

Clinical Supervision: A Competency-based Approach

Welcome, I'm Dr. Carol Falendar and today we'll be talking about competency-based clinical supervision. I'm the co-author of several books on clinical supervision. The first is *Clinical Supervision: A Competency-Based Approach*, the blue one, and then the *Casebook for Clinical Supervision: A Competency-based Approach* is an edited book. We are in press with *Getting the Most Out of Clinical Supervision: A Practical Guide for Interns and Trainees*, and in development this year will be *Diversity and Multiculturalism in Clinical Supervision: Foundation and Practice*. So we're keeping busy.

Why do we do clinical supervision? Many of you do clinical supervision for licensure purposes for training to fulfill requirements for a doctoral degree. In addition, though, we're finding multiple reasons why clinical supervision should be done, perhaps even beyond the developmental period of training. We're finding that with roll-outs and implementation of Evidence-Based Practice, there's greater fidelity monitoring, and that there is in fact greater staff retention if supportive consultation and supervision occurs as part of the roll-out process. And this is a great benefit to organizations if in fact staff remains after the roll-out.

In addition, in a national study that was done with clients who have alcohol abuse diagnoses, there was a significant reduction in turn-over intent when the therapists received clinical supervision. Turn-over intent refers to thinking about leaving or resigning. It's highly associated with emotional exhaustion and emotional exhaustion is a predictor of burn-out, so all of these are factors that one would like to prevent, and clinical supervision is a major factor in prevention.

We're also beginning to see some research on enhanced treatment outcomes. One study out of Australia, Bambling, looked at a brief module of depression treatment, and found significant improvement in treatment outcomes as a result of clinical supervision. Similarly, Callahan et al. found that supervisors can impact client outcome. What that means is, that certain supervisors are associated with, through their supervisees, enhanced client outcome; very similar to research that's been done on how certain therapists are associated with enhanced client outcomes.

Everyone who writes a book about anything has a definition, so we are no different. We have a definition of clinical supervision that's rather lengthy. The first part is: supervision is a distinct professional activity. It may seem surprising to you that this is part of our definition, but in fact, in clinical psychology, clinical supervision has only been viewed as a distinct professional activity quite recently in the last few decades. Counseling psychology knew this earlier, and has been at the forefront of study, research, and theory on clinical supervision.

Okay, it's in which education and training aimed at developing science-informed practice are facilitated through a collaborative, interpersonal process. The collaborative, interpersonal process is the

heart of competency-based clinical supervision. From the onset of clinical supervision, it is collaborative, and we'll talk about that as we go, how in fact one can collaborate from the onset. But this is a difference from some of the more traditional models. Supervision involves observation, meaning that it is important to have live, or videoed, or even audioed observation of the supervisee, or co-therapy at certain intervals in order to be the most effective clinical supervisor.

Evaluation, which includes, of course, attention to the power differential, which is pervasive. Meaning that supervisors hold the power to evaluate, and to be gatekeepers for the profession. This power differential is a significant factor in all of clinical supervision, and cannot be underestimated, as it impacts every aspect and needs to be addressed.

Feedback: feedback one would think would be a critical piece of clinical supervision but in fact there's some evidence that supervisors are not giving feedback. Supervisors may be saying things like "It's a great job; keep up the good work," but that's not feedback. Feedback is tied to particular performance, into smaller increments of behavior, which relate to accuracy of supervisees assessing their own self-efficacy. So, it's important to give positive, and constructive feedback, and to give these consistently as a part of clinical supervision. We'll address this later.

Also the facilitation of supervisee self-assessment, another core value of competency-based clinical supervision is self-assessment, and we're fortunate to have benchmarks, and Hatcher and Lassiter's tools for practicum competencies to help supervisees self-assess. Similarly supervisors should be self-assessing, to model this particular function, and also to enhance their own practice.

Acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving. Supervisors are powerful models, and need to use diverse methods in their teaching and in their supervision. We build upon the recognition of the strengths and the talents of the supervisee. Many supervisees have found that their strengths or talents are almost forgotten, or submerged during their graduate training. So part of the supervision function is to help them reacquaint themselves with some of the strengths and talents, and to focus on those strengths and talents as a building block for future development. This is a very strength-based, positive psychology-oriented approach.

Supervision encourages self-efficacy and by self-efficacy, as I mentioned, this relates to supervisees understanding small increments, and how effective they are at each, small piece of performance. Supervision ensures that's conducted in a competent manner, in which clinical standards, legal proscriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large. So, in addition to that part of the definition, we also include super-ordinate values, and pillars of supervision.

The super-ordinate values are that the supervisors need to manifest integrity-in-relationship. This means that not only are we incredible role models, but that we have tremendous power with our supervisees. We have power to model very positive behaviors, and in fact there's evidence that valued supervisors theoretical models are replicated by their supervisees for up to five years after the training period, and perhaps even for a lifetime. Conversely, supervisors who model boundary violations – and

remember what a boundary violation is, such things as exploitation or sex – those supervisees who observe this in their supervisors in fact commit greater boundary crossings and boundary violations in the majority of the studies that have been done about this, and people love to study that. So integrity is so important.

Supervisors do make ethical missteps. But the question is not so much the ethical misstep, but in how it's handled, and how in fact the supervisor discusses it with the supervisee and accepts responsibility, and acknowledges it.

Second super-ordinate value is ethical values-based practice. This relates also to one of the pillars, and this is that in fact our code of ethics is a central factor. I encourage all supervisors to keep the codes of ethics of all of the disciplines that they supervise on the tops of their desks, and refer to them at least once during each supervision hour, and to acknowledge that supervision is ethics-based. We'll be talking about that extensively.

Appreciation of diversity. We're talking about diversity not simply of the client, but diversity of the supervisee, and diversity of the supervisor. Sometimes that's the most difficult piece for us. And how the three of those spheres intersect, and impact world views, and ultimately interventions and practice.

Science-informed evidence-based practice is the last super-ordinate value, and that relates to in fact how supervisors have the obligation to stay completely informed and ahead of the game, and to know the status of treatments as we in fact gain greater evidence and move ahead.

The pillars of supervision are the last part of the definition. The supervisory relationship is a core component as well. How the alliance is developed, what the alliance is in terms of strength, determines many of the outcomes of supervision. It's the foundation for the entire supervision process, and this is a meta-theoretical approach. All of competency-based supervision is in fact meta-theoretical. The process of inquiry relates to all of those personal and professional contributions that we bring to the supervision process, just as we bring them to the therapeutic process. Multiple factors and processes, which are so important to attend to and to understand in the context of the therapy and the supervision.

The last pillar is the educational praxis, and this is the learning strategies that are tailored to enhance the supervisee's knowledge, and the development of technical skills. Now, just as an aside, many of you in the Veteran's Administration have an incredible record of individuals who stay post-training and become staff members. The statistics are amazing. Therefore, supervision plays such an important role, even more important perhaps because you know that you are training your colleagues, and that this is such an important function, and that really is significant for each of us, for each of you.

Now, getting back to collaboration and how collaboration can work from the very beginning of supervision. Collaboration is clearly developmental. How would one collaborate with a beginning supervisee? Well, the meaning definitely changes, as does the elucidation with experience and enhanced competence. However, from the onset, the collaboration is marked by respect. Respect for

the presenting and the developing competencies of the supervisee. So it entails that whole self-assessment, and interactive collaborative process of understanding the supervisee's starting points in terms of knowledge, skills, and values or attitudes.

At the onset, the supervisee may want more direction, and this is a developmentally-appropriate type of status. However, increasingly, through development the collaboration will become more pronounced, with the supervisee taking a significant role in the process. One of the pieces of the collaboration that we'll refer to several times is transparency. And this relates to transparency about competencies, for the supervisor and for the supervisee. So it's laying out what specific competencies the supervisor has, what even the limits of competency are for the supervisor and for the supervisee. One of the big issues, of course, is that the supervisee may feel that they have limited competency, and yet they are being asked to work with some very, very difficult clients. This is a reality of training, and as we know from our ethics code, it is an ethical stance, but in fact, however, we need to be sure that we provide the appropriate amount of support, oversight and supervision based on the supervisee's competencies presently.

Transparency and feedback is a great enhancer of collaboration. Therefore, if a supervisor has a concern about a supervisee, how quickly should they give the feedback to the supervisee? That was not a rhetorical question. So, in fact, what we're finding is that supervisors harbor worries about supervisees. They sit around, worry, sometimes they talk to colleagues, sometimes they lose sleep over it. They worry and worry. In fact, however, instead of talking directly to the supervisee, they torment themselves. So I would strongly urge, that if you have concerns, you need to in fact think of them in terms of competencies, which we'll get to, and to share these concerns immediately, if not sooner, with your supervisees.

Why? This enhances collaboration, and this also gives the supervisee the fullest chance to either explain or to remediate, or to learn and develop. So, all of these are very important parts of the collaborative process. If in fact you commit with the supervisee to transparency in feedback, this will enhance collaboration, because in fact you will be modeling giving feedback quickly and effectively. And hopefully also this will result, and there's some evidence that it does, in greater disclosures by your supervisees. The major piece of collaboration is respect for the process, and contributions of each member of the supervision team, the supervisor, and the supervisee.

Now, let's move quickly into how is supervision distinguished from consultation. Let's spend a minute, please spend a minute thinking about that. How is it different? What are some of the different processes and components?

Okay, some of the differences would be that the supervisor holds the power and the liability in supervision. In consultation, it is typically between peers, although consultation has other meanings as well, but it is between peers, and there is no necessity that the consultant really acquire depth and breadth of case knowledge. Typically the consultation is on a specific point, and the protégée or

consultee has the responsibility of providing that information to the consultant. Also, the protégée or consultee is under no obligation to take the consultation and implement it in their treatment.

In contrast, in supervision, if a supervisor tells a supervisee, “You must assess for domestic violence, you must assess for child abuse,” this is an imperative and must be done. So those are very major differences between the two.

In psychotherapy, what’s the difference between psychotherapy and supervision? Hopefully major differences, but sometimes really people feel that there’s a very thin line between the two, especially in such things as management of counter-transference, or management of emotional reactivity which is unusual in particular circumstances that is triggered by client behavior or presentation. What we find is that some of the major –Oh, also there is a fine line sometimes between psychotherapy and supervision in repairing ruptures or strains to the supervisory relationship.

The differences include multiple aspects, but the major functional piece is that supervision maintains its focus on the client. If in fact you find yourself talking more about the supervisee, and not about the client, or not about the supervision relationship as it relates to the client, then one should self-assess as drifting off of supervision and crossing a line which is not one you should cross. So, there is also a major, of course that evaluative component in supervision, but I think the important piece is to keep in mind above all else that if one begins inquiring elaborately into supervisee history, or supervisee so-called pathology, you have crossed a line. We’ll be talking toward the end of this training about supervisees who do not meet performance criteria, and there are specific protocols for how to approach this and they do not involve psychotherapy.

What about mentoring and supervision? Brad Johnson and others have written about this beautifully, and one of the big confusing aspects is that many of us want a mentor, especially our post docs or even our interns. Mentoring means assisting them in their professional development, helping them to excel, and to succeed. It might entail such things as introducing them to professional colleagues, co-authoring papers with them, meeting them at conferences and introducing them to divisions or activities, multiple things like that. The confusion arises when the individual is the supervisor and the mentor, and is attempting to do both, and changing hats, so to speak, very frequently during the relationship. So this can be confusing and upsetting, because part of supervision is the evaluative piece, as well as the huge power differential. Part of mentoring is support. So, if you are doing both please clearly differentiate. Have a discussion with your supervisee/mentee and talk to them about how, in fact, it’s going to be possibly confusing, and that you will be telling them when you’re in your mentor role. And that if they have questions or confusions, please to let you know, because you’re still going to be giving them corrective feedback in your supervision role.

Okay, now we’re moving ahead into competence. In terms of competence, it is important for us first to think about stages of change, and our readiness to change. Our readiness to look at our own competency, and our readiness to view competence as a lifelong learning trajectory. There’s some writing that’s been done recently on how stages of change apply to supervision, and those of you, most

of you are familiar with Prochaska's work, Prochaska et al, and we can think about individuals who are in pre-contemplation. Individuals in pre-contemplation are not even thinking about change, so as it comes to supervision, if it were a supervisee it might look like – think what a pre-contemplation supervisee might look like. Supervisee might say or at least manifest the idea, Thank you so much, I'm very happy here, I learn so much better from client contact than I do from anything else, so I think we should maximize my client contact and I'll be checking in with you infrequently. That would be an example, possibly, of pre-contemplation. I'm sure you can come up with others.

Moving on to contemplation and preparation. In fact, Prochaska et al looked at employees in a major mental health organization that was being mandated to change from long to briefer interventions, and when they surveyed the staff, they found that only 20 – 30% were in fact in action phase, were in fact ready to implement the new strategies. Change is difficult. None of us really usually like to change, so we have to think about how readiness impacts us, and how readiness impacts our supervisees, and how we're going to move forward in change with our supervisees.

The complexity of competence is an important piece to consider in this context as well, because the knowledge half-life is very limited. What do I mean by half-life? I'm thinking either of physics, or drugs, and the half life is when in fact the potency is diminished by half. And Dubin studied this in the seventies and he said it was ten to twelve years, in fact, that our half life was ten to twelve years. More recently, people have suggested five years, or even that half of our facts are replaced within a typical span of graduate school. Some people are suggesting that through obsolescence and atrophy we lose much of what we have learned. And so it is very important to think about self-assessment and learning new competencies as we evolve. Technical obsolescence is another area that is important to consider because in fact things are changing very quickly, and you'll see evidence of that as we go.

On the other side of the coin, there's a knowledge explosion that's occurring. The bio-medical research literature doubles every 20 years, and may be more than doubling now. In 2002, when they last assessed it, it was 36 million compared to 130 websites in 1993. Also, please keep in mind that it takes an estimated 17 years for the randomized trial results to be incorporated in the practice community from academia. So, there's a very long lag between research results, evidence-based practices and implementation; except, I think, in your settings, because I think you're very much at the forefront in implementation.

Another factor is statistically illiterate practitioners. In your spare time you might want to look at the Gigerenzer articles, and actually book about how statistically illiterate we are and how critical it is that we gain greater statistical skills and acumen, given that most of our practice and most of our lives, and life decisions are based upon statistics, which may or may not be valid.

The definition of professional competence that has driven the whole competency movement comes from the medical profession: Epstein and Hundert. They suggested that professional competence is –and this is such a beautiful definition – “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflections, in daily practice for the

benefit of the individual, and the community being served.” Think about those aspects. Think about, it’s not just reasoning or technical skills, or knowledge that we would put in, but emotions, values and reflections. Then they added on, that it depends upon habits of mind, including attentiveness, critical curiosity, self-awareness, and presence. How many of us think about our own presence, or the presence of our supervisees? Such an important component!

Okay, the APA Presidential task force on evidence-based practice also addressed competence, that it is addressing and performing tasks consistent with one’s professional qualifications (with specialized training sometimes), sensitive to individual and cultural differences, and anchored to evidence-based practices. As applied to supervision, its assembled knowledge, skills and values, or attitudes that are assembled in work performance. So let’s think about how we’re going to apply all these conceptions of competence to psychology training. To begin, let’s do a small task. Break down into small work groups, and what I’d like you to do is have a partner or a small group. And I’d like you to think about what clinical competencies you expect your supervisees to have very early on in the training sequence, with respect to self-harm assessment in your setting. What knowledge, skills, or skills sets, and attitudes do expect your supervisee to have in order to be effective with self-harm assessment? Please take five or seven minutes to do this task in your small groups.

[Pause for small group work.]

Okay, let’s come back together, and think about what kinds of things you found, or decided upon in terms of the competencies associated with self-harm assessment. So, I think if we put all those together, the knowledge and the skills sets usually have high agreement, or are very situationally-specific, but the most difficult one might be the attitudes. Because you need to be thoughtful about the whole range of attitudes clinicians have towards self-harm assessment, and many of these might be influenced by other factors, by personal factors, by religious belief structures, by all kinds of other beliefs. So, that would be an area that’s important to explore. The importance of this task also is that this is also kind of a foundational task for you to personalize benchmarks and other types of measures and competency documents, to your setting. To itemize the particular competencies that are most important to your programs.

Speaking of benchmarks, let’s move in from the competencies cube to benchmarks. As most of you know, a competencies conference was held, and publications came out of that competencies conference. And one of those was the Rodolfa et al Foundational and Functional Competencies cube. And this competencies cube has been hugely influential in the field of competencies. It has served as the foundation for benchmarks. So, the foundational competencies, as they’re represented are quite profound, because they include reflective practice and self-assessment, scientific knowledge and methods, relationships, ethical standards and policy, individual/cultural diversity, and inner-disciplinary systems. And please note that the benchmark’s group added to the Rodolfa paradigm professionalism, which is a very significant foundational competency.

Then, the functional competencies. And you can review these. Remarkable is that we also added, we separated supervision and teaching, and added advocacy. And, as you know, the cube relates to the inner section of the foundational and functional, with the third dimension being development.

So how do we move from competencies to practice? The first step of movement from competencies to practice is the self-assessment. And, we want supervisors and supervisees to self-assess. You can have access to the supervisor competencies document. It was a result of the competencies conference in 2002, and it was published in 2004. It's available in your training materials, so it would be really important for you to self-assess on that document. Similarly, the supervisee's competencies documents reflect consensually-derived by discipline practice, expectations for practice. And all of these translate into competency-based supervision practice. So, these need to be incorporated into a contract, with mutually-derived goals and tasks.

Moving to the self-assessment of supervisor competencies that you'll have available. The complexity of the supervision of the supervisor's process is highlighted in this document. Because, supervisor's need to have knowledge, not simply of all the models, theories, modalities, research on supervision, but also of everything in all of those things in each client being supervised. Also, of the professional and supervisee development, knowledge and skills, and knowledge and skills in evaluation process and outcome of diversity in all its forms. And as well, values that correspond to supervision, which are articulated, knowledge of the social context, significant training and supervision and assessment of supervision competencies. So it's a very broad swath of competencies for the supervisor, and an on-going learning task as the whole field of supervision and clinical work evolves.

We receive some confirmation for the structure also by Rings et al, who confirmed the essential components of the framework that was proposed in the 2002 competencies conference. Competencies documents are available to you, of course the benchmarks document is available both at the APA web site and also in the Fouad article, which was published in 2009, Fouad et al. And this describes the specific essential components, and behavioral indicators of each of the foundational and functional competencies. If you're supervising other disciplines, you can refer to the web sites for these other documents. A most recent one is *Neuropsychology* by Stuckey-Bush and Donders, which was published in 2010, which describes competencies approach to neuropsychology.

So the first step is self-assessment. How accurate are we as self-assessors? Well, in fact, that is an area of significant concern. Many people have studied this. Most of them have studied it with physicians, and what they have found is that physicians and psychologists as well, are not very good at self-assessment. For one thing, we've had very little training on self-assessment for the most part. It has not been a core value of graduate training. So, what we find, or what many of the studies find, is that individuals who self-assess themselves as most competent, are in fact those individuals who are substantially compromised in their competence when it's assessed by other objective means. Conversely, we find that individuals who rate themselves as low to moderate competence are rated by those other objective means as being most competent. So those individuals are very, self-assessing very

looking into the things they feel they could developing, and self critical. So, our assessment accuracy is not good at this moment.

There is some evidence that if we base the self-assessment on smaller increments, and make it more behavioral and more focused, it's going to be significantly more effective, which lends some credence to benchmarks as an assessment device. Although I understand that some of you have concerns about the specificity, or its applicability, especially as a summative evaluation tool, but we can talk about that more later. It's very effective for formative evaluation, I feel.

In the world, there has been a major movement toward not just self-assessment, but also possibly towards assessment of competence at various points throughout one's career, and a movement towards revalidation, which actually is being implemented for physicians, to be revalidated. All of this came out of a series of white papers from the United Kingdom, and in fact the picture of one of the individual's white papers was written about Harold Shipman, is on the slide. Harold Shipman was a physician who practiced in an area of UK. And, he saw a large number of patients, and regulators found that he was prescribing narcotics at a very high rate for the size of his practice. So they sent out someone to investigate. They talked to Dr. Shipman, and Dr. Shipman said, I see people in pain. What do you expect? They have to be medicated. I medicate them and help them with their pain. However, his rates of prescription continued to increase, until they were perhaps a hundred times what was average for the size of his practice. So they a more thorough investigation, and lo and behold, they found that Dr. Shipman was addicted to drugs, narcotics, and he was addicting his patients. He was briefly censured, he moved and started a practice in a new area, which is possible to do in UK with no record following him, as it is in many parts of the world.

And he began again, and this time he started doing home visits for the elderly. Now this is very popular, and his practice took off quickly. But people were beginning to notice that many of his patients were dying. So, they sent out regulators, and they asked him questions about it. He said: what do you expect? I see old people. Old people die; nothing I can do. This went on until, in fact, one morning he had an appointment scheduled at about 11 with the mother of a leading Magistrate. And the leading Magistrate spoke to her mother earlier in the morning, and the mother said she was feeling wonderful, her doctor was coming to visit to give her a final health clearance before she left on a cruise, and she'd be meeting the daughter the next week in London for tea. This lady, the mother, was dead at 11:15, after he doctor's visit, and she signed over all of her assets to Dr. Shipman at 11:10. So, this was the beginning of the Shipman inquiry, which coincided with all these other inquires. And, the question that was posed as a result of all these inquiries was: How do we know if someone is competent, even at the point of licensure? And certainly, how do we know if they remain competent through their career?

What is the major tool we use for ensuring on-going competence? Who knows? Yes, it's continuing education. Is continuing education a plan-ful effort in which one self-assesses carefully, identifies areas systematically that need to be developed, and then pursues those areas and learns them through one set criterion? Typically, no. Typically, the reasons for choosing continuing education are

things like regulations, or convenience, or cost, or even, sometimes, lunch. So, it may not be serving the purposes for which it was designed in its entirety.

So, there is this movement toward revalidation, and an important aspect of this is assessment of competence. What I'd like us to do at this point is to segue to another exercise. And again, I'd like you to break up into small work groups. And this time, I'd like you to take the excerpts from the benchmarks document, which was given to you, what I'd like you to do is, each group to identify a supervisee who you're currently working with. To think about this supervisee, their strengths, and their areas that need improvement. And I'd like you to role-play giving feedback to that supervisee, which are anchored in the benchmarks document. Please spend a few minutes doing this, and then, one of the people in the group should reflect on the feedback, and amplify, or you can do this as a group process in order to work on your skills in providing feedback based on benchmarks.

[Pause for small group work.]

Okay, it would be important for you also to think about what this process was like, whether this was a process that you use as a matter of course, and if not, how you might be able to implement this, because it's a very, very important, impactful way to provide consensually-agreed upon feedback about the level that your supervisees are functioning. Now, you may wonder, working with post docs, whether this is also applicable. Yes, it is, because you have the different developmental points, and you would simply be targeting it at a different developmental point. You know, like with Piaget's theory, though, there may be areas where supervisees may have incredible strength, and areas where they're still in development, maybe even more at the internship level or possibly even practicum. So, it would be so important for you to consider these systematically, and to work on them collaboratively with the supervisees, and provide them with very specific, targeted feedback about their competencies, and target it also to, relate directly to your observation, or to the supervision process.

Now another aspect of supervision that relates to feedback, and relates to everything we've talked about, is meta-competence. Meta-competence is the ability to know what we do not know. How hard is that? Most of us do not spend too much time thinking about what we don't know. So, it is very reliant upon self-awareness, self-reflection, and self-assessment. One of the major foci of supervision is to enhance the development of meta-competence. We should also model meta-competence, and talk to the supervisees about growing awareness of things that each of us has become aware we do not know, or need to enhance our skills in.

One of the big lessons of meta-competence, or a particular aspect applying it to supervision is that when we rely totally on supervisee's reports through their discussion, just come in and present, Well, this case went well, da da da, that is basically bound, of course, by meta-competence. Because supervisees, like us, only know what we know. And if you are reliant totally on their report, you never have the opportunity to think about the entirety of the clinical session in vivo. So, I would really encourage you to think about back to observation.

A second component that's important to consider about competence assessment, because some of you, of course, are very involved in the formative assessment aspects, would be the toolkit, which was published in 2009, and article by Kaslow et al. And this is a complete toolkit for assessment of competence, and there are multiple strategies proposed, ranging from of course the thing we've talked about self-assessment, but also more formative ideas of having simulated case situations, role-plays, which might be validated. And then could be conducted with multiple supervisees, standardized patient-client interviews, written exams, which are more traditional, portfolio reviews –many possibilities here, including the 360 degree what they call in the article evaluations, or 360 degree feedback.

That, of course, is a modality that comes from business. And, one draws a circle around an individual, typically in business they start first with the managers or supervisors, draw a circle with anyone who has contact with that individual professionally. So, it would be peers, supervisors, and administrative hierarchy, and subordinates, and to really circle everyone, and to give them rating scales on certain dimensions, which have been determined to be valued for the setting. Some of the traditional measures that are looked at are respectful behavior, communication skills, collaboration, things like that. And, use of that scale, then, allows on to accrue information from every level of the organization, to organize it systematically, and then to present it as developmental feedback for the supervisees as well, and this is an incredible learning tool. It may be an assessment tool as well, although business has shied away from using it directly as assessment, has used it more for feedback and development.

Finally we get to what is competency-based clinical supervision? Competency-based supervision is an approach in which all these aspects of competency we've been talking about are explicitly identified. The knowledge, the skills and the values and they are assembled to form clinical competencies, from which learning strategies and evaluation procedures are derived, to meet the criterion-referenced competence standards in keeping with evidence-based practice, and requirements of local, clinical setting. That means that benchmarks, or another document like it, is a criterion-referenced competence standard. So that everything is anchored in the criterion reference and that supervisees develop all these plans, to develop all of their competencies based on the self-assessments, and the feedback that you give them on the accuracy of their self-assessments, and develop a supervision contract.

What are the steps in competency-based supervision implementation? The first step is orientation to the competency-based approach. Second is a collaborative identification of competencies that are going to be the focus of training. And these will of course include self-assessment and supervisor feedback, and may have other aspects as well. Then a collaborative identification of the requisite knowledge, skills, and values that define the focus of supervision. This takes a little bit of thought, and ingenuity. Then, the collaborative identification of the individual's areas of strength, and areas for enhancing knowledge and skills. And then the development of the supervision contract, an on-going formative evaluation, up to the determinative, summative evaluation. Of course, all of this being identified and laid out clearly, so the supervisees have no surprises about what the process will be.

Some of the steps towards the best practices of supervision would be: the supervisor first examines his or her own clinical and supervision expertise and competence. So this really relates to supervisees, I mean supervisors, sorry, doing a very comprehensive self-assessment, and thinking quite globally about areas of clinical and supervision expertise. Then the supervisor needs to delineate the expectations. This is such an important part of supervision, supervisory expectations including standards, rules and general practices for the setting. There is evidence that the greater the clarity of the expectations, the more successful the supervisees will be. It's also called role-evocation, and that means simply pointing out all the aspects of the role that the supervisee is going to be expected to fulfill.

Then, the supervisor identifies the setting-specific competencies, and the standards that the supervisee must attain to complete the supervised experience. It's important to note, that many settings, when they've implemented benchmarks or other competency measures or tools, have omitted this step. That is, they have not decided in their own minds, or in their own systems, what does completion really look like? What is successful completion, what is the minimal standard that is acceptable to complete this training sequence? And that is a question that is very important for you to determine, because for one thing, most settings will not address every single benchmarks area. And, secondarily, you will have your own competencies that you may be adding, and you really want to be clear about what has to be attained.

Then the supervisor collaborates with the trainee and develops an agreement or contract, for informed consent purposes, and to ensure clarity and communication in establishing those competencies and goals, and tasks to achieve them, as well as logistics. And then the supervisor models and engages the trainee in self-assessment, and development of meta-competencies. So, this is increased self-awareness and incorporating feedback on developmental competencies, from the onset of supervision and throughout.

A very first step in development of the supervision process is, development of the supervisory alliance. And this is the core of the supervisory relationship. It's a core competence, both in therapy and in supervision. In supervision, this is derived from Borden's work, and it came out of work in therapy. So, think for a minute, what is the difference between therapy and supervision? What's a major difference between them? We talked about this a little earlier, but not as specifically. A difference is that in supervision, evaluation and the power differential are significant parts of the relationship. So it differs from the therapy relationship.

In this context, in development of the alliance, the supervisor and the supervisee develop mutually defined goals and tasks of training. So they specifically identify knowledge, skills, and attitudes assembled to form specific clinical competencies, and learning strategies and evaluation procedures that are involved in the development of those competencies, and they're clearly articulated so the expectations are laid out. Clarity in the training goals and the collaborative identification of the means to achieve the goals will really result in a strong emotional bond, and with greater probability that the training goals will be achieved.

Some of the keys to the alliance are: the clarity, which we've mentioned several times, including clarity about difference, and clarity about feedback. What do I mean by difference? By difference I mean, that there are going to be significant individual differences between the supervisor, the supervisee, and the client. It would be very important to talk, at least in early supervision sessions, about the differences between the supervisor and the supervisee. Some of these may –we'll talk about diversity later – some of these may be diversity differences. Some of these may be military experience differences. Some of these may be regional differences. It's really important to think about what you feel comfortable self-disclosing. And this is not all about you, but it's a self-disclosure of one or two things that mark the difference, and which set a tone that this is an important aspect to consider in supervision.

And then clarity about feedback is: two-way feedback. Not simply that you will be giving feedback to your supervisees regularly, and I hope your standard for feedback is going to be very high, that you'll be giving some form of feedback, maybe like the benchmarks exercise, perhaps every supervision session, or at least very frequently. Not just at intervals like twice a year, four times a year, but on-going and frequent. And, that you will be open to feedback from your supervisees. And I know that this is the most difficult part, but you want to elicit supervisee feedback, and be responsive to it. Sometimes the first level of supervisee feedback, which may be easier for supervisees to give because as you know, supervisees find it difficult to give feedback, because of the power differential. Legitimately, they're concerned what kind of impact it's going to have on the process. What you might find is easier, is for the supervisee to give you feedback on elements of the supervision, such as whether the amount of time spent on various topics is appropriate from their perspective, whether there are certain aspects of the supervision process they'd like to have more of, such as maybe more case conceptualization, maybe more processing of emotional factors, maybe more contextual kinds of considerations, whatever.

So that would be a preliminary level of feedback that might be very useful. Also, if you're wondering how you can ascertain how strong your supervisory alliances are, in order to move in a really good direction in the development of alliances. In our first book, *Clinical Supervision: A Competency-based Approach*, in an appendix are measures from the supervisor's perspective and from the supervisee's perspective, by Barick, and these are derived from some other measures that she used in her dissertation. Those are measures of the strength of the supervisory alliance. Those might be useful tools for you to introduce in supervision.

Secondly, we've talked a lot about the transparency, no surprises piece, but that is a significant key to the supervisory alliance. Surprises are not a good idea. Changing the expectations, or simply not notifying the supervisees of the expectations until late, is not a good idea. And the definition of all power differentials, including administrative. Some of you will have administrative roles as well as your supervisory role. So be thoughtful and engage the supervisee in discussion of what possible issues may arise from that. With the power differential, an important aspect would be to talk to the supervisee about the transparency. That in fact, you know you're going to be the evaluator, that's a given piece of the role. And, that you commit, that you will be open and transparent in terms of the feedback that you're going to be giving the supervisee.

Thus, if you have concerns about your supervisee, about meeting performance criteria, you will be sharing those at the earliest moment, and you will be planning and strategizing with your supervisee about means to maximally successful, or to deal with issues that may arise that are impediments to success. Similarly, you're going to be manifesting in all aspects of your supervision, integrity. You will be giving, and welcoming, continuous constructive feedback –giving, and welcoming. And truly welcoming. Many supervisors, when I lecture with supervisees I often ask them if they would try giving some constructive feedback to their supervisors. And many times they come back saying, that really wasn't a very good idea. I tried a feedback sandwich –many of you may know what a feedback sandwich is; you say something like, "you are truly an excellent supervisor, I'm so enjoying this experience. I wish we could do a little bit more theoretical discussion. But overall, you are truly incredible and I'm learning so much. Thank you so much." And the supervisor says, "theory? theory? Theory is my middle name, how could you think I don't discuss theory? I'm shocked. I'm actually thinking this might be an area I'm going to have to follow-up with because this is really very significant that you haven't noted that we speak a lot about theory."

Which brings us right to identifying relationship strain. Could that cause some strain in the relationship? Yes. There are many things supervisors, and actually supervisees can do that will introduce strain into relationships. How do you know if strain has been introduced into your supervisory alliance? You'll know from a qualitative change in behavior of the supervisee. What you will see – it might even be manifest in your own behavior – but the supervisee will withdraw. The supervisee who was so forthcoming in disclosing previously is going to be not so. There may be some even direct expression of criticism or hostility, like "That intervention that you gave me to do was useless." Or some kind of non-compliance or passive responding, simply not doing what you instructed them to do, or modifying it in a way that was not in line with what you were intending. Acting in or acting out would be a reenactment, which would be, in fact, a manifestation of an affective state perhaps that was manifest in the clinical session. Re-enacting it during the supervision session, or vice versa.

So, any of these things could happen. And, as you know, when strain is introduced, supervisors respond strongly when there's a change in their supervisee behavior. So what happens is the supervisee withdraws, and the supervisor becomes more confrontative, more demanding, more critical. And the relationship spirals downhill. What can also happen is this can lead to double or triple traumatization. Especially, as we know about a third of mental health professionals have had previous exposure to trauma, significant trauma. About a third of professionals, according to several studies, have been, come from families of alcohol abuse, substance abuse, child abuse, various traumatic backgrounds – higher than the normal population. Therefore, they may be more susceptible to cumulative trauma. Then, there's the vicarious traumatization from client material. And in your settings, there's highly traumatizing client material, for sure.

Then there's the response of the supervisor to the supervisee. And many supervisors are a little bit stressed, and may be less than empathic for a supervisee who gets overwhelmed by client material. So, they might be a little bit more dismissive than the supervisee would have expected. This can result in a strain, or even a rupture, and some sequelae are that the supervisee may stop disclosing, shut

down, or engage in what we call spurious compliance. Spurious compliance is pretending to do what the supervisor tells them to do, but in fact doing what they think is right. Very bad supervision outcome. We also know that supervisees, being early in their experience, and sometimes young chronologically, not necessarily but maybe both, really they're more susceptible to traumatization through all of these factors. And we have evidence that some supervisees are even manifesting PTSD. Several of the symptoms in terms of intrusive thoughts, and nightmares, and sleep disturbance, etc.

Is non-disclosure related to strain? Well, there's a positive correlation between supervisory alliance strength, and supervisory/supervisee disclosure. So, 97% of supervisees in one study reported they did not tell their supervisors everything. That should be no shock to supervisors. Non-disclosure does occur. And what are some of the things, and another study, actually several studies have replicated this, that negative reactions to supervisors are generally, almost universally not shared. So, keep that in mind. Personal issues may not be shared – more than half in this study. And that might be okay and it might not be all right, if in fact those personal issues are impacting the supervisee in some way. Clinical mistakes are not disclosed, and that is a source of concern, because of course we want supervision to be focused on helping the supervisees to learn from the clinical mistakes and to move ahead. It's a learning experience. And also to discuss how these may impact the on-going treatment of the client. So, one thing we recommend is that supervisors model –not making mistakes – but model discussion of what can be learned, and even talk about the clinical mistakes that they have made, or are making. And how this can be an amazing learning experience, and how it can even play out in the clinical work, in terms of fallibility. Forty-four percent reported evaluation concerns. I think evaluation concerns are so normative, that would be expected, but we should be mindful that supervisees, at all levels, are concerned about evaluations. It's just part of the situation.

Now, the last two I think are of grave concern, along with clinical mistake: general observations about the client, and negative, critical, and disapproving, and unpleasant reactions to the client. These are clearly very significant aspects of treatment, and very important to address. Therefore, one strategy would be to talk to your supervisees about these studies, and let them know, and tell them this is really a critical aspect of treatment. I think in the settings you're in especially, there might be many of these factors. Some of the ones that I've encountered, and that have been studied as well are clients who have an odor. The supervisees are wary of telling their supervisors because they're concerned they might seem judgmental or over-sensitive or something. That's just one example. So try to problem-solve ways to get around some of these non-disclosures.

Now sometimes, if a strain is not addressed, or if a very significant incident occurs, there could actually be a rupture. Think for a minute, whether in fact there has really been a rupture in any kind of supervision experience either you've had, or that you've heard about, in which there's been an actual breakdown of the collaborative relationship. What happens, if there is such a rupture, the ability to empathically attune is significantly diminished. And the mis-attunement can occur for multiple reasons: socio-cultural, personal, and it can lead to a perception that the supervisor is not understanding. Negative reactions to clients actually could be a result of this, because we have some data that in fact, when there's strong affect in supervisory interactions, that through isomorphism, or other processes,

parallel process, this may be reenacted in the client session. So, if the supervisee is feeling empathically mis-attuned with the supervisor, this really has a really great probability of occurring in the client session, and would be highly detrimental.

How do we address strains and ruptures? There are multiple ways of doing it, but it seems like collaboration would be an important piece of this too. What we encourage is to note the change in supervisee or supervisor behavior. First of all to be thoughtful, to step back and reflect on what was the point where the relationship changed? Things were going along smoothly, but then last week the supervisee kind of stepped back, and didn't seem to be talking much. Let me think if there's anything that happened last week that could be associated with that. Now, sometimes, in some instances you'll be able to identify something, from your behavior, or from the circumstances of the setting. Other times, you really won't know. But you need to really consider the intensity or the significance of the strain marker, meaning the supervisee's behavior. And, you don't want to spend all your time addressing these things, but if it's something significant, I think most of you in this room can identify one point in time when you had a strain or rupture with a supervisor that probably was not addressed.

Some people will note, even in retrospect, that things went downhill, and maybe it did relate to the introduction of a strain or rupture in a relationship that was moving kind of nicely. Remember that it's difficult, if not impossible, to repair strains and ruptures if you don't have a strong supervisory alliance. So keep that in mind. However, first you attend to the rupture, or strain marker then you think about possible precipitants. If you make a decision to act upon the behavior of the supervisee and the marker, you want to have a discussion, acknowledging or at least identifying what, and reflecting either on just the change in behavior if you can't identify what it is, or even if you do identify what it is the supervisee might not agree, so you can hypothesize it, but you may not know, definitively. And then, you acknowledge your own contribution. And this is a really important part of the repair process, to acknowledge your own contribution, and validate the supervisee's experience. And then explore links to other occurrences, because often when there is a strain or rupture, it relates to a whole line of other behaviors. And then think about how this relates to client treatment. Collaboratively agree on action, and consider revising the formulation, or monitoring or making revisions.

An example I can just tell you quickly, just to give you a little more specific highlight. A supervisor noted that the supervisee's behavior really changed dramatically. The supervisee seemed withdrawn, withholding, and kind of distant during supervision. And, it was quite surprising because this was a supervisee who had been so actively involved in supervision, so forthcoming, so verbal, so enthusiastic. So the supervisor thought back, couldn't really put her finger on what it could have been, but then was thinking about some e-mail exchanges that she had with some colleagues, and how she had described the supervisee pretty specifically to the colleague. And she was thinking about that, and she went back to her e-mail, and checked, and in fact one of those e-mails she sent to the supervisee, not to the intended colleague, from whom she was trying to get consultation. So once she identified that, she was able to approach the supervisee, and talk to them, and reflect on the strain that had occurred. Help the supervisee understand why, in fact, she was e-mailing, and that it was an error that

it went to that supervisee, acknowledge her own contribution, and so on. So be thoughtful and think about aspects or areas that may have occurred in your own supervision practice.

Now, let's move into an initiation into the role of personal factors in supervision. This is the "c" word, or counter-transference, is one category of these, or emotional reactivity that's atypical in response to a client's presentation. There are personal and professional factors that are influencing the conduct of treatment and they become completely intertwined. And these relate to all these different areas, including our belief structures, our culturally-imbedded values including those reflecting individual differences and diversity, unresolved conflicts. And supervision is subject to all these influences as well. So in counter-transference, or the "c" word, management –again, there has to be a relationship, a supervisory alliance between the supervisor and the supervisee, before you can manage these phenomena.

This is, management and identification of counter-transference, or these kinds of emotional reactivities are a critical informer of the therapeutic process. And there both positive and negative forms of personal influence, but it informs the therapeutic process significantly, and can be a propelling force. It can manifest in unusual, idiosyncratic or uncharacteristic acts or patterns, including parallel processes in the supervisory relationships. What do we mean? We're talking about, what if the supervisee comes in and says "every time I see that one client, I get so bored. I start yawning, the minute the client walks in." Of course, this could happen to the supervisor as well. In addition, the supervisee may say that the client elicits feelings of anger, tension, many different things like that. So be vigilant, and watchful for kind of an idiosyncratic response to client presentation.

How do you approach managing this? Well, first of all, it should be described in the supervision contract, that in fact these issues are going to be addressed. Then, there should have been an explicit orientation to it, because our supervisees come from a wide range of theoretical training perspectives. And, although CBT is really thinking a lot, and CBT supervisors are writing a lot about management of such phenomena, identification of them, some of it may not have happened yet at the graduate training level. So they may not have been really introduced to personal factors very specifically. You want to model your own counter-transference or reactivity. So give an example of when something happened, of when a particular client reminded you of someone, something like that, and how you were able to manage it, or at least identify it. And then, talk about the positive contributions of these, in a kind of a strength-based approach.

So, the next step would be to collaboratively identify the counter-transference or "c" word, and to reinforce the identification as a competency, which it is, and then to manage. Now let's take an instance, for example, you can think of one in your mind as well. One that comes to me is, a supervisee was seeing, you know I work mainly with children and families when I was Director of Training. But, the supervisee was seeing mother-son dyads or mother-daughter dyads as part of his training. And what I noticed in his first assigned case was that he really pejoritized the mother, that he built up the adolescent to the point that it didn't make any sense. This was the third referral from the probation department, a very, very troubled youth, and the clinician/supervisee said she was an angel, she was

amazing, she was wonderful, and the mother was the problem. We worked on that the first time, but then when the second case came in, and the same phenomena occurred, I suggested to the supervisee, "It looks like you have some issues with mothers." And the supervisee said, "You noticed." This is to be reinforced, because it does reflect some self-insight.

Now, the question is, where do you take it from there? You do not want to go into the rest of the session talking about his mother, and how difficult it's been for him, or what kind of a traumatic childhood he had. More importantly, would be to help him to move ahead, to differentiating his client mothers from his mother, and to think of the strengths, increasing his empathy for the client mother or mothers in contrast to his own mother. So he might proceed with things like, well, you know, the client mother, the first one I'm seeing, is a single Mom and she's really stuck by this kid all the way through even though there have been some arrests and things. And, she has worked two jobs throughout to support them, and to keep them in housing, so, these are all things that are pretty strong. So give him the assignment to continue to work on that, and assist him also with giving him techniques to manage his anxiety, if in fact he is experiencing anxiety dealing with that particular mother or mothers because of the feelings that it may elicit in him. And then, help him by putting it in a conceptual treatment frame. So, conceptualize what the treatment's going to look like, how it's going to be structured, so that it's an additional step in helping him differentiate the client from the personal experience.

In the vast majority of cases, this works after one, or two, or very few kinds of interventions. And the supervisee will come back and say it really was transformative. In instances where the supervisee cannot get past this, or presents more of a problem in which you really need to be direct with the supervisee to let them know that a competency of the setting is to be able to work with this particular group of clients, in my example, mothers. And it would not be sufficient, not to be able to do so in the setting. So, the supervisee is going to need to avail himself of external resources to be able to deal with this problem. That might be personal therapy; it might be other things. And, you do know there's research, that personal therapy is not necessarily associated with quick fixes, because the personal therapy may or may not address the situation that you're referring for, nor do you have access as a matter of course, to the therapist. So, those are issues, and there's a lot written about that. Also, it would be important to have in your supervision contract, something about the possibility that personal therapy may be indicated.

Okay, we keep talking about the supervision contract, and finally we got to it. The development of the supervision contract is such an essential component of the process, and it's the basis of the alliance, it helps to articulate all those expectations, and the informed consent piece which the supervisee needs to have. What exactly are the expectations, and what are the plans if they're not being met. Defining the parameters of the relationship, the process, and articulating the goals and the tasks, and refining these as time goes on.

So, in the slide, some of the general parameters are described, in terms of what the expectations might be, both for supervisor and supervisee. You can decide on the level of specificity, driven by your context and own expectations. I put in things like, I expect the supervisees to have their

client notes ready or available either online or in paper when they come for supervision. Some of the more tricky ones are the confidentiality, and you have to be guided by your own setting. What the limits of confidentiality are for the disclosure supervisees make to you. It is important to discuss this, though, as part of the contract because many supervisees assume that there's a high level of confidentiality in their disclosures to supervisors. There is some confidentiality, for sure, but there are many limits. Such as, you will be reporting back to schools in the case of internship, or back to licensure boards in the cases of both. Therefore, it's not strictly confidential. Furthermore, there are limits of confidentiality which actually correspond to client confidentiality. So if a supervisee were to tell you they were suicidal, homicidal, or had committed some kind of an ethical infraction, none of those things would be kept confidential. So it would be important to discuss that so that the supervisee has some sense of what those limits are and doesn't simply expect that everything will be strictly confidential.

Okay, also what is the outcome if performance criteria are not achieved? What will happen, what types of feedback they'll get, and what types of plans might be put into effect. How you're anchoring your performance expectations on benchmarks, or competency document, and what forms of formative and summative evaluation will be enlisted. And there are some references for examples, or further articulation of supervision contracts.

Okay, moving into diversity and multiculturalism. Respect, appreciation, and attention to all aspects of diversity. Diversity factors, first of all, we've got the role of the self of the supervisor. So as a supervisor you need to think about all of these different categories on the slide, diversity factors, and build an equation of your own personal, multiple identities, based on all of these, thinking of all of these. Because all of these different aspects impact your world view, and your case conceptualizations, and what information you selectively identify to deal with in terms of supervision and clinical work. This is an ever-expanding group of topics, and you may have some to add as well. But think about them. It's a useful exercise, building upon work of Celia Falicov, or Pamela Hayes, to look at comparing your profile, your multiple identities, with those of your supervisee. And then comparing those with your client as well. You may not want to do all, but you can do a sub-set.

There is data to help us to understand that our belief in the importance of multicultural competence outpaces our behavior. Many of us believe we're multi-culturally competent, but when in fact it comes to practices, specific items on the multicultural competencies questionnaires that have been developed, do not adhere to multi-cultural competence. Similarly, there's a disparity in a subsequent study about religion. That individuals believe that they are in fact multi-culturally competent with respect to religion, but then their practices belie that fact, so that they may not incorporate it into a systematic assessment. They may not view it as a possible factor in treatment or in helping the client to grow.

Okay, so here's a graphic of the intersecting factors to be thinking about all of our own biases, and strengths and assumptions that we come to supervision with. Our attitudes, and our knowledge, and our belief structures, and how all of these biases and prejudices and all feed into supervision. As I mentioned earlier, supervisors have been somewhat less eager to consider their circle. That we're good

at clients, relatively good; we're pretty good at supervisees, but we're least good at considering ourselves and we need to be doing that as well.

What are some facilitative supervision strategies to enhance diversity competence? There's a sense that we need to consider the whole grid of socio-political diversity influences. All those things on the previous slide, but also to consider them, not just with respect to the client and the supervisee-therapist, but also consider them in terms of the intervention, and think about the valence of the intervention through different lenses, and we want to think of the lenses across the different systems, the systems of each of us. There's significant data to indicate that although again as supervisors we feel multi-culturally competent, we also believe we raise diversity a lot in supervision. And you know what? Supervisees do not hear it. Supervisees say that if, in fact, race or diversity issues are raised in supervision, it is raised by the supervisee, not by the supervisor. And a wide range of studies have reported this.

A strategy would be to raise it, to bring it up, to lay it on the table. And as we talked about at the beginning of the alliance, to begin to introduce it, and then to bring it up and talk about what diversity factors are impactful in this particular client presentation, that may be actually utilized in the treatment or integrated into treatment. Remember, that it's not a one-shot deal; this is something that is integrated into all aspects of conceptualization and treatment interventions. And then elaboration on conceptualizations, including socio-political issues, such as privilege, oppression, and socio-economic status. Many aspects need to be elaborated.

Micro-aggressions can occur in supervision or in clinical work or just in settings, and these can occur in everyday exchanges. They can be behavioral, verbal, environmental. They can be intentional, or un-intentional. Often they're really un-intentional verbalizations or occurrences, and they send denigrating, invalidating, hostile, or disparaging messages. And these can also result in strains or ruptures, to supervisory or therapeutic alliances. Sue has done some wonderful work on this, and more recently, also there are examples of racist and sexist micro-aggressions. So I would encourage you to talk about this with your supervisees, and to think about how this might be manifest. I think in many settings, some of these things are just taken as part of the vernacular. And it might be an important aspect to address because once the Vets, or the military personnel go out trying to get jobs, it's not going to be viewed, possibly, as positively.

Okay, providing effective feedback and outcomes. How do we give effective feedback? I've told you repeatedly how important it is. An important process of feedback, as we know, that individuals, recipients of feedback, implicitly compare the feedback to their own self-assessment. What that means is, if we get feedback, we're much more open to it if it corresponds to our own idea of our functioning. If it's highly disparate from anything we've thought about, we really just don't even think about it. This is true with supervisees as well. This is an additional benefit of benchmarks; that it gives us anchors for the kinds of feedback, and opens the doors, because the supervisees will have self-assessed on these documents, and then will be receiving feedback on them in various small increments.

Factors that make feedback more, or less easy to accept, are: first, it's more easy if it does coincide with the supervisee's impression of his or her own behavior; if it's presented as a developmental goal, or part of a supervision plan, that it's part of development; if it's behaviorally-linked –this seems to be a key – specific, and close in time to when the actual behavior was observed. This is another beauty of audio or video or live observation, that specific behaviors can be noted. And, if the supervisor models a reflective process regarding the feedback. And this is, when the supervisor receives feedback, reflects upon it and models how that can be done, and integrates it into their on-going behavior or at least tries to contextualize it and understand it, and then integrate it.

Feedback that's viewed as negative can be hard to accept and integrate, and can be demotivational. That's why it's so important that even if one is giving what is deemed negative feedback that it be framed constructively, in terms of plans, action plans for improvement. Improvement is most likely if recipients are positive about receiving feedback, believe change is possible and desirable –that is, motivated to change – and use it to develop performance goals and to take action for improvement. And a key is how the supervisee responds to the feedback. Does it inform the supervisee's self-assessment? Is it impactful, is it integrated and acted upon? Supervisees who are responsive to self-assessment –it's a great strength.

Another aspect of upping the ante for you, is integrating –some of you have already done this very impressively –but integrating client outcome reports into supervision. How is this done? Well, the supervisee can play a critical role in this. The client completes an outcome measure. It can be a behavioral measure that is developed within; it can be one that comes from Lambert, or from Scott Miller, or others. And then the client completes this every week, and the supervisee charts the progress of the client and brings this to supervision. And this serves as a guide in the supervision process to identify which interventions or which processes are working, and which ones need to be revised. What is found by Lambert, and Miller, and others who are studying outcomes is this is incredibly impactful, especially in very difficult clients who are not moving very nicely, quickly. So it's a wonderful strategy.

Now, some people including Lambert have suggested that not just should we be tracking client outcomes, we should be tracking supervisory satisfaction as a matter of course. So another task you could do is have supervision satisfaction forms as part of a periodic check-in. Only a minority of Psychologists use outcome measures and those who did were trained during their training, usually during internship or post doc to do so. But outcomes are of course a very significant, essential part of practice, and more so as time goes on.

Okay, moving into professional practice, ethics and law, ethics values-based practice. I would refer you, first of all, to a review and to some latest developments in ethical standards. Of course, our APA Ethical Principles of Psychologists and Code of Conduct from 2002. More recently, a really exciting document from Canadian Psychological Association is the "Ethical Guidelines for Supervision in Psychology." Also forthcoming very shortly is "Ethical Supervision Resource Guide," which is going to include many vignettes that were developed with international participation of Psychologists. And in this resource guide, there are problem-solving modes, and they work through ethical problem-solving,

and how the steps work, and how in fact one can consider the very multiple options of resolving issues. The last one is the “Universal Declaration of Ethical Principles for Psychologists.” This is a wonderful, monumental effort of an international group of Psychologists, and it helps us to understand our own ethnocentricity. I would really encourage you to Google these documents, and look them up, and study them. Very exciting.

Now one of the worries supervisors always have about supervision is direct liability or liability in general. So there’s direct, and there’s vicarious. Let’s start with direct. And the first part of direct is negligent supervision. Negligent supervision is something we can control. It relates to a supervisor’s own negligent acts. And some of the things we can do is, we need to know what the supervisee is doing. What does that mean? Well, it’s interesting. One of the major ethical errors that supervisors make, from the perspective of supervisees is not adequately knowing what the supervisee is doing. So that requires knowledge, not simply of the range of their cases, but also more direct, I think, observation of their work, which we’ve talked about repeatedly.

Also, it is negligent supervision to instruct the supervisee to do something that’s contra-indicated, either through ignorance or negligence. Knowing of supervisee error but failing to take corrective action. Knowing that the supervisee didn’t do a very thorough suicide assessment, but just saying, “Oh well, we’ll do it next week.” Those are all examples of negligent supervision, and we talked about carelessness in monitoring the supervisee’s work.

The supervisor is also liable vicariously, and that’s called “Respondeat Superior.” They are reliable because of their relationship with the supervisee. Three conditions that are met are: supervisees voluntarily agree to work under the direction and control of the supervisor and will act in ways that benefit the supervisor. The supervisee must be acting within the defined scope of tasks permitted by the supervisor, and the supervisor must have the power to control and direct the supervisee’s work.

Now, interestingly, there have been lawsuits that have been resolved, both in the Minnesota Supreme Court and in the 9th Circuit, in which counter-transference, or management of therapist’s reactivity, emotional reactivity, is now mandated legally. Because negligent supervision includes mishandling of transference, counter-transference. Sexual relations between a Psychologist and a client is a well-known hazard, and therefore the prudent, good supervisor watches carefully for signs of boundary issues, and addresses these, and deals with them as part of the training. In one of the cases, there was a clinician who made romantic and sexual overtures, and actually kissed and touched during therapy sessions. And the supervisor was notified and took no action, and so that’s really, of course, not okay. So please be really thoughtful about that, because it’s an important part of supervision, and actually quite neglected. We’ll talk about it a little more about what to do.

What about supervisory boundaries? Well, we have boundary crossings and we have boundary violations. Boundary crossings are deviations from the strict, professional role. Sometimes they’re part of a well-constructed treatment plan, sometimes they’re not. There are boundary violations, and that is

a blatant misuse of power, to exploit or harm a client. And that would include all forms of exploitation, as well as sex between client and therapist.

In the Internet era, our whole disclosure and the boundaries are redefined, because there's diminished intentionality of disclosure and Overzheur writes about this elaborately. We're in an era of transparency and increased disclosure. Supervisees and clients can find out almost anything about us. And you could spend a few minutes making a list of the kinds of things that are available online, or through just coming to your office, or seeing you in person, what kinds of things a client can really understand and know about you, just based on those kind of exposures, but especially online if they were to Google you. They can find out a wide range of things. I was meeting with some supervisees a few weeks ago and I was telling them what kinds of information just in people search were available, and I was shocked that they were shocked. They were completely shocked their phone numbers were there, and their home addresses, and that one could go to Google maps and see their house. So, these are all aspects of reality that we need to be thoughtful about.

Social networking, though is one that sometimes slips through the cracks, in terms of identification of what it means in the supervisory situation, and I would encourage you to think really carefully about standards for social networking and e-mailing, and texting for that matter. All of which are increasingly common practices. There was a study done in 2010 in which they said that, they surveyed people about use of social networks. And what they found was that in their sample, no one under the age of 54 used social networking, and mainly it was used by early career and graduate students. I think that this is expanding as well, but it does relate to a generational difference, and a generational difference in approach. So, we need to be really thoughtful and mindful and talk about it, also about what you do if your clients want to friend the supervisee. You need to have standards and discussions about all that. In the medical profession there's a lot of literature coming out about how residents are texting or e-mailing to communicate with clients, and they're not using professional language. It's abbreviated, it's with expressions and things, not being cognizant that this is part of the medical record. So these are issues that need to be brought to light and talked about in your settings.

Back to boundaries. We need to balance, "sometimes a taco's just a taco," which is what Melba Vasquez suggests, against inadvisable, capricious or even exploitative boundary crossings or violations, considering always the welfare of the client and the supervisee, avoiding harm, doing no harm. The potential for exploitation, which sometimes may not be obvious without some thought. Conflict of interest and risk of impairment of clinical judgment. And I think, in many supervision kinds of things, that's the biggest one, that the supervisor wants the supervisee to feel good about things, and therefore sometimes agrees to crossings that he or she wouldn't do himself. So, to be thoughtful about all those.

Now in terms of supervision in the military, I defer to Brad Johnson, who has written extensively and beautifully in this area. But I wanted to highlight an article that came out this year, 2010, Johnson and Kennedy. Some of the suggestions he made in this article about essentially important aspects of supervision in the military are to ensure that supervisors have the requisite expertise in military Psychology and supervision, which are important aspects. To assist supervisees in their self-assessment,

their self-care, and assessing on-going competence. And he speaks quite eloquently about the incredible stresses, and how supervisors need to monitor their self-care, and how they manage the stress of the setting. Assisting supervisors in managing their own reactions and preparing –especially their own reactions preparing interns for high-risk activities such as deployment. And attending specifically to supervisors with no prior military training, suggesting that perhaps they’re even at greater risk because of their lack of prior military training.

Does sexual behavior –changing topics again – does sexual behavior happen? We know that sexual behavior, we know, we think that sexual behavior happens, is experienced maybe 3.6 to 48% by Psychology and mental-health related students. And that includes sexual advances, seductions, and/or harassment by their educators or supervisors. Eighty percent or more of mental health educators believe it’s unethical or poor practice to engage in sexual contact with a supervisee or student, especially during the working relationship. Eighty percent, and then 13% of all participants said they would engage in sexual conduct if they knew no one would find out. This is not reassuring, right? Sadly, also, when the students were surveyed in this current study, many of them, more than half, would not feel safe to pursue action, even if they had first-hand knowledge of sexual contact, because they were concerned about their anonymity, and concerned about repercussions.

This is such an important aspect of supervision, and we need to address it more directly. Of course, it is impacted now by sexual harassment laws, and many other aspects, but unfortunately supervisees with the power differential, are in a very powerless situation. So, these kinds of allegations, of course, have to be taken extremely seriously.

How do we advise our supervisees to deal with sexually inappropriate behavior? In this instance, Hartl et al –and this comes out of the VA – Hartl et al. advised how your supervisee should deal with clients when they ask for a date, when they say the supervisee’s “hot,” or if the supervisee, or they want the supervisee to “hook up.” So, the response to sexually inappropriate behaviors is multi-faceted and, let’s talk for a second though. Do supervisees usually come to you and tell you that they are sexually attracted to a client?

Okay, so 88 to 90% of Psychologists report that at one time or other in their career, they were attracted to a client. So we know that’s normative. We also know that’s part of supervision. It’s so important, it’s an informer of clinical work and it needs to be dealt with, and yet, it appears that very few supervisees disclose this, because they’re fearful. They’re fearful that they’re supposed to be paragons of mental health, and they do not really view it –attraction – as part of the whole range of counter-transference responses, which are normative.

So, how –but getting back to the converse, which is if the client is sexually attracted to the supervisee. First, there’s the discussion with the supervisor, and understanding the internal emotional response. Now this internal emotional response could range very widely from mutual attraction to horror, and somewhere in between. And responses very specifically when risk is involved, to manage the risk, and minimize the risk. And then the direct responses, really thinking conceptually that this is a

lack of awareness of an appropriate social interaction. It's also a lack of awareness of the parameters of the therapeutic setting, and of the relationship. So you would need to teach the supervisee to respond in ways to shape more appropriate behavior, maintaining the collaborative working alliance, and most importantly not shaming the client. Responding so that it reaffirms the therapeutic boundaries, and is proportionate to the risk represented by the behavior.

So, if the supervisee reports to you that the client came in and asked for a date, you could role-play with the supervisee, after going through these steps, talking about how the supervisee's going to address it the next time. And how it could be framed so nicely, that it is so good that the client disclosed this, and how this is incredible therapeutically because it shows that the client is ready for some kind of a relationship, and setting a firm limit that the relationship is not going to be with the supervisee, for legal, ethical and therapeutic reasons. And helping the supervisee to do so.

Now, in terms of these boundary crossings and relationships and all, there are also many multiple relationships possible in supervision, overlapping relationships. Things, many are normative for the setting. So we need for you to acquaint your supervisee about what the standards are in the particular context. Again, Brad Johnson's written a lot about imbedded environments, imbedded personnel, and the multiplicity of roles that a supervisee may have, or a supervisor, for that matter, in those roles, transforming within seconds from being a therapist, to being tested for drugs with a urine cup and the person doing the testing being his client from the previous minute. So all those kinds of things in mind, how important it is to draw upon context first.

But, in situations where there is more flexibility, and where the multiple relationship is an option but not necessary, Gottlieb, Robinson and Youngren have a really nice set of questions to ask, to help the supervisee come to a resolution about whether in fact they should move ahead with the relationship. Some of the things might be in an out-patient setting, to attend a client's wedding, for example. So, is entering into a relationship in addition to the supervisory one necessary, or should the supervisor avoid it? Can the additional relationship potentially cause harm to the supervisee? If harm seems unlikely, or avoidable, would the additional relationship prove beneficial? And is there a risk the additional relationship could disrupt the supervisory relationship? And, probably the hardest one is, can the supervisor evaluate the matter objectively? It's important to go through this and to really think it through, and to utilize what the risk management specialists tell us, what's the best case scenario, and what's the worst case scenario you can imagine if these things were to occur; it can be a fun exercise, and make it a little more systematic in terms of making some choices.

Okay, what about supervisees who do not meet performance criteria? Well, let's talk about why this is so important. A monumental study that comes out of the medical profession is Papadakis et al. And this is that they identified 235 graduates of three leading medical schools, who are disciplined by a state medical board between 1990 and 2003, and they matched them with a control group, matched by medical school and graduation year. Their hypothesis was that disciplinary action by a state medical board would have been predicted in behavior during medical school by these individuals. And, lo and behold, their hypothesis was supported. That, in fact, disciplinary action was strongly associated with

prior unprofessional behavior in medical school. And there were two major categories that were identified. One was severe irresponsibility, unreliable attendance at the clinic, not following up on activities related to patient care. And, severely diminished capacity for self improvement – failure to accept constructive criticism, and argumentativeness, and a display of a poor attitude.

Now, how important is this study? We may not, we cannot afford to overlook these kinds of behavior. We need to serve as gate-keepers to the profession, and to protect our clients. Our clients are vulnerable, and we need to protect them. You can search in your memory for instances in the current press that support the Papadakis's findings, of individuals who may have erred gravely in their training, and then who end up doing very terrible kinds of acts. So, it's our ethical imperative to address this, because of incompetence or lack of ethical sensitivity, this is going to inflict harm on the consumers, or on our clients. And these are people who we have agreed to help and to protect. So it's the highest level of responsibility of the supervisor.

What is a supervisee with professional competency problems beyond what we talk about in Papadakis? Well, Lamb defined these so beautifully, and we will draw upon his work. He, they are supervisees who exhibit interference in their professional functioning as reflected in one or more of the following ways: one is they're unable, or unwilling to acquire and integrate professional standards into their professional behavior. What does that look like? Think about it for a minute from your own experience. From my experience, it was with dress. A supervisee who simply could not maintain the standards of not showing midriff and cleavage and things when she was coming in for work. So, and who did not respond at all to feedback about it until it was extremely serious and escalated to the highest level.

Secondly, inability to acquire professional skills to reach an acceptable level of competence. Third is an inability to control personal stress, or psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning. And I'm sure that you may have some personal experience with each of these.

Further, these supervisees do not acknowledge, understand, or address the problem, even when they are addressed or pointed out to them. The problem is not simply one of a skill deficit that they could rectify by taking an academic or a didactic course, and the quality of services delivered is adversely affected. We suggest that a critical dimension is how responsive supervisees are to feedback in general. Supervisees who are responsive to feedback in general typically improve for the most part. There are exceptions but generally.

Okay, the problem is not usually restricted to one area of functioning. Disproportionate amount of attention by training personnel is required, and the behavior does not change through feedback, remediation, or time. The latest title for these, Forrest, Miller and Elman have titled these trainees as TPPC's, or trainees identified with professional competency problems, or trainees with professional competency problems. A nice way of viewing competency problems goes back to our competencies frame. So I would identify the performance not meeting criteria, and consider the knowledge, skills and

attitudes and the intersection of those. And approaching it that way makes it a little more manageable in developing your remediation plan. And remember that remediation plans can and should be an important part of training. That individuals can remediate, and then go back to normative development within the program. So it is an important aspect, and supervisors need to learn to make these remediation plans, to develop timelines, to set very small increments of time for the supervisee improvements. Say if its delinquent notes, to set a specific timeline with numbers of notes that need to be completed by a particular date, with check-ins at that point, and to continue to check consistently over time, going forward for the problem behavior.

Okay, self-care and ethical imperative. Self-care is one of the most essential parts of supervision, and it's amplified in each of your settings. As you know, it is an ethical imperative, referred to the code of ethics 2.06 a and b, that we need to refrain from initiating an activity, when we know or should know there's a substantial likelihood that personal problems will prevent performance of work-related activities in a competent manner. And when we become aware of personal problems that may interfere, we take appropriate measures, and determine whether we should limit or suspend or otherwise regulate our practice. So, although the pursuit of technical competence has much to recommend it, you know, and I believe it's quite true we inadvertently subordinate the value of the personal formation and maturation of the Psychologist. And nowhere is this more true than in our supervisees. We really need to help them to get back to the self-care strategies that they had before they immersed themselves in graduate school.

We know that stressors, challenges, conflicts and demands result in distress, and distress leads to decrease in functioning, burn-out, depersonalization, and emotional exhaustion, and lack of satisfaction and accomplishment, and even results in a lack of compassion. And, this is simply not acceptable. And also these are markers we need to be vigilant for. In your settings, clinical work with victims of trauma or violence, are very much at high risk for vicarious traumatization, or compassion fatigue. We know that individuals often report that they do not feel that they got adequate support for their vicarious traumatization, and sometimes the supervisees were actually worried about disclosing the degree of vicarious traumatization because they didn't want to feel, be identified as dysfunctional.

Okay, most important to well-functioning is back to our self-awareness and self-monitoring, and self-assessment, which we should all model. Now some of the questions we could be asking is: if I had a client with symptoms like mine, what would I recommend. Or, if I'm depressed, is it related to the chronicity and severity of the clients I'm taking on, without thinking about the impact. So we need to be thinking both about the input, but also thinking about how we're managing these stresses, and the kinds of techniques we engage in. Through self-regulation, balancing, and correcting our balance, and interpersonal connections, education, supervision resources. And, very high career sustaining Psychologists who are respondents suggest that, strategies for high-career sustaining throughout one's career is to: vary work responsibility, use positive self-talk, maintain a balance between personal and professional lives, maintain time with family members, take vacations, maintain one's professional identity, turn to spiritual beliefs, participate in CE activities –so today was a career-sustaining strategy – read the literature and keep up-to-date, and maintain a sense of control over work responsibilities.

Similarly, we know that supervision is a protective activity, and supervision keeps us alive and alert, and active. So we need to communicate the joy and the positivity of our supervision practice to our supervisees. The joy of seeing, hitting a bulls-eye, it's described as, in supervision. And the joys of seeing our supervisees going off to promising careers, integrating the things that we taught them into their lives and their futures.

So, this was a brief overview to competency-based clinical supervision. I would refer you to the articles and books that are written on it. You can find them easily online or at bookstores. I wish you the best in your clinical supervision, and thank you so much for this opportunity.