to specific client cases. Yet, Ellen thought that the suggestions she received from these case presentations were still not specific enough to reduce her concern and assist her when working with clients diagnosed with eating disorders. Ellen stated that she wondered what she should know in her work and questioned her approaches as a result of her perception that she needed more instruction from her supervisor. Ellen’s wondering and questioning about needing more instruction may suggest that, when working in new settings or with clients with different
demographics, Ellen preferred instruction about specific ways to possibly work with clients.

Ellen worked with her clients at a specialized eating disorder treatment center that offered varying levels of care. To meet the needs of clients presenting symptoms of varying levels of severity, Ellen explained that the specialized treatment center offered additional resources. Some resources aided the families and friends in supporting their loved ones diagnosed with eating disorders. These included support groups to learn about possible ways to aid their loved one in the growth process. Ellen reported that clients presenting with symptoms aligned with the diagnosis of an eating disorder also benefited from dietetic meal planning, and she spent time talking with her supervisor about how treatment plans should incorporate clients’ meal plans. Another possible service available to clients was psychiatric support through the assessment for medication and then medication management. Medical support was available for those clients presenting with health concerns. These additional resources may have provided her with assurance that clients were being treated holistically and getting their needs met. Because Ellen was able to collaborate and consult with other professionals working with clients, she may have had less of a need to seek out additional consultation and support from her supervisor in comparison to counselors working independently with clients.

Ellen’s experiences in supervision also impacted reported behaviors, feelings, and thoughts in response to some of the clients who were diagnosed with eating disorders. Ellen discussed how counseling clients impacted her positively, especially when she applied her supervisory education to her life and her supervisor encouraged her to
maintain self-care. Ellen reported sharing with her supervisor her increased confidence, for example, in her relationship with food. Through Ellen’s supervisory education about nutrition and balanced eating of all foods, Ellen stated that she grew in her personal health care and felt confident in challenging societal messages about whole foods versus processed foods or “good” versus “bad” foods (Interview 2). Ellen applied this knowledge learned in supervision to her work with clients by stressing moderation of all types of food intake. Reinforced by the supervisor’s focus on self-care, Ellen reported that her experiences in supervision had a positive impact on her counseling work which may have enabled her to be more prepared for challenges clients presented (e.g., comorbidity), and she may have been more resistant to burnout.

Finally, Ellen’s supervisory experiences were affected by her unique relationships with her two supervisors. Despite the differences in these relationships, Ellen stated that she felt aided in her growth as a counselor by both supervisors. Within her supervisory relationship with her individual supervisor, who also facilitated one of her group supervision experiences, Ellen reported an egalitarian relationship. Ellen added that this supervisory relationship was also not negatively judgmental and that this facilitated support. Ellen reported, “I think she’s not judgmental. I never felt like she was critiquing or criticizing my approach. She does give me positive feedback and tells me I’m doing a good job . . . which is helpful” (Interview 1). According to Ellen, this supervisor provided support, empathy, and non-judgmental listening, and she reported having a better relationship with this supervisor in comparison to her relationship with her other group supervisor.
Ellen described her relationship with her other group supervisor as uncomfortable. In this relationship, Ellen described the supervisor having an overwhelming personality at times and, regarding the hierarchy in the relationship, she felt more like a client or a student. Despite her reported discomfort, Ellen noted she grew in understanding of her clients who were diagnosed with eating disorders and reported progress with her counseling skills when working with this population. This group supervisor taught Ellen about possible therapeutic approaches to use when working with clients diagnosed with eating disorders, and encouraged reflection about the impact of her counseling work on her.

Ellen’s disclosure about these supervisory relationships suggested that she preferred a supportive relationship, yet a supportive relationship was not the only way for her to benefit from supervision. For example, learning possible therapeutic procedures from a supervisor was also helpful. In reviewing Ellen’s reported supervisory experiences, it seems that a favorable supervisory relationship would entail some combination of instruction and support.

**Frankie’s structural description.** “How” Frankie connected her thoughts and feelings to her supervisory experiences was shaped predominantly by: (a) her previous work with people who were diagnosed with eating disorders or were in recovery prior to her professional work as a counselor; (b) the population of clients diagnosed with eating disorders; (c) resources offered at a specialized eating disorder treatment center; (d) behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders; and (e) supervisory relationships. Frankie discussed experiences in individual
supervision and two separate group supervisions. She reported that the supervisor who facilitated her individual supervision, also facilitated one of her group supervision experiences.

Frankie reported that before receiving her degree in counseling, she had worked in a non-counseling capacity with people who were diagnosed with eating disorders or were in recovery. Frankie stated that she had been interested in body image dissatisfaction, health, and wellness prior to receiving a degree in counseling and prior to working as a counselor in the field of eating disorders. This initial background experience with eating disorders gave her additional understanding of the population and helped prepare her for work as a counselor. When compared to supervisees having no experience working with clients with eating disorders, Frankie may have started supervision with a little less apprehension. Her background experience working with clients with eating disorders prior to receiving her degree in counseling may have helped prepare her, and she may have required less support from her supervisor in comparison to another supervisee interacting with this population for the first time.

The population of clients diagnosed with eating disorders also shaped Frankie’s supervisory experiences. This population of clients often presented with comorbid diagnoses (e.g., Depression, Bipolar Disorder, or Obsessive-Compulsive Disorder). Therefore, Frankie’s supervisors assisted her with support and ideas for working with the diagnosis of an eating disorder as well as comorbid diagnoses that may have been present. Frankie reported that her first group supervisor taught her therapeutic approaches used in working with clients with eating disorder diagnoses. In contrast,
Frankie’s individual supervisor, who also facilitated her second group supervision experience, taught her more about possible approaches to working with clients presenting with diagnoses in addition to eating disorders. Because of Frankie’s experience working with people who were diagnosed with eating disorders or in recovery prior to her working as an outpatient counselor, Frankie may have needed less support than a supervisee working with this population for the first time. Overall, her supervisors’ instruction of therapeutic approaches to use with clients was helpful and may have allowed Frankie to feel more confident in her work with clients.

Frankie worked with her clients at a specialized eating disorder treatment center that offered varying levels of care. This specialized treatment center offered additional resources. Support groups were offered for clients, and family and friends of clients. Also, dietetic meal planning was available to clients to structure their caloric intake for recovery. The eating disorder treatment center also offered psychiatric services for those clients who needed to be assessed and provided with medication and then monitored while on medication. Clients presenting with health concerns were treated by medical support. These additional resources may have provided Frankie with assurance that clients were being treated holistically and getting their needs met. Also, being part of a team approach to treatment allowed Frankie to have opportunities for consultation and support from other professionals working with the clients. Because she had other resources, she may not have had a need to seek out additional consultation and support from her supervisor as often as counselors working independently with clients (e.g., in a private practice setting).
Frankie spoke about relating to clients who experienced a “sense of hopelessness and desperation about losing weight” and a “desire to lose weight” (Interview 2). Frankie stated that it was helpful for her to discuss her behaviors, feelings, and thoughts within both individual and group supervision in order to receive support when she felt fatigued by her work as a counselor. Frankie was reminded by her supervisor to maintain her self-care practices to “[be] happy in [her] own life” (Interview 2). Frankie stated that owning comfortable clothing was one self-care practice to which she was committed in order to increase body satisfaction. Because she shared her feelings and thoughts with her supervisors, she was able to utilize supervision as a helpful resource.

Although Frankie described both of her supervisory relationships differently, she reported both to be supportive. With regard to her first group supervisor, it seemed that her supervisor was helpful by educating her about possible therapeutic approaches to utilize when working with particular clients diagnosed with eating disorders. Also, based on Frankie’s statements, her supervisor provided support and feedback in response to her disclosures about the impact of her counseling efforts on her feelings and thoughts.

Though this first group supervisor was supportive and helpful, Frankie reported discomfort in the relationship overall. Frankie stated that this relationship might have been uncomfortable because her supervisor performed some responsibilities common to a “boss.” Frankie clarified that she desired more “emotional distance” from a person who was her “boss” because this person made financial and promotional decisions (Interview 1; Interview 2). Frankie mentioned that she was fearful about being “vulnerable and processing countertransference” through self-disclosure with her supervisor (Interview
1. She stated that she worried about self-disclosures negatively impacting the outcome of her career, but still chose to disclose feelings and thoughts about her body image that were triggered by clients’ disclosures about negativity toward their bodies. After disclosing her feelings and thoughts in supervision, Frankie was better at redirecting her focus from herself to her clients’ concerns. Thus, regardless of Frankie’s reported disconnection with her first group supervisor, she shared most of her feelings and thoughts during group supervision, knowing that she needed whatever support and feedback could be provided. This sharing allowed for her to report an overall positive supervisory experience.

Frankie stated that her relationship with her supervisor, who facilitated individual supervision and her second group supervision, was supportive and validating, evidenced by her supervisor’s good listening skills, focus on teaching about ethical concerns, advocacy, and normalization of challenges when working with clients. Frankie stated that her supervisor focused on ethical matters to insure that Frankie was taking appropriate measures to provide safe and quality services for clients. Frankie also reported that her supervisor modeled advocacy about ethical client care practices for professional counselors in a multi-licensed mental health environment. Frankie reported that her supervisor assisted her with concerns or challenges when working with clients and then guided Frankie in making decisions that they both deemed appropriate.

**Composite Textural Description**

The composite textural description is the summary across all five participants that explains “what” was experienced in supervision. The following describes “what” the
participants disclosed as their experiences in both individual and group supervision. The
textural description addressed the processes of supervision including: (a) time in
supervision, (b) educational discussions about working with clients diagnosed with eating
disorders, (c) modeling by the supervisor, and (d) individual and group supervision.

According to all five participants, supervision was held weekly (one hour for
individual supervision and one hour for group supervision) and focused on learning about
working with specific clients diagnosed with eating disorders. In addition to their
education regarding therapeutic approaches, supervisees grew in their professional
counselor identity and received support (e.g., normalization of supervisees’ behaviors,
feelings, and thoughts in response to clients) for challenges they faced while working
with this specific population.

Through educational discussions about working with clients with eating disorders,
all supervisees spoke of their receptiveness to receiving supervisors’ instruction in the
early stages of work with this new population. The focus of supervision was on
particular clients and included learning about the genetics, neurobiology, and nutrition
issues associated with these disorders, and types of therapeutic approaches commonly
used with the disorders and comorbid diagnoses. Supervisees reported using this
knowledge to create treatment plans with their specific clients. To ensure that
supervisees were growing in their professional identity, supervisors assigned reaction
papers, which provided some structure for the supervisory sessions and encouraged the
supervisees to reflect on their professional journey.
Supervisees were given opportunities to witness their supervisors’ modeling of procedures. Supervisees were exposed to possible treatment modalities they could choose to implement in the future with clients through their supervisors’ modeling of therapeutic procedures. The supervisees stated that they grew in understanding of themselves as counselors and what clients experienced in counseling through their supervisors’ modeling of practices followed by their own role-playing of procedures like the empty chair technique of Gestalt Therapy. Some supervisors modeled and taught “centering” communication through positive self-talk. After use of this self-care practice, supervisees’ reported increased self-reflection as well as improved reflective listening with clients.

All five supervisees reported receiving both individual and group supervision. Similarities between individual and group supervision included: (a) case consultation, feedback, and instruction of alternative treatment approaches and modeling of procedures; and (b) discussion about the impact of counseling work on supervisees’ feelings and thoughts. In individual supervision, supervisors tailored the discussion to meet the unique needs of supervisees. Within group supervision, supervisors facilitated dialogue among members, including: (a) sharing diverse approaches and encouraging alternative modalities to use with clients in response to supervisees’ case presentations; and (b) supporting each other in response to disclosures about the impact of counseling work on their behaviors, feelings, and thoughts (e.g., concerns about competencies or negative feelings about body image). All five supervisees reported that feedback and support were impacted by supervisees’: (a) perceptions of their relationships with other
supervisees and the supervisor, and (b) openness to disclosing their feelings and thoughts with other supervisees and the supervisor.

**Composite Structural Description**

The composite structural description is a summary across all five participants that displays the underlying dynamics or participants’ meanings or beliefs about the experience, representing “how” the feelings and thoughts are connected to the phenomenon. These supervisees stated that their feelings and thoughts about their experiences of supervision were shaped by a myriad of structural descriptive themes including: (a) competencies as a counselor; (b) population of clients diagnosed with eating disorders; (c) resources offered at specialized eating disorder treatment centers; (d) behaviors, feelings and thoughts in response to clients diagnosed with eating disorders; and (e) supervisory relationships.

Three of the five supervisees spoke of concerns about their competencies in working with clients diagnosed with eating disorders. Supervisees reported that their experiences of supervision were impacted by concerns about their competencies. Their supervisors provided increased structure in the form of instruction and support to aid them as they grew in their counseling experiences. The supervisees reported that this structure gave them the increased assurance that they were able to work with this population. When these supervisees received more structure from their supervisors in response to their concerns about competencies, supervisees stated that they felt more satisfied with their experiences. Regardless of amount of time spent in supervision, all supervisees were relatively new to the counseling profession and seemed to report more
confidence in their competencies when their supervisors provided instruction. It seemed that the amount of time these supervisees experienced in supervision did not lead to a decreased desire for their supervisors’ instruction. This may have been, in part, due to the complexity of presenting symptoms of the clients with whom they were working.

The population of clients diagnosed with eating disorders impacted all five supervisees’ experiences of supervision. This population of clients often presented with symptoms of eating disorders and comorbid diagnoses (e.g., Depression, Bipolar Disorder, or Obsessive-Compulsive Disorder), and supervisees reported concerns about working with clients to reduce symptoms and achieve treatment plan goals. The presenting symptoms of eating disorders and comorbid diagnoses may have led to the desire for more instruction in supervision. When supervisees spent more time receiving instruction during supervision, they felt more confident about their work with clients and more positive about their supervisory experiences.

All five supervisees worked with clients who had a primary diagnosis of an eating disorder within a specialized eating disorder treatment center, and this setting impacted supervisees’ meanings about their experiences of supervision. Within the specialized eating disorder treatment centers, varying levels of client care were available to address clients’ presenting symptoms, including comorbidity. These levels of care were: outpatient, intensive outpatient, and partial hospitalization. These levels of care also impacted “how” the supervisees experienced supervision because the supervisees discussed varying levels of severity of clients’ symptoms in supervision which impacted not just the topics discussed, but entailed safety plans to ensure client care and reduce the
risk of harm or suicide. The severity of symptoms in clients and the complexity of comorbidity increased when moving from outpatient to intensive outpatient to partial hospitalization. For this reason, the number of clients a supervisee worked with weekly declined as the severity of symptoms and comorbidity increased. Three supervisees working with clients presenting with more severe and complex symptoms spoke about receiving increased amounts of instruction and support in supervision around ethical and safety standards. When supervisees received this instruction from their supervisors, they felt more confident about their abilities to uphold client care. These increased feelings of confidence led to reported positive perceptions of supervision.

The specialized eating disorder treatment centers were equipped with additional available resources alongside counseling services. Thus, the supervisees’ supervisory experiences may have entailed discussions about possible therapeutic approaches with clients while also discussing the applicability of additional resources including: (a) support groups for family and friends of clients with eating disorder diagnoses; (b) dietetic services for clients, including the creation of meal planning and meal counseling groups for clients to learn more about healthy eating; (c) psychiatric services, including assessment, diagnosis, and medication management; and (d) medical support to address clients’ presenting health concerns. Because of these additional resources, all supervisees talked about coordinating care with other treatment professionals and sought consultation with their clients’ treatment team when appropriate. All of these resources may have contributed to “how” supervision was experienced because they brought forth additional topics and resources that factored into client care to address presenting symptoms and
comorbidity. Furthermore, working with other professionals to treat clients holistically provided additional opportunities for consultation and support outside of supervision. In comparison to supervisees working independently with clients, these supervisees who worked alongside other professionals may have desired less consultation and support from their supervisors.

The supervisees described their behaviors, feelings, and thoughts in response to working with clients diagnosed with eating disorders. They described increased body dissatisfaction, “fat talk,” and concerns about modeling appropriate eating in meal counseling groups with clients. Four of the supervisees realized their responses could distract them from their work with clients and felt a need to prevent this from happening. They reported using supervision at times as an outlet to process their responses and to uphold a focus on their clients.

The supervisees revealed that their supervisors responded to their disclosures by: (a) at times, “normalizing” their feelings and thoughts as part of the experience of being a counselor; (b) teaching them how to establish boundaries with their clients (e.g., making it necessary for clients to meet specific criteria to stay at a lower level of care); and (c) emphasizing the importance of self-care through procedures like “centering” communication. Four supervisees did not always disclose all of their concerns with their supervisors and stated that they worried about being perceived negatively or as not “healthy enough” to be working with clients if they experienced any dissatisfaction with their own bodies. This seemed to emphasize the importance of the supervisory relationship to facilitate honest and authentic conversations. Such conversations may
have provided supervisees occasions to express their feelings and thoughts about their responses to clients which may have increased opportunities to focus on their clients in counseling. It is understandable that supervisees reported more positive experiences in supervision after revealing their responses to clients with their supervisors because then their supervisors used supervisory time to support and instruct them.

The supervisory relationship also impacted the supervisees’ experiences of supervision. If a supervisee described a positive supervisory relationship, she also disclosed more helpful supervision experiences. A positive supervisory relationship was described as: (a) “comfortable,” as evidenced by connective communication with displays of good listening from supervisors, and “uncomfortable” when the supervisee was challenged to grow in her professional development; (b) “supportive” when the supervisee experienced her supervisor’s reassurance of help, nonjudgmental listening skills, and instruction; and (c) “trustworthy” when the supervisee experienced the supervisor’s competency.

**Textural-Structural Synthesis**

The composite textural description and the composite structural description were combined to create a unification of the meanings and essences of supervision across all participants. This unification is referred to as the textural-structural synthesis. The researcher considered how the phenomenon of supervision could be perceived by imagining how the structural and textural impacted each other. For each textural description, the structural description highlighted “how” participants perceived “what” they experienced in supervision. The structural description explained the beliefs and
meanings about what they experienced. Also, “what” the participants experienced in supervision impacted the structural process or “how” participants felt and thought about their experiences. One example of the structural description impacting the textural description might be “how” supervisees’ feelings and thoughts about the severity of clients’ symptoms impacted “what” topics and instruction were covered in supervision. An example of the textural description impacting the structural description may be a supervisor teaching an inexperienced supervisee resulting in the latter developing more positive feelings about her competency in working with clients. The textural-structural synthesis is explained by each textural descriptive theme being considered in relationship with each structural descriptive theme. The textural descriptive themes included: (a) time in supervision, (b) educational discussions about working with clients diagnosed with eating disorders, (c) modeling by the supervisor, and (d) individual and group supervision. The structural descriptive themes were: (a) competencies as a counselor; (b) population of clients diagnosed with eating disorders; (c) resources offered at specialized eating disorder treatment centers; (d) behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders; and (e) supervisory relationships. During this analysis, the researcher discovered that some textural descriptive themes lacked a connection with all of the structural descriptive themes or were not fully explained in enough detail by participants to reflect on the interaction between the textural descriptive themes and structural descriptive themes to add meaning to the synthesis. For example, the textural descriptive themes, educational discussions about working with clients diagnosed with eating disorders, modeling by the supervisor, and individual and group
supervision, did not have a connection with the structural descriptive theme resources offered at specialized eating disorder treatment centers.

Within the eating disorder treatment centers, all five supervisees received one hour of individual supervision and one hour of group supervision weekly regardless of their level of experience as a counselor or the complexity of comorbidity their clients presented. This amount of time among supervisees permitted them to discuss their feelings and thoughts about: (a) supervisees’ competencies as a counselor, (b) the population of clients diagnosed with eating disorders, (c) resources offered at specialized eating disorder treatment centers, and (d) supervisees’ responses (i.e., behaviors, feelings, and thoughts) to clients diagnosed with eating disorders. After the supervisees’ disclosures about their work with clients, supervisors guided supervisees in ways to counsel clients diagnosed with eating disorders, which increased supervisees’ competencies. These supervisees realized they were not working alone with the clients because they were supported by their supervisors and a treatment team. As part of a treatment team comprised of the additional resources of dietetics, psychiatric services, and medical support, the supervisees had numerous opportunities to consult with other professionals. This consultation may have provided them with the additional instruction and support that they needed, resulting in an increased assurance that the client issues were being addressed. Because of these additional resources and opportunities for consultation and support outside of supervision, supervisees may have desired less support from their supervisors within the supervisory relationship than supervisees who worked in a more independent setting (e.g., private practice) with clients. However, this
collaboration with other professionals outside supervision would be discussed within supervision to ensure that client care was being upheld. During this data collection, no supervisees indicated that they did not have enough time in supervision.

For all five supervisees, educational discussions sprang up in supervision—in part—from: (a) instruction about therapeutic approaches and procedures for working with clients diagnosed with eating disorders, and (b) reaction papers on topics related to weekly counseling experiences. Three supervisees indicated that concerns about competencies as counselors were met by their supervisors’ instruction related to approaches for working with specific clients diagnosed with eating disorders. This instruction allowed supervisees to feel more confident about their work as counselors and was aligned with positive reports of supervisory experiences. Supervisees also reported that instruction was helpful and provided them with support when they spoke of the complexity of this population of clients with eating disorders, and the symptoms and comorbidity they presented. This instruction provided them with the direction they desired in order to be assured they were working toward meeting clients’ treatment goals. Once again, when supervisees felt more competent about their work, they were also more likely to report positive experiences in supervision. When supervisees disclosed their behaviors, feelings, and thoughts in response to clients, the supervisors responded with instruction about therapeutic procedures (e.g., “centering” communication, setting boundaries) to allow them to refocus on their clients’ concerns and receive support from their supervisors. Because supervisees were better able to accomplish supervision goals after their disclosures, they also reported more positive supervisory experiences.
Through this supervisory instruction, the supervisors displayed their knowledge about working with clients with eating disorders. After exposure to their supervisors’ knowledge and experiencing instruction about possible approaches for working with clients, the supervisees indicated that they trusted their supervisors. With this increased trust, the supervisory relationship was reported to have improved. And from this trusting foundation, the supervisees may have also felt more comfortable in supervision and more supported by their supervisors. The supervisees’ responses to their clients may have also been positively impacted through the use of reaction papers. Through these reaction papers, the supervisees were given an opportunity to grow in awareness of their responses (including behaviors, feelings, and thoughts related to their counseling) and then use supervision as an opportunity for discussion and enhanced understanding. Once again, when supervisees were open about their concerns, their supervisors could assist them with instruction and support. Therefore, the supervisees’ openness with their supervisors about their concerns working with clients impacted their reported levels of satisfaction about their supervisory experiences.

The supervisors modeled procedures for all five supervisees. Two supervisees reported specific modeling of breathing and “centering” communication in supervision to increase supervisees’ understanding of these practices, for use with clients as well as for supervisees to use themselves for self-care. Through modeling of these procedures, supervisees learned how to breathe and ground themselves. This “centering” reduced the two supervisees’ feelings of concern about competencies as counselors and increased their confidence about their abilities to work with the population of clients diagnosed
with eating disorders. After supervisees’ concerns were reduced, often their confidence increased, and supervisees were more able to reflect upon their responses to clients (including behaviors, feelings, and thoughts) and focus on issues presented by each client (i.e., helping clients to meet their treatment goals). Throughout these experiences, supervisees reported differences in their supervisory relationships. Supervisors were flexible in their roles with supervisees. They were more consultative when the supervisee was in a later stage of development as a supervisee and the supervisee was reporting decreased feelings of concern about competencies, increased confidence in their work with this population of clients, and minimal impact on their behaviors, feelings, and thoughts in response to clients. Supervisors were more instructional and supportive when the supervisee was in an earlier stage of development, evidenced by supervisees’ reports of concern about competencies, uncertainty in their work with the population of clients, and challenges managing their behaviors, feelings, and thoughts in response to clients. In the consultative role, the supervisory relationship was more egalitarian, and when the supervisor was instructional and supportive, the supervisee reported a relationship that was more directive in description.

All of the supervisees reported that group supervision complimented their individual supervision sessions. The supervisees disclosed the following commonalities about their group supervision experiences: (a) case consultation, feedback, and instruction of alternative therapeutic approaches and modeling of procedures; and (b) discussion about the impact of counseling work on the supervisees (i.e., behaviors, feelings, and thoughts in response to clients). Group supervisory sessions aided the
supervisees in decreasing their concerns about their competencies and increasing their confidence about working with this population of clients by providing them with additional instruction around possible treatment approaches as well as normalizing their concerns related to perceived inadequacies. Group supervision also provided the supervisees with a place to discuss the impact of their work on them professionally (i.e., their behaviors, feelings, and thoughts in response to clients) and to receive support. The supervisees talked about how role-playing was helpful in providing them with opportunities to practice procedures they could use with their clients diagnosed with eating disorders. Through these role-playing exercises, supervisees grew in awareness of how they behaved in their roles as counselors and what it may have been like to be in the role of the client. Then supervisees were able to process this awareness within the group supervision sessions and make changes to allow for professional growth. The supervisees disclosed that they felt connected to their supervisor and the other group members when the supervisor facilitated a supportive environment and encouraged the supervisees’ expression of their feelings and thoughts. In both individual and group supervision, strong supervisory relationships were connected to supervisees’ reports of more positive supervision experiences.

**Summary of Chapter III**

This chapter reported on data pertaining to the phenomenon of supervisory experiences for counselor supervisees working with clients diagnosed with eating disorders. The researcher presented an analysis of the data as related to the following research questions: “What are the reported supervisory experiences of counselor
supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?”

After the researcher described the five participants’ demographics, the data were revealed. The data were analyzed according to Moustakas’ transcendental methodological approach (1994) that incorporated data analysis modified by Stevick (1971), Colaizzi (1973), and Keen (1975). The data included: textural and structural descriptive themes, individual textural and structural descriptions, composite textural and structural descriptions, and a textural-structural synthesis. Chapter 4 discusses how previous literature and research relates to the data, explores limitations of the study, provides recommendations for further research in order to continue this line of inquiry, ponders implications for clinical supervisors working with supervisees counseling clients diagnosed with eating disorders, and considers implications for counselor education and supervision.
CHAPTER IV
DISCUSSION

In the present study, the researcher sought to illuminate the phenomenon of supervisory experiences through the following research questions: (a) “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and (b) “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?” The research questions were used to generate textural and structural descriptive themes, individual and composite textural and structural descriptions, and a textural-structural synthesis. According to Moustakas (1994), the textural description refers to “what” is experienced and the structural description refers to “how” it is experienced. The structural description is further explained as the beliefs and meanings that are connected to a phenomenon. In the current study the textural and structural descriptions impacted each other and influenced the textural-structural synthesis of supervision.

Current Findings and Previous Literature

The researcher took the findings from the current study and reflected on how they related to the previous literature about supervision of counselor supervisees who work with clients with eating disorders. The researcher analyzed these findings from the current study according to textural and structural descriptive themes.
“What are the Reported Supervisory Experiences of Counselor Supervisees who Work With Clients Diagnosed With Eating Disorders?”

In the present study, the researcher discovered that the textural descriptive themes of supervisory experiences entailed: (a) time in supervision, (b) educational discussions about working with clients diagnosed with eating disorders, (c) modeling by the supervisor, and (d) individual and group supervision. Not all of these textural descriptive themes were addressed in previous literature.

Time in supervision. Previous literature did not address the length of time in either individual or group supervision. This textural description reveals an area of research about optimal time spent in supervision that counselor educators may want to consider in future studies.

Educational discussions about working with clients diagnosed with eating disorders. Grant’s (2006) mixed methods research explored student counselors’ supervisory experiences while working with clients with complex presenting problems. Grant’s findings revealed that “experiential and interpersonal learning, direct practice, and supervision” all aided students’ progress (p. 220). The current investigation supported Grant’s findings because supervisees stated that they benefited from supervisors’ instruction about therapeutic approaches (e.g., Dialectical Behavior Therapy) to use with clients diagnosed with eating disorders. The participants’ disclosures also supported Grant’s findings that a focus in supervision on case conceptualization and treatment planning was essential to meet the needs of the client population. The supervisees in the current study discussed learning therapeutic
approaches in response to their presentation of specific clients during case conceptualization. Supervisees reported that case conceptualization occurred in both individual and group supervision.

Findings from the current study supported Delucia-Waack’s (1999) suggestion for supervisors working with supervisees specializing in counseling with clients with eating disorders. Delucia-Waack suggested that the supervisors prioritize ethical and safety issues. In the current study, three participants talked about their supervisors’ focus on ethical and safety issues to make certain that the severity of the clients’ symptoms and comorbidity were treated with the most appropriate level of care. This sometimes meant that clients had to transition from an outpatient setting to intensive outpatient or partial hospitalization to improve. If a transfer was necessary, supervisees made certain to provide appropriate referrals.

Similar to findings presented by Frederickson (2001), Gazzola and Theriault (2007), and Worthen and McNeill (1996), supervisees in the current study described practices consistent with broadening and narrowing educational discussions during supervision. Narrowing meant that the supervisory process became structured according to the supervisor’s agenda. From supervisees’ disclosures during the present study, attention to ethical standards was an example of narrowing the discussion during supervision. Similar to Gazzola and Theriault’s (2007) findings, supervisees in the current study reported supervisors providing more structure and limiting freedom to make decisions when ethical issues were being considered. Furthermore, supervisors used narrowing by giving supervisees fewer decision making opportunities when they were
working with a population of clients for the first time. Supervisees in the current study reported supervisor practices consistent with broadening the discussion during supervision when they were more experienced and in more of a collaborative relationship with their supervisors. Within this collaborative supervisory relationship, consultation seemed to be more of a possibility. Supervisees reported having more choices about their counseling practices when there was a focus on broadening discussions in supervision.

**Modeling by the supervisor.** In the current study, supervisees reported their supervisors modeling possible therapeutic procedures (e.g., empty chair technique). These reports of modeling supported previous research about the supervisory relationship (Delucia-Waack, 1999; Hamburg & Herzog, 1990). Within the supervisory relationship, the supervisor is given an opportunity to model ways of responding to clients. For example, all five supervisees presented feelings of concern (e.g., about comorbidity, modeling of eating in meal groups with clients, competencies about their work with clients) in response to their clients. In response to supervisees’ presentation of concern, supervisees reported their supervisors’ modeling of procedures like “centering” communication. This “centering” communication may be a helpful procedure to use themselves and with clients who present with symptoms of anxiety. The current investigation supported Hamburg and Herzog’s suggestions that supervisors’ modeling of possible therapeutic procedures may allow supervisees to reduce their own feelings of concern and be more comfortable using various procedures with clients.

Hamburg and Herzog (1990) reported their findings about increased supervisee comfort after watching supervisors model procedures. In the current study, three
supervisees reported increased positive feelings and thoughts about their competency and their supervisory relationships after supervisors modeled counseling procedures. Knowledge about these procedures, after witnessing supervisor modeling, helped supervisees reduce their concerns about competencies. After supervisors modeled procedures, supervisees also reported this contributed to a helpful supervisory relationship.

**Individual and group supervision.** Supervisees discussed similarities with their individual and group supervision experiences that were consistent with Stoltenberg’s (2005) Integrated Development Model (IDM). Stoltenberg et al. (1998) researched development of supervisees according to mastery of stages. According to Stoltenberg et al., supervisee development progresses through four stages: (a) Level One: self (counselor)-focus, (b) Level Two: self (counselor)-focus begins to combine with other (client)-focus, (c) Level Three: self (counselor)-focus is balanced with other (client)-focus, and (d) Level Three (i): self (counselor)-focus is balanced with other (client)-focus where client populations are diverse. In each of these four stages, growth is evaluated on the following structures: self-other awareness, motivation, and autonomy. Stoltenberg et al. defined self-other awareness as balancing the awareness of self with the client in session. Motivation refers to how invested the supervisee was in her development as a counselor. Autonomy means that the supervisee feels confident working with clients, making decisions, and taking responsibility for her actions in sessions without constant supervisor direction. Applying Stoltenberg et al.’s developmental process, the supervisee may progress from Levels One through Three, but
then struggle at Level Three (i) when applying skills to working with the specific population of clients with eating disorders. Supervisors create a positive supervisory experience for supervisees when they facilitate learning skills that are developmentally aligned with the supervisee. By assessing the supervisee’s level of development at the onset of supervision, the supervisor is able to tailor instructions to meet the supervisee’s unique needs. Similar to Stoltenberg et al.’s recommendations, supervisees in the current study reported receiving more instruction and support when in the initial stages of their development as a counselor or when they were new to working with clients diagnosed with eating disorders. According to Stoltenberg et al., supervisees may need less instruction and support in their later stages of development or after attaining experience working with clients with eating disorders, yet supervisees in the current study stated that they would have preferred the instruction and support offered to have continued throughout supervision. Supervisees’ beliefs and meanings behind this preference are discussed when structural descriptive themes are addressed later in the chapter.

Similar to reported findings by Worthen and McNeill (1996), the supervisees in the current study noted more positive feelings about both individual and group supervision when supervisees: (a) received tailored instruction and support in supervision, and (b) experienced “strong” supervisory relationships. The results in the current study supported Worthen and McNeill’s findings that supervision was helpful when supervisors: (a) supported supervisees by “normalizing” their “deficits” (e.g., times when counseling skills needed refinement), (b) considered the supervisees’
developmental stage when providing instruction and support, and (c) facilitated trust within the supervisory relationship.

Similarities were noted in both individual and group supervision with Bernard and Goodyear’s (2009) description of Bernard’s (1979) supervisory roles in her model, known as the discrimination model. This model focused on two aspects of the supervisory relationship: role and function. According to Bernard and Goodyear (2009), Bernard’s (1979) roles of the supervisor (“teacher,” “counselor,” and “consultant”) are used to facilitate the growth of the supervisee in three areas: “intervention” (previously referred to as process), “conceptualization,” and “personalization” (p. 52). The role of “teacher” is directive and used to educate and inform supervisees. In the role of “counselor,” the supervisor attempts to help a supervisee become more reflective about issues related to “intervention,” “conceptualization,” and “personalization.” The “consultant” role of the supervisor is intended for collaboration between supervisors and supervisees. The supervisor uses the roles of “teacher,” “counselor,” and “consultant” to address three areas of focus for supervisees’ skill development: “intervention,” “conceptualization,” and “personalization.” The supervisor addresses the focus of “intervention,” originally referred to by Bernard (1979) as “process,” when she assesses how the supervisee communicates with clients (e.g., reflection of clients’ feelings; reframing of a situation). The supervisor uses “conceptualization” to help the supervisee provide a rationale for the approach to therapy based on a client’s presentation. “Personalization” is how a supervisee presents herself as a person in the therapeutic relationship (e.g., compassionate, directive).
The supervisees in the current study did not refer to their supervisors according to Bernard and Goodyear’s (2009) description of Bernard’s (1979) roles of “teacher,” “counselor,” and “consultant” in the discrimination model. However, all supervisees described their supervisors by using descriptions consistent with Bernard and Goodyear’s roles of “teacher,” “counselor,” and “consultant.” For example, a supervisee may have talked about her supervisor helping her understand her behaviors, feelings, and thoughts in response to clients but may not have mentioned the role of a “counselor.”

“What Meanings do Counselor Supervisees Make of Their Supervisory Experiences When Working With Clients Diagnosed With Eating Disorders?”

In the present study, the participants’ descriptions included the structural descriptive themes about the meaning participants attached to their supervisory experiences. Structural descriptive themes consistent with previous literature were: (a) competencies as a counselor; (b) population of clients diagnosed with eating disorders; (c) behaviors, feelings, and thoughts in response to clients diagnosed with eating disorders; and (d) supervisory relationships.

**Competencies as a counselor.** Results from the present investigation are consistent with previous literature about using supervisory approaches to decrease supervisees’ concerns about their competencies. Previous literature provided information about how to work with inexperienced supervisees to build their skills and confidence in their competencies. Models presented in previous literature included: the Integrated Development Model (IDM; Stoltenberg, 2005), the Discrimination Model (Bernard,
1979; Bernard & Goodyear, 2009), and the Systems Approach to Supervision (SAS; Holloway, 1994).

Stoltenberg (2005) suggested that individual supervision might be more helpful when the supervisor targets the process toward the supervisee’s level of development. After ethical and safety concerns are addressed, the supervisor may be helpful in identifying the supervisee’s deficits and in providing instruction to address skill development. Matching the supervisor’s approach to supervision with the supervisee’s stage of development may help to enable professional growth of supervisees.

For supervisees in the early stages of development, an increase in supervisory instruction may be beneficial. This follows Stoltenberg’s (2005) line of research about the IDM Model of Supervision that states supervisees require more instruction and support from their supervisors in early stages of development and when working with a new population of clients. For three participants in the current study, their concerns about working with clients or feelings of incompetency were decreased when their supervisors took the lead and taught them possible therapeutic approaches and procedures to use with specific clients. Because of their supervisors’ direction, participants felt reassured they were being instructed in a manner that would allow them to be more effective when facilitating the counseling process with clients. Unlike Stoltenberg’s research, all participants, regardless of their stage of development as a supervisee, preferred more instruction and support from their supervisors. This may suggest that even supervisees in the later stages of development experienced some uncertainty about their decisions around the facilitation of clients’ treatment.
Supervisees in the current study described their supervisors displaying characteristics in accordance with past literature about the supervisory roles of “teacher,” “counselor,” and “consultant” (Bernard, 1979; Bernard & Goodyear, 2009). In previous literature, Bernard and Goodyear described the supervisory roles of “teacher” and “counselor” as roles used more commonly to facilitate supervision of supervisees who were considered “inexperienced” or new to the field of counseling. The “consultant” role was often used with supervisees who demonstrated increased levels of counseling skills. Bernard explained that a supervisor acts in the role of “teacher” when she is instructing the supervisee. The supervisor displays characteristics aligned with the role of “counselor” when helping the supervisee process the meaning of interactions with clients. In Bernard’s role of “consultant,” the supervisor is less instructional, while providing support and collaborative decision-making. Together, the supervisor in the role of “consultant” and the supervisee process and brainstorm alternative approaches for working with clients.

In the current study, supervisees reported increased clinical competencies when their supervisors displayed characteristics consistent with Bernard’s roles (“teacher,” “counselor,” and “consultant”) at unique stages of the supervisees’ development or experience (e.g., inexperienced, experienced, or working with a new population). For example, if the supervisor’s role as a “consultant” was paired with an “inexperienced” supervisee (i.e., new to supervision or working with the population of clients diagnosed with eating disorders for the first time), dissatisfaction on the part of the supervisee was reported. One supervisee in the current study stated that she worried about what she
should” know and questioned the approaches she implemented with clients. Her perception was that she needed more instruction from her supervisor. For “inexperienced” supervisees, they seemed to appreciate a combination of supervisors’ instruction and support consistent with Bernard’s roles of “teacher” and “counselor.” One reason for this desire to experience a combination of characteristics consistent with these roles might have been a result of the challenge supervisees experienced in learning new therapeutic approaches. While learning these new therapeutic approaches and experiencing a modeling of these procedures, a combination of challenging instruction and support from their supervisors may have helped to make these experiences more manageable.

The Systems Approach to Supervision (SAS; Holloway, 1995) described the tasks of supervisors and functions (i.e., skills) of supervisees. Participants in the current study used words to describe what they learned in supervision and how their supervisors facilitated this instruction in ways that were consistent with Holloway’s description. Similar to Holloway’s description of supervisor tasks, the participants described: “monitoring and evaluating,” “instructing,” “modeling,” “consulting,” and “supporting and sharing.” In the current research, supervisors monitored supervisees by providing them with feedback around strengths and weaknesses. Supervisors instructed supervisees about therapeutic approaches and ethical procedures to aid in supervisees’ development. Supervisors modeled behavior for working with clients, sometimes via role-playing in supervision. Through consulting, supervisors facilitated collaborative communication with supervisees to better understand clients’ needs. Supervisors practiced the tasks of
supporting and sharing by balancing encouraging and challenging comments with the supervisee, while sharing perceptions about the supervisee’s actions, emotions, and thoughts. Participants added that the above mentioned supervisory tasks (e.g., instructing, modeling) enabled them to have positive supervisory experiences because they felt more competent in their work with clients and were better able to manage their behaviors, feelings, and thoughts in response to the presentation made by clients.

Participants in the current study also spoke of their supervisors’ skills taught during supervision, and these were consistent with Holloway’s description. Holloway stated that supervisors teach the following skills: “professional role development,” “counseling,” and “case conceptualization.” According to Holloway, one of the supervisee’s functions (i.e., skills), “professional role development,” is explained as the supervisee’s ability to uphold ethical standards while facilitating counseling. “Counseling skills” refer to the supervisee’s ability to communicate empathically with clients and utilize various counseling techniques. A supervisee’s ability to “case conceptualize” depends on her understanding of the client’s history and presenting problems to form a diagnosis and create a treatment plan. Participants in the current study reported having experienced skill development consistent with Holloway’s description. They added that the intentional focus of educating them in these three function areas improved their feelings of competency around their work and allowed them to manage the impact of their counseling efforts on their behaviors, feelings, and thoughts. For example, if a supervisee in the current study experienced increased
competency, she might be less anxious about addressing a client’s comorbidity or attending to ethical issues to uphold client care.

Participants did not refer directly to Holloway’s (1994) description of the supervisee functions (i.e., skills) of “emotional awareness” and “self-evaluation.” However, participants indirectly referred to these skills by discussing their growth towards understanding their (supervisees’) behaviors, feelings, and thoughts in response to clients, their feelings and thoughts about supervisory relationships, and how this impacted their efforts as counselors. According to Holloway, the supervisee’s “emotional awareness” is considered within client-counselor and supervisee-supervisor relationships. This means that the supervisee is aware of how her emotions may impact others (e.g., understand the impact of her emotions on clients). “Self-evaluation” of the supervisee allows for reflection on strengths and weaknesses to facilitate client progress.

**Population of clients diagnosed with eating disorders.** Similar to previous literature and research, supervisees in the current study reiterated the description of the complexity of clients diagnosed with eating disorders (Escobar-Koch et al., 2010; Franko & Keel, 2006; Milos et al., 2003; Warren et al., 2009). Specifically, the participants in the current research spoke of clients’ complexity as related to comorbidity. Comorbidity impacted “how” supervisees experienced supervision because the supervisors had to plan processes that addressed the symptoms of the eating disorder alongside symptoms aligned with another diagnosis or other diagnoses. Participants reported feelings of concern about comorbidity in clients, and worried about these concerns interfering with their (supervisees’) focus on the therapeutic relationship. Supervisees sought instruction
and support from supervisors in response to these concerns about clients’ presentation of
comorbidity. Supervisees understood the importance of a strong therapeutic relationship
and Grant’s (2006) research supported this focus. According to Grant, supervisory
attention to creating and repairing the therapeutic relationship while counselors worked
with clients presenting with comorbidity was essential.

According to Costin (2009), this population of clients with eating disorders
existed within a societal environment that put an emphasis on the “thin ideal,” making it
difficult for both counselors and clients to uphold a healthy attitude toward their bodies.
These societal influences impacted participants’ reported supervisory experiences in the
current study. To counter these societal pressures, supervisors provided supervisees with
therapeutic approaches to use with clients. The availability of varying levels of care and
additional resources at the specialized eating disorder treatment centers may have also
countered societal pressures. Previous literature did not address the impact of the varying
levels of care or resources offered through specialized eating disorder treatment centers
on supervisory experiences. This may be a topic to explore in future research.

Behaviors, feelings, and thoughts in response to clients diagnosed with eating
disorders. Similar to the previous research (Costin, 2009; Franko & Rolfe, 1996;
Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Satir et al., 2009; Zerbe, 2008),
supervisees in the current study reported concerns about their work with clients
diagnosed with eating disorders. For example, two supervisees reported feelings and
thoughts of concern about reducing symptoms and meeting treatment goals for clients
presenting with comorbidity. The present research supported findings from the previous
literature (Delucia-Waack, 1999; Hamburg & Herzog, 1990) by illuminating the impact on supervisees’ behaviors, feelings, and thoughts in response to clients’ presentation. The participants in the current study also spoke about supervision as a resource to manage behaviors (e.g., modeling of eating in meal groups with clients), feelings, and thoughts (e.g., concerns about comorbidity) to allow them to focus better on progress toward treatment goals with clients.

Previous literature addressed the impact that working with clients may have had on supervisees’ behaviors (Warren et al., 2009), feelings, and thoughts (Delucia-Waack, 1999). Supervision was one resource supervisees used to manage this impact. Research conducted by Warren et al. illuminated supervisees’ changes in behavior; 30 out of 43 (70%) participants reported a change in their food behaviors in response to clients. Warren et al. did not note the specifics of changes in food behaviors. However, consistent with Warren et al.’s findings, one supervisee in the current study reported learning in supervision about the practice of healthy food behaviors in response to clients’ unhealthy behaviors with food (e.g., restriction or bingeing). In response to clients’ presentations of unhealthy behaviors, the supervisee revealed that she practiced moderation in consumption of all foods. The current research also supported Delucia-Waack’s findings (1999) of changes in supervisees’ behaviors, feelings, and thoughts in response to clients. More specifically, one supervisee in the current study disclosed changes in her thoughts about food in response to her work with clients with eating disorders. After speaking in supervision about her clients’ unhealthy food behaviors (e.g., restriction or bingeing) and irrational thoughts about food (labeling of
foods as “good” and “bad”), this supervisee learned in supervision to let go of labeling food “good” and “bad,” and eat all foods in moderation. Awareness of the possible impact on supervisees’ behaviors, feelings, and thoughts in response to clients led to supervision as one resource to teach supervisees self-care practices. It may be that the supervisees’ practices of self-care to address their behaviors, feelings, and thoughts in response to clients allowed them to better focus on their clients’ presenting concerns and treatment. Without these self-care practices, supervisees might have been distracted by their own behaviors, feelings, and thoughts in response to clients.

**Supervisory relationships.** The current study supported past research that reported the supervisory relationship as one of the most important factors in supervisee development (Gazzola & Theriault, 2007; Orlinsky et al., 2001; Worthen & McNeill, 1996). Worthen and McNeill’s (1996) phenomenological investigation showed that a strong supervisory relationship also led to more positive experiences in supervision. This is a finding similar to one from the present study. The current investigation added that a more helpful supervisory relationship led to greater sharing by supervisees of their behaviors, feelings, and thoughts in response to clients. According to Worthen and McNeill, a supervisor who “conveyed an attitude that manifested empathy, a nonjudgmental stance toward them [supervisees], a sense of validation or affirmation, and encouragement to explore and experiment” (p. 29) facilitated a “good supervisory experience.” Supervisees in the current investigation described a positive supervisory relationship as comfortable, supportive, and trustworthy, yet one in which the supervisor challenged the supervisee into a place of discomfort at times to facilitate development.
The current study also spoke to previous literature about: (a) non-hierarchical relationships, and (b) gender as two aspects of the supervisory relationship that impacted the supervision experiences.

**Non-hierarchical relationships.** Constructivist approaches to supervision, specifically Edwards and Chen’s Wu-wei (1999) postmodern supervisory approach, focus on the supervisor and supervisee sharing power and knowledge within a non-hierarchical and collaborative relationship. This relationship does not assume the supervisor is more informed than the supervisee about facilitation of clients’ treatment and seeks to establish a strength-based supervisory relationship. Two participants in the current study indicated that they had experienced a more “egalitarian” (i.e., non-hierarchical and collaborative) supervisory relationship and stated that this was helpful, especially because the supervisees felt more comfortable sharing their behaviors, feelings, and thoughts in response to clients. These participants spoke about their dislike for hierarchical relationships. At the same time, participants spoke frequently of concerns about their competencies and the population they counseled. Participants in the current study believed that to alleviate these concerns, they needed instruction about therapeutic approaches for working with specific clients. It seemed that supervisees’ desires for a non-hierarchical relationship, and for instruction, conflicted. When supervisors offered this instruction, the supervisees’ opportunities to play more of a collaborative role in the relationship diminished. This illuminates the challenges for supervisors in response to what may be considered conflicting requests from supervisees.
Gender. Gender was reported in previous research to impact the supervisory relationship (Winters, 1994). In the current study two supervisees reported that they would be less comfortable with a male supervisor while working with clients diagnosed with eating disorders. These supervisees reported that a male might not understand body disturbance (e.g., body image dissatisfaction, body dysmorphia) in a way a female might. Winters (1994) proposed that gender was an important factor to consider because both supervisors and supervisees have gender-related beliefs and values that impact their interactions with each other.

The findings of Doughty and Leddick (2007) suggested that both male and female supervisors offered more instruction to female supervisees. Doughty and Leddick reported that when both male and female supervisors offered too much instruction to female supervisees, female supervisees missed opportunities for collaboration and empowerment. Regardless of the supervisee’s level of development, the female supervisees in the current study stated that they desired instruction. If supervisors had never facilitated supervision through the consultant role as supervisees developed, these supervisees may have missed opportunities for collaboration and empowerment. Fortunately, the supervisees in the current study reported that their supervisors provided instruction, but not too much instruction.

Granello (2003) explored the impact of the supervisee’s gender on the supervisory relationship. Granello found that female supervisees use more indirect and passive forms of communication in supervision in contrast to the more direct and active voice of their male counterparts. This could help explain participants’ concerns about the amount of
instruction received in supervision. The participants may not have voiced their desires to
their supervisors. That being said, female participants in the current study and female
supervisees overall may not get their goals for supervision met as often as males. This
may be another area for future investigation.

Methodological Decisions and Limitations

It was important for the researcher to reflect on the strengths and limitations of the
methodological decisions made in this research. Though limitations were present, the
researcher implemented an approach that increased the trustworthiness of the research.
The researcher upheld aspects of trustworthiness, including credibility, transferability,
dependability, and confirmability throughout her data collection processes. This
methodological approach included: (a) prolonged engagement with participants in two
face-to-face interviews to obtain detailed and rich descriptions of their supervisory
experiences, (b) member checking of data collection, (c) peer review, (d) negative case
analysis, and (e) memoing in a research journal. Research limitations and delimitations
were explored to uncover areas for improvement in future studies consistent with this line
of inquiry. The researcher described the components of trustworthiness in Chapter 2.
For this section, the researcher explains the limitations and delimitations of the research
and how she sought to minimize these.

Limitations

Limitations are aspects of a study that are out of the researcher’s control (Simon
& Goes, 2013). For example, social desirability could have influenced the results.
Supervisees may have spoken more favorably about their experiences in an attempt to be
positively perceived by the researcher. However, the researcher believed that the supervisees would be less motivated than supervisors to describe their supervisory experiences in a positive way. In an attempt to decrease social desirability bias, the researcher chose supervisees instead of supervisors to explain supervisory experiences.

**Delimitations**

Delimitations are boundaries defined by the researcher and within the researcher’s control (Simon & Goes, 2013). According to Simon and Goes, “Delimiting factors include the choice of objectives, the research questions, variables of interest, theoretical perspectives [the researcher] adopted, and the population [the researcher] chose to investigate” (para. 5). According to Patton (2002), bracketing, reflexivity, and triangulation strengthen the trustworthiness of a research study. A delimitation of the study was that triangulation was not sought. In future studies to investigate this subject matter, it may be possible to triangulate the data through the use of additional data collection methods (e.g., observation of supervision) to yield more trustworthy results. Multiple data collection methods may have captured different aspects of the phenomenon being studied, facilitated additional insight, and increased the trustworthiness of the study.

The research sample is a delimitation. The researcher chose a purposeful sample of participants to capture experiences of a group of counselors working in eating disorder treatment centers. The researcher selected participants who met inclusion criteria and remained open to adding participants until the saturation point of presenting themes was attained. This sample was limited in that all participants were females who worked with
clients at eating disorder treatment centers. The findings may have been different had participants been both females and males who had been working in a general mental health agency or in a private practice.

A final delimitation is that findings from this study might not apply to supervisees who work with other populations of clients. The findings from the current study illuminated supervisory experiences for counselor supervisees who work with clients diagnosed with eating disorders. Supervisees working with other populations of clients may report different and additional supervision experiences.

In summary, despite limitations and delimitations in this study as previously noted, it is worthwhile to mention that many of the findings were consistent with previous literature (Costin, 2009; Delucia-Waack, 1999; Franko & Rolfe, 1996; Frederickson 2001; Gazzola & Theriault, 2007; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999; Orlinsky et al., 2001; Satir et al., 2009; Worthen & McNeill, 1996; Zerbe, 2008). This adds credibility to findings from the current study.

**Recommendations for Future Studies**

Future studies might consider the following recommendations: (a) making use of triangulation in data collection, and (b) using samples with both males and females from different types of treatment centers.

Triangulation of data may improve data collection and increase trustworthiness. Denzin (1978, p. 291) referred to triangulation of data as “the combination of methodologies in the study of the same phenomenon.” Such triangulation of data might help verify the accounts of supervisory experiences, rather than relying simply on
supervisees’ recollections of their experiences. Interviews are based on memory of experiences. The researcher recalled times when supervisees were unable to recall details in response to specific questions and these details may have added more information to the description of the participants’ experiences. Further research studies may include triangulation of data to possibly elicit more details and improve results by using: (a) observations of supervision, (b) focus groups, (c) face-to-face interviews with supervisors, and (d) analysis of supervisees’ and supervisors’ journaling. For example, observation of supervisory sessions may illuminate supervisory experiences (e.g., the use of questions in helping a supervisee make use of a counseling theory). Focus groups may be another means to triangulate data. In a focus group, a few supervisees could come together to discuss their supervisory experiences and this may allow them to recall aspects of supervision that had been forgotten. The supervisees could help each other add to the description of their supervisory experiences. Face-to-face interviews with supervisors in addition to supervisees would also offer additional perspectives about the process of supervision. This would allow the researcher to more fully understand the supervisory processes. Last, reading journals from both supervisors and supervisees about experiences in supervision may offer information about the processes and individuals’ beliefs and meanings associated with supervisory experiences.

Samples from different types of treatment centers may also bring forth different results. All participants in the current study worked at specialized eating disorder treatment centers. Because they were employed at these centers, they had access to many resources for clients, including psychiatric, dietetic, and medical. Counselors working in
a private practice or community agency would have to make additional efforts to consult
with other professionals in their clients’ lives, and this would impact some of their work
in supervision. Additionally, future research studies may want to consider interviewing
both male and female supervisees to draw out additional perspectives.

**Implications for Supervision**

Findings from the current study may be considered in clinical supervision when
working with clients diagnosed with eating disorders. These considerations are
applicable for both individual and group supervision and pertain to: (a) supervisor’s
feedback and evaluation, (b) assigned reaction papers, (c) group supervision, (d) focus on
the development of the supervisory relationship, (e) separation of “boss” and supervisor
roles, and (f) discussion about supplementary resources.

**Supervisors’ Feedback and Evaluation**

Feedback is a necessary and helpful part of supervision; supervisors provide
information to supervisees about their strengths and areas for continued improvement
(Bernard & Goodyear, 2009). With this information, supervisees can better understand
their professional development and make goal setting plans with their supervisors to be
assessed in the evaluation process of supervision. Participants in the current study
discussed their feelings and thoughts about receiving feedback in supervision. One
participant preferred her supervisor to provide more positive feedback. This participant
stated that she didn’t associate a positive supervisory experience with critique and
negative feedback. Another supervisee in the current study stated that live or videotaped
supervision would have been helpful to enhance the feedback she received from her
supervisor. She felt limited in her ability to explain exchanges between herself and a client. She knew that much of what she wanted to communicate could not be explained through her recollections. She stated that she would have preferred feedback after having her supervisor watch the complete session between herself and her client.

To allow for supervisees to be more open to supervisor’s feedback, both positive and negative, it may be helpful for the supervisee to be included in a collaborative way on plans for feedback and goal setting as well as the evaluation process in supervision (e.g., participation in the formulation of the supervisory contract as a part of informed consent, including a description of summative and formative evaluations). If supervisees are included in the process at the beginning, they may understand their supervisors’ perspectives and also feel included in a more egalitarian relationship. As previously discussed, supervisees in the current study were more receptive to non-hierarchical supervisory relationships. Within a more egalitarian relationship, they may be less defensive when receiving negative feedback, believing that the supervisor is facilitating a process that will lead to development and attainment of supervision goals.

Regardless of supervisees’ feelings and thoughts about feedback, supervisors have a responsibility to critique supervisees’ professional work and provide both positive and negative feedback to improve supervisees’ approaches with clients and meet supervision goals. Evaluating supervisees’ actions and progress is different from judging the supervisee as a person. Rather than attacking supervisees personally, supervisors may need to reiterate that the intentions of feedback and goal setting in the evaluation process are to improve supervisees’ work with clients.
Although supervisees did not speak directly about their evaluation processes, feedback and goal setting are part of evaluation. Evaluations inform supervisees of their strengths and weaknesses and help to provide supervisees with skills to change necessary behaviors. Evaluations are initiated with a plan and this process is discussed at the onset of supervision (Borders et al., 2011). These plans are typically a part of supervision contracts and outline the expectations of supervision and consequences of underperformance. In evaluation plans, supervisors inform supervisees that performance is assessed in areas such as: “relationship building, multicultural and advocacy competencies, professionalism, and/or items that address the traditional range foci in supervision (e.g., counseling performance skills, cognitive counseling skills and case conceptualization, self-awareness, and professional behaviors)” (Borders et al., 2011, p. 12). According to Borders et al., both feedback and evaluations are critical parts of the ACES *Supervision Best Practices Guidelines*. This best practices document about supervision stated that both formative and summative evaluations should be used to monitor and improve supervisees’ growth and then assess their development during and at the end of the supervision period. According to ACES, “in general, formative evaluation occurs in every supervision session and informs the supervisee of . . . her incremental progress or lack of progress. Summative evaluation occurs at regular, stated intervals, and includes a written statement of supervisee performance” (p. 12). It is recommended by ACES to present evaluation as an expectation prior to beginning supervision, to gauge the supervisee’s reactions to the process, and to discuss how it may be helpful in her development as a counselor. This commonly occurs through a
supervisory contract, which acts as an informed consent and agreement (Osborn & Davis, 1996). It is helpful for the supervisor to be transparent about these plans, so to prepare the supervisee for the “criteria for success, and consequences of underperformance . . . prior to beginning supervision” (p. 13). Participants in the current study frequently mentioned receiving feedback, which may have been part of their formative evaluation processes. This may have occurred in part because they were interviewed in the middle of their supervision rather than at the end when summative evaluations would have been occurring. They also reported that they preferred “positive” feedback to “negative” feedback. The researcher understood their description of “positive” feedback as validation and a focus on their strengths, and “negative” feedback as communication about not meeting expectations and discussion of improvements necessary for further development. According to Hawkins and Shohet (1989), a balance of positive and negative feedback is helpful. A supervisor providing only positive or only negative feedback may want to reflect on her perspective. A balance of positive and negative feedback and goal setting through the evaluation process in supervision may allow supervisees to be aware of areas needing improvement, allowing them to work on these issues while under the instruction and support of supervisors.

**Assigned Reaction Papers**

Assigning reaction papers to supervisees throughout supervision could facilitate supervisee-generated discussions around topics of interest or concern to supervisees. Participants in the current study stated that these reaction papers allowed for intentional reflection and provided them with possible topics for supervision. Through reaction
papers, the supervisee is given an opportunity to first reflect on professional topics and then bring portions of the topics to supervision for continued processing and potential decision-making. This reflection may be helpful in realizing the impact of their counseling work on their behaviors (e.g., behaviors with food), feelings and thoughts (e.g., concerns about body image or body dissatisfaction), and to then discuss these reflections in supervision in order to assist supervisees in working with their clients.

**Group Supervision**

Group supervision may be a helpful and supportive resource in combination with individual supervision for supervisees throughout their work with clients. The group environment can offer supervisees a variety of perspectives from the supervisor and fellow supervisees about their ongoing work with clients and it may offer support by normalizing supervisees’ behaviors (e.g., behaviors with food), feelings, and thoughts (e.g., concerns about body image or body dissatisfaction) in response to working with clients diagnosed with eating disorders. Group supervision may also offer opportunities for the supervisor and supervisees to demonstrate approaches for working with clients. This demonstration may allow supervisees to feel more comfortable using a variety of approaches with clients. Similar to individual supervision, relationships impact the effectiveness of group supervision as well. For group supervision, cohesion is necessary to facilitate a trustworthy environment where supervisees feel comfortable sharing and being vulnerable with each other (Bernard & Goodyear, 2009). When group members share with each other their behaviors, feelings, and thoughts in response to their work with clients, they may increase opportunities for support and encouragement. With this
support and encouragement, supervisees might be able to better manage their behaviors, feelings, and thoughts in response to clients’ disclosures.

One of the participants in the current study reported that she felt disclosures and feedback in group supervision, relative to counseling with clients, were not as helpful as they could have been. Specifically, the participant stated that group cohesion was lacking and she perceived group members not feeling comfortable sharing with each other. This seems to suggest that it may be essential for supervisors to spend adequate time facilitating relationships (e.g., focusing on using group bonding exercises at the onset of group supervision or inquiring about common experiences) in order to increase group cohesion among supervisees and in order to increase trust and maximize benefits of the group.

Focus on the Development of the Supervisory Relationship

All five participants in the current study suggested that a strong supervisory relationship might be correlated with positive and helpful supervisory experiences. Furthermore, like the relationship between counselor and client, a supervisory relationship based on trust provides a solid foundation for professional communication. With a strong foundation based on trust, a supervisee may feel more comfortable sharing vulnerabilities such as concerns about competencies when working with clients and behaviors (e.g., food behaviors), feelings, and thoughts (e.g., concerns about body image) in response to clients. Therefore, a focus in the beginning of supervision would be on strengthening the relationship between the supervisor and the supervisee. For example, sharing of professional interests, goals for supervision, and professional aspirations may
be important to establishing a foundation of trust. Without trust, the supervisee may fear disclosure of professional issues out of concern for how her supervisor might respond. Without discussions about behaviors, feelings, and thoughts in response to clients, a supervisee may experience difficulty focusing on clients. According to Stoltenberg (2005), the first level of development is described as a focus on (counselor) self, and difficulty focusing on clients may be a normal part of development. Although the researcher did not ask about counselor impairment, none of the counselor supervisees mentioned that they were impaired when working with clients.

For all five supervisees in the current study, trust also increased when they experienced the supervisor’s knowledge and competence through supervisory instruction. After this exposure to the supervisor’s knowledge and competency, the supervisees felt more trusting of the supervisor’s instruction. It may be helpful for a supervisor to discuss some of her experiences in a professional disclosure statement with supervisees and spend time instructing supervisees, with regard to particular client cases, to increase their feelings of trust in the supervisor.

According to the ACES best practices document on supervision (Borders et al., 2011), the supervisor is responsible for “Operat[ing] with awareness that the supervisory relationship is key to the effectiveness of supervision as well as the growth and development of the supervisee” (p. 7). The supervisor acknowledges the power differential in the relationship and makes decisions about when to move toward more of an egalitarian and collaborative relationship while upholding the responsibilities of her authoritative role. According to these supervisory best practices, the supervisor should
expect supervisee “resistance as a normal response to challenge, growth, and change” within the relationship, as part of the growth process and manage it in “productive ways, using culturally appropriate strategies to guide, challenge, and encourage supervisees” (p. 7).

The strength of the supervisory relationship is critical to the helpfulness of supervision. Once a supervisee has established a strong relationship with a supervisor, she may find it challenging to transition to working with another supervisor. The supervisee may have grown accustomed to one supervisor’s style and may find changes associated with another supervisor’s style difficult. Similar to switching bosses in any workplace setting, expectations need to be clearly articulated, rather than assumed by either party. Clear expectations, according to the ACES best practices document on supervision (Borders et al., 2011), should be documented in the supervision contract. Within this contract, expectations for supervision are made transparent. These expectations include: “criteria for evaluation; consequences for underperformance; tasks, functions, and goals of supervision; and ethical and legal considerations” (p. 2).

**Separation of “Boss” and Supervisor Roles**

One supervisee in the current study reported discomfort in her relationship with a supervisor because the supervisor also fulfilled responsibilities of a “boss” (Frankie, Interview 1; Interview 2). Responsibilities of a “boss” included: “financial and promotional decisions” (Frankie, Interview 1). Additional duties of a “boss” may include salary changes and caseload assignments. Frankie stated that she hesitated about being “vulnerable and processing countertransference” because it could impact the outcome of
her career. However, she reported she still chose to disclose information (e.g., behaviors, feelings, and thoughts in response to clients). For Frankie, an example of information is feelings and thoughts about her body image that were triggered by clients’ disclosures about negativity toward their bodies. Frankie disclosed this information regardless of her perception of conflicting roles between a “boss” and supervisor because her desires for support were greater than her concerns about the consequences. Unlike Frankie, not all supervisees may be concerned about being vulnerable with a supervisor who also fulfills responsibilities as a “boss.” Yet supervisees who feel they must censor disclosures with their “bosses” may be limited in their development if this failure to disclose impacts their ability to uphold focus on their clients. For this reason, it may be best to limit “bosses” from also being clinical supervisors for employees.

**Discussion about Supplementary Resources**

Supplementary resources were available to clients seeking counseling at specialized eating disorder treatment centers, and this provided supervisees working at these centers opportunities for collaboration with the providers overseeing other aspects of clients’ health. For participants in the current study, supplementary resources included: (a) support groups for family and friends of clients, (b) psychiatric services for diagnosis and medical management of clients, (c) dietetic support for clients’ meal planning and nutrition support, and (d) medical personnel to address the clients’ physical health concerns. Collaboration outside of supervision makes it necessary for supervisors to be aware of conversations occurring between their supervisees and other health providers to uphold ethical client care practices. It is essential that supervisors assist
supervisees in their conversations with allied health providers. For supervisees working outside of specialized eating disorder treatment centers, the access to allied health providers may require an increased commitment to this collaboration during supervision.

**Implications for Counselor Education and Supervision**

Some of the previously discussed implications for supervision may be incorporated into doctoral supervision training curriculum, and these include: focus on the development of the supervisory relationship, assigned reaction papers, supervisor’s feedback and evaluation, discussion about supplementary resources, and group supervision. An additional area for consideration in doctoral supervision training when counselor supervisees are working with clients diagnosed with eating disorders is modeling of food in meal groups with clients. At the core of this training would be the focus on the development of the supervisory relationship. The training may discuss ways to build rapport and understanding of counselor supervisees’ experiences. To better understand counselor supervisees’ experiences, supervisors may assign reaction papers to supervisees as a helpful tool in aiding supervisors in their empathy regarding supervisees’ experiences.

This doctoral training may emphasize collaboration between supervisors and supervisees regarding expectations for feedback and evaluation of supervision goals. From the beginning, collaboration on creation of the supervisory contract may enhance the supervisory relationship and also give supervisors an opportunity to include supervisees in the discussion about expectations for feedback and evaluation. It may be
helpful for supervisors to learn how to clarify the use of feedback and evaluation as tools in the service of a supervisee’s professional development.

Supervisory discussion regarding coordination of care may be identified as an expectation with a number of clients, including those with an eating disorder diagnosis. This would include discussion about the use of supplementary resources and facilitating such discussions might become part of a doctoral degree level course on supervision. Because of the need for collaboration with other health providers to coordinate care for clients, the supervisor may establish an expectation with supervisees that discussion around coordination of care is a necessary part in supervision.

One additional part of doctoral supervision training may entail facilitating group supervision in addition to traditional individual supervision. It would be important for doctoral students to learn about facilitating group supervision in order that supervisees might experience support and suggestions about alternative therapeutic approaches from other group members.

One last consideration for doctoral supervision training for counselor supervisees working with clients diagnosed with eating disorders may be modeling of food behaviors with clients. The training could teach supervisors guidelines for modeling eating with clients diagnosed with eating disorders to offer their supervisees. When eating in a meal group, supervisees may want to make certain that they bring an amount of food they will be able to finish in a meal group session with clients. Since clients are required to finish all food they bring as established in their meal plans, supervisees may want to model the same. Meal plans created by dietitians entail diverse food choices, so it is also important
for supervisees to bring different foods to meal groups, so they model openness to a variety of foods. Clients with eating disorders often narrow themselves to limited food choices, especially since they often label food “good” and “bad.” When supervisees eat a variety of types of food, they model healthy eating. If supervisors were taught these guidelines in their training, they could then use these when working with counselor supervisees working with clients diagnosed with eating disorders.

**Summary of Chapter IV**

This final chapter displayed how the data collected from the investigation related and contributed to clinical supervision research. The data were compared to previous literature according to the research questions for the current investigation. Next, the methodological decisions and limitations were explored, displaying areas for improvement in future investigations on clinical supervision for counselors working with clients diagnosed with eating disorders. The applicability of this research was considered for the practice of clinical supervision. The implications for supervision and for teaching in Counselor Education and Supervision doctoral programs were discussed.

This phenomenological study sought to capture the supervisory experiences of five counselor supervisees who worked with clients diagnosed with eating disorders by addressing the following research questions: “What are the reported supervisory experiences of counselor supervisees who work with clients diagnosed with eating disorders?” and “What meanings do counselor supervisees make of their supervisory experiences when working with clients diagnosed with eating disorders?” Future studies, using additional research approaches, may provide added understanding of these
experiences and improve supervisory practices of counselor supervisees working with clients diagnosed with eating disorders.
APPENDICES
APPENDIX A

KENT STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD FOR HUMAN PARTICIPATION APPROVAL LETTER
Appendix A

Kent State University Institutional Review Board for Human Participation

Approval Letter

RE: IRB # 14-152 entitled “Counselor Supervisees’ Experiences of Supervision When Working with Clients Diagnosed with an Eating Disorder”

Hello,
I am pleased to inform you that the Kent State University Institutional Review Board reviewed and approved your Application for Approval to Use Human Research Participants as a Level II/Expedited, category 7 project. **Approval is effective for a twelve-month period:**


*A copy of the IRB approved consent form is attached to this email. This “stamped” copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB tries to send you annual review reminder notice to by email as a courtesy. **However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials.** Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact the Office of Research Compliance at Researchcompliance@kent.edu or 330-672-2704 or 330-672-8058.

Respectfully,
Kent State University Office of Research Compliance
224 Cartwright Hall | fax 330.672.2658

Kevin McCreary | Research Compliance Coordinator | 330.672.8058 | kmccrea1@kent.edu
Paulette Washko | Manager, Research Compliance | 330.672.2704 | Pwashko@kent.edu
APPENDIX B

SCRIPT FOR TELEPHONE CALLS TO DIRECTORS OF EATING DISORDER
TREATMENT CENTERS AND PRIVATE PRACTITIONERS
Appendix B

Script for Telephone Calls to Directors of Eating Disorder Treatment Centers and Private Practitioners

Script for initial telephone calls:

1. May I speak with the Director (or any available Private Practitioners)?

2. My name is Nicole LaSelle, and I am a Doctoral Student at Kent State University, and for my dissertation research, I am investigating state licensed female counselor supervisees who work or worked with clients with eating disorders about their supervisory experiences. I am calling your particular location because I am interested in limiting participants in my research to female counselor supervisees who are working or have worked with clients with eating disorders and received supervision in the past two years.

3. Are you currently under supervision or have you been working under supervision in the last two years (as you work with clients with eating disorders)?

4. Do you know of any current or previous supervisees in your agency or private practice who work with clients with eating disorders who may be interested in participating in this study? If so, may I send you a recruitment advertisement to post in your staff room and a letter detailing the research and potential participants?

5. If there are counselors who work with or have worked with clients with eating disorders at your location, and who have received supervision in their work with these clients, might it be possible for me to present my proposed research study at a future staff meeting to inform individuals how they might become participants in this study?
APPENDIX C

FLYER FOR RECRUITMENT
Appendix C

Flyer for Recruitment

Request for Research Participants
This study will consider the supervisory experiences of female counselor supervisees licensed with their state board who work with or have worked with clients with eating disorders in the last two years.

Please consider contributing to a research effort to hopefully advance the knowledge about supervision of female counselor supervisees who work with clients with eating disorders. Participant responsibilities would include: (a) Two to three interviews (approximately 60 minutes in length) about the counselor supervisee’s supervisory experiences while working with clients with eating disorders, and (b) verification of created themes from the participant’s interviews to correct inaccuracies. Pseudonyms will be used in an effort to protect the identity of participants.

If you are willing to consider this opportunity, please contact me, and I would be happy to provide additional details about this research.

Nicole LaSelle, MS.Ed., PCC
Doctoral Candidate
Counseling and Human Development Services
Kent State University
Email: nlaselle@gmail.com
Phone: (937) 572-7001
APPENDIX D

DIRECTOR/PRIVATE PRACTITIONER RECRUITMENT LETTER
Appendix D

Director/Private Practitioner Recruitment Letter

Date

Dear _____________,

Thank you for your willingness to consider involvement in my investigation, Counselor Supervisees’ Experiences of Supervision When Working with Clients Diagnosed with an Eating Disorder. I am a doctoral candidate in Kent State University’s Counseling and Human Development Services Program and I am embarking on data collection for my dissertation research. For this investigation, I am conducting a phenomenological qualitative study about the supervisory experiences of counselor supervisees who work with clients with eating disorders.

The Kent State Institutional Review Board has approved this study, and I am working closely with my advisors Jane Cox, Ph.D. and John West, Ed.D. From the findings of this investigation, I hope to gain an understanding of supervisory experiences of counselor supervisees who work with clients with eating disorders and also uncover what may enhance supervision as a resource for future supervisors and supervisees.

For participants, I am in search of female supervisees who: (a) have attained a master’s degree in counseling; (b) have counselor licensure through her professional state board; and (c) are currently working or previously worked under supervision in the last two years with female clients diagnosed with anorexia nervosa, bulimia nervosa, binge eating disorder, or OSFED. Participation expectations include: (a) engage in two to three approximately 60 minute audio-recorded interviews face-to face or over the telephone or via video chat, based on living proximity to the researcher’s location in Dayton, OH; and (b) review and give feedback on the researcher’s description of each interview at the onset of the next interview and via telephone after the final interview. To help uphold confidentiality within the limits of the law, pseudonyms will be used to replace identifying information, including: participants’ name, supervisors’ name, and practice locations in transcriptions and in future publications and presentations.

I have enclosed flyers for recruitment of study participants for you to post at your place of employment. I would be willing to come and present my proposed research at a staff meeting as well, if you are open to this idea. If you have questions about this study, please feel free to contact me via email: nlaselle@gmail.com or telephone: 937-572-7001.

Thank you for your assistance with this research project.

Sincerely,

Nicole M. LaSelle, MS.Ed., PCC
Doctoral Candidate, Counseling and Human Development Services
Kent State University
APPENDIX E

SCRIPT FOR TELEPHONE CALLS WITH POTENTIAL PARTICIPANTS
Appendix E

Script for Telephone Calls with Potential Participants

Script for initial telephone calls:

1. This is Nicole LaSelle, Doctoral Student at Kent State University, who is investigating state-licensed female counselors who work or worked with clients with eating disorders about their supervisory experiences.

2. I want to thank you for expressing an interest in participating in my study.

3. I am limiting participants in my research to female counselors who are working or have worked with clients with eating disorders and received supervision in the past two years.

4. Are you currently under supervision or have you been working under supervision in the last two years (as you work with clients with eating disorders)?

5. Do you still have an interest in participating in my study?

6. If so, may I send an Informed Consent Form and Demographic Questionnaire for you to sign. I can send hard copies with an enclosed self-addressed envelope or I can send the documents as attachments for you to print, scan, and return as attachments. Which method would you prefer?

7. Do you have any additional questions that I may answer at this time?

8. If you have any additional questions, please do not hesitate to contact me via email (nlaselle@gmail.com) or telephone (937-572-7001).

9. Do you know of any current or previous supervisees in your agency or private practice who work with clients with eating disorders who may also be interested in participating in this study?

10. Thanks for your time. (If agreeing to participate, I look forward to collaborating with you throughout the duration of the study.)
APPENDIX F

INFORMED CONSENT TO PARTICIPATE IN RESEARCH STUDY
Appendix F

Informed Consent to Participate in Research Study

Study Title: Counselor Supervisees’ Experiences of Supervision When Working with Clients Diagnosed with an Eating Disorder

Principal Investigator: Dr. Jane Cox

Co-Investigators: Dr. John West and Nicole LaSelle

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose:

I am conducting a study about the supervisory experiences of counselors who work with clients diagnosed with eating disorders for my dissertation and in partial fulfillment of a Ph.D. degree in Counseling and Human Development Services at Kent State University. The research questions for my study are: What are the reported supervisory experiences of counselors who work with clients diagnosed with an eating disorder? What meanings do counselors make of their supervisory experiences, as they work with clients diagnosed with an eating disorder? How is the experience of supervision helpful or unhelpful for supervisees who work with clients diagnosed with an eating disorder? From the findings of this investigation, I hope to gain an understanding of supervisory experiences of counselors who work with clients with eating disorders and also uncover what may enhance supervision for future supervisors and supervisees. The data from the study may improve supervision processes for counselors working with clients with eating disorders. Research results will possibly be presented in professional presentations and publications.

Procedures:

Upon your agreement to participate in this qualitative phenomenological study, I will email or telephone you to schedule a time for the first interview. For this investigation, your expectations include: (a) fill out a demographic questionnaire, (b) participate in two to three approximately 60 minute audio-recorded interviews face-to-face if you live in close proximity to my location in Dayton, Ohio, or over the telephone.

Counselor Supervisees’ Experiences of Supervision When Working with Clients Diagnosed with an Eating Disorder
or video chat, and (e) review and provide feedback for approximately 15-20 minutes on
my emailed summary of your interview at the onset of the next interview and over
telephone after the final interview to verify accuracy. This will allow you to correct my
description of your supervisory experiences. These interviews and data collection are
expected to take place within four and a half months total.

Audio Recording:

All interviews will be audio recorded for purposes of data collection and analysis
in this study. The researcher will listen to the tapes for transcription. Portions of these
interviews may be included in the published dissertation, professional publications and
manuscripts, and shared at local, state, regional, national, and international conferences or
workshops. In an effort to uphold confidentiality, within the limits of the law, the
participants’ names, supervisors’ names, and practice/agency names will be replaced with
pseudonyms. All audiotapes will be stored in a locked file cabinet during the duration of
the study and destroyed upon completion of the investigation.

Benefits:

The potential benefits of participating in this study may include an additional
understanding of supervision as you discuss your experiences in supervision with the
interviewer. The counseling supervision community may improve their supervisory
practices when working with supervisees who work with clients with eating disorders
based on the potential findings of the investigation.

Risks:

There are no anticipated risks beyond those encountered in everyday life. If you
find any questions asked in the interview to be upsetting or uncomfortable and do not
wish to answer them, you may refuse to answer them. Further, you may feel free to
discontinue your participation in the study at anytime.

Privacy and Confidentiality:

Efforts to uphold confidentiality, within the limits of the law, will be made in the
following ways throughout the study: (a) all audiotapes and hard copies of demographic
questionnaires and consent forms will be stored in a secured and locked area, and only
the researchers will have access to the data; (b) all transcriptions will be stored as
electronic files with password protection; and (c) identifying information including your
name, your supervisor’s name, and practice location will be replaced with pseudonyms in
transcriptions, and in future publications and presentations. The limitations of the law are outlined in 4757.5.10 of the Ohio Administrative Code, Standards of ethical practice and professional conduct: reporting unethical actions by the Ohio Counselor, Social Worker, Marriage and Family Therapist Board (2013).

Your research may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or to others.

Voluntary Participation:

Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your welfare or willingness to continue your study participation.

Contact Information:

If you have questions or concerns about this research, you may contact the Principal Investigator, Jane Cox, Ph.D. by email: (jcox8@kent.edu) or phone: (330) 672-2662; Co-Investigator, John West, Ed.D by email: (jwest@kent.edu) or phone: (330) 672-2662; or Co-Investigator, Nico LaSelle by email: (alaselle@gmail.com) or phone: (937) 572-7001. If you have questions about research rules at Kent State University, please contact W. Grant DeGlimpsy, Ph.D., Vice President for Research, Division of Research and Graduate Studies at: (330) 672-0717. The Kent State University Institutional Review Board (IRB) approved this study. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672-2704. If you agree to participate, please return one copy of this participant consent form in the enclosed envelope and keep the second copy for your records.
Participant Consent Statement

I have read this consent form, have had an opportunity to have my questions answered to my satisfaction, clearly understand the study and expectations of me as a participant, and voluntarily agree to participate in the study. The researcher has my permission to email or telephone me for scheduling purposes. The researcher may also email me summaries of my transcriptions for verification of data analysis. I realize that I may discontinue the study at any time for any reason at all. I understand that a copy of this consent will be provided to me for future reference.

Signature

Date

Counselor Supervisors' Experiences of Supervision When Working with Clients Diagnosed with an Eating Disorder
APPENDIX G

AUDIOTAPE CONSENT FORM
Appendix G

Audiotape Consent Form

KENT STATE UNIVERSITY

Study Title: Counselor Supervisees’ Experiences of Supervision When Working with Clients Diagnosed with an Eating Disorder

Principal Investigator: Dr. Jane Cox

Co-Investigators: Dr. John West and Nicole LaSelle

I understand that all interviews will be audio-recorded for the purposes of data collection and analysis in this study. I am aware that the researcher will listen to the tapes for transcription. Portions of these interviews may be included in the published dissertation, professional publications and manuscripts, and shared at local, state, regional, national, and international conferences or workshops. In an effort to uphold confidentiality, within the limits of the law, the participants’ names, supervisors’ names, and practice/agency names will be replaced with pseudonyms.

I am granted permission to hear my audiotaped interviews before they are used for analysis. I choose to:

_______ listen to my audiotapes before they are used for analysis. I will sign an audiotape consent form for the researcher to use them in her research analysis and conclusions afterward.

_______ not listen to my audiotapes before they are used for analysis. I will sign the consent form displaying my agreement for the researcher to use them in her research analysis and conclusions.

Audiotape Consent Statement

I grant the researcher permission to use audiotapes of my interviews for her research analysis and conclusions.


Signature

Date

Counselor Supervisees’ Experiences of Supervision When Working with Clients Diagnosed with an Eating Disorder

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Appendix H

Demographic Questionnaire

Pseudonym Name: ________________

Counselor Supervisees’ Experiences of Supervision When Working With Clients Diagnosed With an Eating Disorder

The following information will provide the researcher with data about you relative to the study. To assist in upholding your confidentiality, please do not write your name anywhere on this demographic questionnaire.

1. Age: ______________________________

2. Race: ______________________________

3. Ethnicity: ___________________________

4. Are you currently or were you a supervisee, who worked with clients with eating disorders in the last two years? Yes or No

5. Are you or were you supervised by a state licensed supervisor while working with clients with eating disorders? Yes or No

6. If you were or are supervised by state licensed supervisor, while working with clients with eating disorders, how long have you or did you work with this supervisor? How much time do you or did you spend in supervision with this supervisor weekly?

7. If you are currently working with clients with eating disorders, how long have you worked with this population? Please indicate months spent:

8. While under supervision:
   - Were you working full-time (40 hrs.) or part-time (less than 40 hrs.) per week?
   - How many clients did you typically see in a week? ______________________
   - How many clients do you or did you work with who have or had the diagnosis of an eating disorder in an average week? ______________________

9. What kind of treatment setting do you or did you work in when working with clients with eating disorders and receiving supervision (e.g., inpatient [hospital or eating disorder treatment center] or outpatient [agency or private practice])?
APPENDIX I

FLOW CHART FOR PHENOMENOLOGICAL DATA COLLECTION AND ANALYSIS PROCEDURES
# Appendix I

**Flow Chart for Phenomenological Data Collection and Analysis Procedures**

| Week I. Pre-Interview Procedures | Receive approval from the KSU Institutional Review Board  
| | Contact directors of in-patient eating disorder treatment centers and private practitioners of outpatient practices found via Google searches, or through EdReferral or Psychology Today, by telephone for potential participants  
| | Send director/private practitioner a recruitment letter and an advertisement to post in a staff room through postal service  
| | Present proposed research study at a staff meeting for interested directors and private practitioners  
| | Contact peer reviewers and provide information regarding the study and their future involvement  
| | Request help from a colleague who works or worked with clients with eating disorders about her supervisory experiences to practice an interview and finalize the interview guide |

| Week II. Pre-Interview Procedures | After individuals respond with interest about participation in the study, contact those who are currently working under supervision or worked under supervision within the last two years and have clients with eating disorders on their caseload to verify eligibility (purposeful sampling)  
| | Based on purposeful sampling and Creswell’s recommendations, select at least five participants who meet eligibility requirements to participate in the study  
| | Send out informed consent form, audiotape consent form, and demographic questionnaire for screening purposes through postal mail with an enclosed return envelope to potential participants and by email for those individuals who are able to scan and return via email  
| | Schedule first interviews with participants (location chosen by participants) |

| Weeks III-VII. First Interview (Round I) | Complete facesheet (time, location, environment)  
| | Complete Round I interviews (semi-structured, based on interview guide) |

| Weeks IV-XII Data Analysis (Round I) | Within one week of each audio recording of an interview, the following will be completed:   
| | (a) Process notes taken before, during, and after interviews in reflexivity journal. Researcher will reflect on her approach with participants and examine any potential biases   
| | (b) Transcribe Round I interviews   
| | (c) Reflect and bracket with research journal   
| | (d) Identify and group meaning units into themes for each interview   
| | (e) Write the textural and structural descriptions for each interview   
| | Send peer reviewers one transcript and aligned textural and structural descriptions for the transcript for feedback and incorporate feedback to increase the study’s credibility   
| | Send textural and structural descriptions to participants via email   
| | Schedule a second interview with all participants (face-to-face with those who live in close proximity to Dayton, OH; through telephone |
| Weeks XIII-XV. Second Interview (Round II) | Complete facesheet (time, location, environment)  
|  | Review first interview textural and structural descriptions for the purpose of member checking with each participant  
|  | Complete Round II interviews (include follow-up questions from the first interview) |
| Weeks XIV-XVIII. Data Analysis (Round II) | Within one week of each audio recording of an interview, the following will be completed:  
|  | (a) Process notes taken before, during, and after interviews in reflexivity journal. Researcher will reflect on her approach with participants and examine any potential biases  
|  | (b) Transcribe Round II interviews  
|  | (c) Reflect and bracket within research journal  
|  | (d) Identify and group meaning units into themes for each interview  
|  | (e) Write the textural and structural descriptions for each interview  
|  | Send peer reviewers one transcript and textural and structural descriptions for the transcript for feedback and incorporate feedback to increase the study’s credibility  
|  | Send textural and structural descriptions to each participant via email  
|  | Schedule a telephone conversation in approximately a week to review participants’ feedback in response to the textural and structural descriptions |
| XIX-XXI. Creating individual textural and structural descriptions for all participants to create composite descriptions and the final textural-structural synthesis | Complete member checks with participants via telephone for the final textural and structural descriptions  
|  | Reflect and bracket within research journal  
|  | Create textural and structural descriptions for all participants  
|  | Using the individual textural and structural descriptions for all participants, composite textural and structural descriptions to represent the experience of the phenomenon for all participants are created  
|  | From the composite textural and structural descriptions, a cross analysis is conducted to create a textural-structural synthesis to describe the phenomenon  
|  | These individual textural and structural descriptions, composite textural and structural descriptions with participants’ highlighted contributions, and textural-structural synthesis across all participants with participants’ highlighted contributions are sent to all participants through email  
|  | Complete member checks with participants via email for individual textural and structural descriptions, composite descriptions, and textural-structural synthesis. If the participant is uncertain about the individual textural and structural descriptions, composite textural and structural descriptions, textural-structural synthesis or has additional feedback to offer, the researcher will schedule a telephone conversation with the participant  
|  | Conversations over email between the researcher and the participants continue until the participant states that the researcher had conveyed her experience accurately in the report |
APPENDIX J

FACESHEET
Appendix J

Facesheet

Pseudonym Identification:

Time:

Date:

Location:

Unique Environmental Factors (e.g., noise, lighting, music):
APPENDIX K

INTERVIEW GUIDE
Appendix K

Interview Guide

First, I’d like to extend my gratitude to you for participating in this investigation. I want to remind you that I will make attempts to uphold your confidentiality through the use of pseudonyms for your name, your supervisors’ names, and your practice locations. The purpose of this investigation is to capture supervisees’ descriptions of what and how they experience supervision when working with clients with eating disorders. Therefore, when you are answering these questions, please refer only to previous and current supervisory experiences when working with clients with eating disorders. Prior to the interview process, I will first discuss the demographic sheet with you.

Interview #1:

1. How long have you been or were you supervised while working with clients with eating disorders?
2. How many supervisory experiences have you had while working with clients with eating disorders?
3. While under supervision, can you recall approximately how many clients with eating disorders are or were on your caseload on average?
4. While under supervision, describe your practice setting (e.g., inpatient [hospital or eating disorder treatment center] or outpatient [agency or private practice]).
5. Please describe your last supervisory session.
6. What are topics generally discussed during your supervisory sessions?
7. If relevant, describe your current experiences in supervision; that is, what generally occurs in supervision? Describe these supervisory experiences while considering your work with female clients diagnosed with an eating disorder.
8. If relevant, describe your previous experiences in supervision; that is, what generally occurred during supervision? Describe these supervisory experiences while considering your work with female clients diagnosed with an eating disorder.
9. Regarding your current or previous supervision, what experiences were significant for you? Why were these experiences significant for you? What thoughts and feelings underlie these experiences? What meanings do you make of these supervisory experiences?
10. Describe a specific experience where your current or previous supervisor was helpful? What made this experience helpful for you? What were you thinking and how were you feeling in this experience? What could have made this experience more helpful? What could your supervisor have done to make this experience more helpful for you? What was especially significant to you about this experience? What meanings do you make of these helpful supervisory experiences?
11. Describe your relationship with your current or previous supervisor (Bernard, 1979; Bernard & Goodyear, 2009; Grant, 2006; Gray & Smith, 2009; Holloway, 1994; Orlinsky, Botermans, & Rønnestad, 2001; Worthen & McNeill, 1996).

12. What supervisory roles did your supervisor demonstrate in supervision (e.g., consultant, counselor, teacher; Bernard, 1979)?

13. How might you describe your supervisor’s style, or the way in which this person worked with you in supervision?

14. What topics did you feel comfortable discussing in supervision? What topics did you feel uncomfortable discussing in supervision?

15. Has your work with eating disorder clients ever impacted your behaviors, feelings, and thoughts about your body, food, or weight? If this impacted your work with clients, did you feel comfortable discussing this with your current or previous supervisor? If you have already had this discussion, how did your supervisor respond to your disclosure? (Delucia-Waack, 1999)?

16. How could your current or previous supervision be a more meaningful experience for you when working with clients with eating disorders? (e.g., specific activities, discussions; Delucia-Waack, 1999)

17. Is there anything else that you might want me to know about your supervisory experiences that I have failed to ask?

18. Is there anything that you might have mentioned earlier that you want to expand upon?

Interview #2:
Member Checking Questions for Initial Description from Interview #1:
Please provide comments and feedback about the description created from your previous interview.

1. How well did the description accurately represent your experiences of supervision while working with clients with eating disorders?

2. How might I improve this description of your perspective?

3. After having some time to reflect on the first interview, was there anything that you wanted to add to your responses when describing your experiences in supervision while working with clients diagnosed with eating disorders?

4. Just to refresh your memory about the highlighted research questions for the study: What were your supervisory experiences as you were or are working with clients diagnosed with eating disorders? What meaning did you make of these experiences? When you think of these questions, is there anything else that you’d like to mention to give me a better understanding of your experiences?

5. Attempt to finish anything still left for discussion after Interview #1.

Follow-up telephone call:
Member Checking Questions for Description from Interview #2 (Member checking questions are discussed over the telephone):

1. How well did the description accurately represent your experiences of supervision while working with clients with eating disorders?

2. How might I improve this description of your perspective?

3. After having some time to reflect on the first interview, was there anything that you wanted to add to your responses when describing your experiences in supervision while working with clients diagnosed with eating disorders?

4. Just to refresh your memory about the highlighted research questions for the study: What were your supervisory experiences as you were or are working with clients diagnosed with eating disorders? What meaning did you make of these experiences? When you think of these questions, is there anything else that you’d like to mention to give me a better understanding of your experiences?

5. Attempt to finish anything still left for discussion after Interview #1.
Please provide comments and feedback about the description created from your previous interview.

1. How well did the description accurately represent your experiences of supervision while working with clients with eating disorders?
2. How might I improve this description of your perspective?

Attempt to finish anything still left for discussion after Interview #2.
APPENDIX L

EMAIL AND TELEPHONE CONFIRMATION INDICATING DATE AND TIME

FOR INTERVIEWS
Appendix L

Email and Telephone Confirmation Indicating Date and Time for Interviews

Email:  Dear Participant,

We are scheduled to meet on __________ at (Location). If you have any questions about the upcoming interview, or should an emergency arise, please email me at: nlaselle@gmail.com or telephone me at: 937-572-7001.

Thanks once again for your ongoing participation in the study.

Sincerely,
Nicole LaSelle

Telephone: Hello. I am simply calling to confirm the date and time for our scheduled interview. We are planning to meet on __________ at (Location). If you have any additional questions about the upcoming interview, or should an emergency arise, please email me at: nlaselle@gmail.com or telephone me at 937-572-7001.
Thanks once again for your ongoing participation in the study.
APPENDIX M

MEMBER CHECKING EMAIL FOR REVISED DESCRIPTIONS
Appendix M

Member Checking Email for Revised Descriptions

Dear Participant,

Please read the edited description, which is a revision based on our conversation about my description of your interview. Then, please:
(a) verify the description is complete and requires no edits, or
(b) state the description is incomplete and requires additional edits.

If additional edits are necessary, let’s arrange a telephone conversation. Please provide a couple of times of availability via email or telephone. If you have questions beyond additional edits, please do not hesitate to contact me at: nlaselle@gmail.com or (937) 572-7001 at your earliest convenience. Thanks once again for your time and contribution to this research study.

Sincerely,
Nicole LaSelle
APPENDIX N

MEMBER CHECKING TELEPHONE CONVERSATIONS
Appendix N

Member Checking Telephone Conversations

I am phoning you to insure that I fully capture your thoughts regarding your supervisory experiences.

1. Are there aspects of the description of themes that need editing to fully capture your supervisory experiences?
2. If yes, what aspects of the created description of themes need editing to insure that they fully capture your supervisory experiences?
3. Would you be willing to provide additional examples to insure that I fully understand and then appropriately capture your experience?
REFERENCES
REFERENCES


