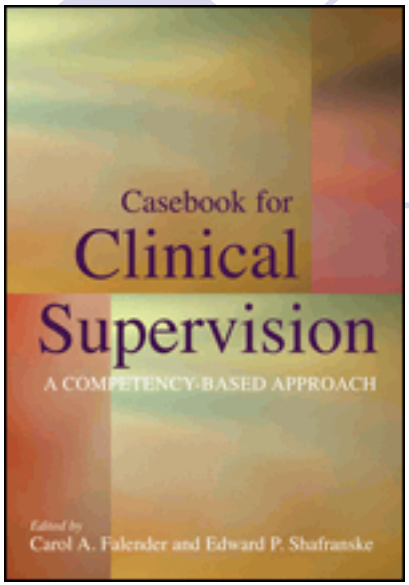
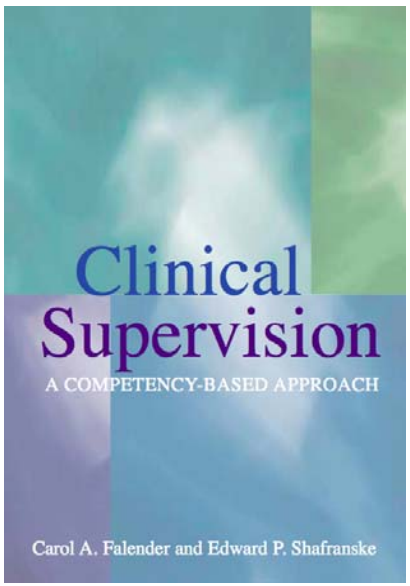
Clinical Supervision: A Competency-based Approach

Carol Falender, Ph.D.
www.cfalender.com
carolafalender@aol.com



Casebook for Clinical Supervision: A Competency-Based Approach (APA, 2008)

Carol A. Falender &
Edward P. Shafranske (Eds.)



Clinical Supervision: A Competency-Based Approach (APA, 2004)

Carol A. Falender &
Edward P. Shafranske

Why Clinical Supervision?

- Licensure and training
- Improving job satisfaction
  - Lambert, 2006
- Enhanced treatment outcomes
  - Bambling, King, Raue, Schweitzer, & Lambert, 2006
- Clinical supervision negatively associated with emotional exhaustion and turnover intention—supervision is a protective factor
  - Knudsen, Ducharme, & Roman, 2008

What is New in Clinical Supervision?

- Benchmarks and Toolkit
  - http://www.apa.org/ed/graduate/competency.html
- Canadian Psychological Association Ethical Guidelines for Supervision in Psychology http://www.cpa.ca/cpasite/userfiles/Documents/COESupGuideRevApproved7Feb09revisedfinal.pdf /
- Universal Declaration of Ethical Principles for Psychologists
  - http://www.cpa.ca/cpasite/userfiles/Documents/Universal_Declaration_asADOPTEDbyIUPsySIAAP_July2008.pdf

Critical Incidents

- Identify at least one “critical incident” or time you encountered a supervision situation that was memorable—positively or negatively! (Ideally it will be one you can share with the group.)

Components of Supervision Definitions

- Hierarchical transmission
- Safety and support
- Evaluative component
- Power differential
- Primacy of ensuring client safety and welfare
  - Monitoring of supervisee
- Alliance
- Enhancing development of supervisee

Falender & Shafranske (2004) Clinical Supervision Definition

- Supervision is a distinct professional activity
- In which education and training aimed at developing science-informed practice are facilitated through
- A collaborative interpersonal process
- It involves observation, evaluation, feedback, facilitation of supervisee self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving.
- Building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy.
- Supervision ensures that clinical (supervision) is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large.
  - (p. 3)
- Plus Superordinate Values and Pillars of Supervision

Superordinate Values

- Integrity-in-Relationship
- Appreciation of Diversity
- Science-informed, Evidence-based Practice
  - Falender & Shafranske, 2004

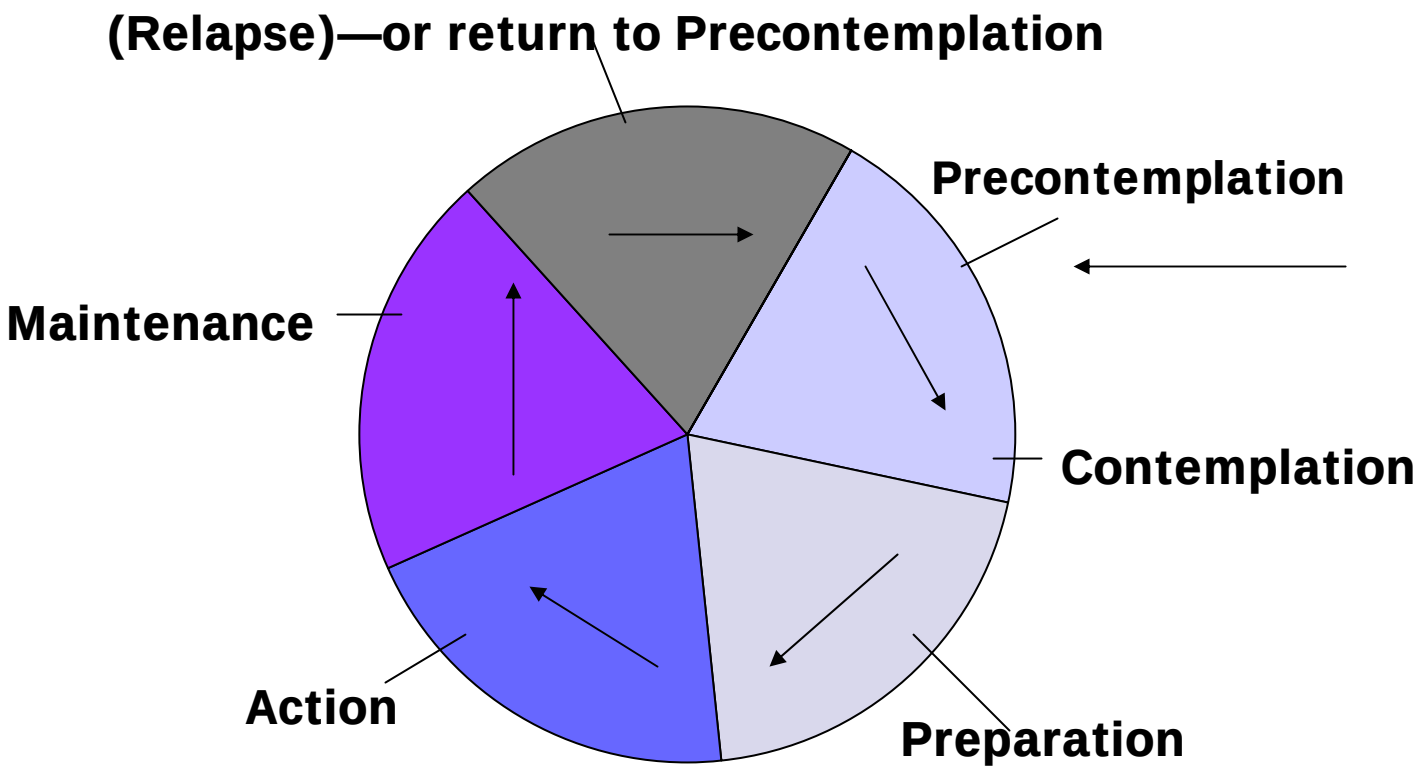
Pillars of Supervision

- Supervisory relationship
  - Foundation for alliance shared by supervisor and supervisee
- Inquiry
  - Processes facilitating understanding of therapeutic process AND awareness of professional and personal contributions
- Educational praxis
  - Learning strategies, tailored to enhance supervisee's knowledge and develop technical skills
    - Falender & Shafranske, 2004

Supervision Distinguished From:

- Consultation
- Psychotherapy
- Mentoring

Stages of Change – Supervisors AND Supervisees



Proshanska, Levesque, Prochaska, Dewart & Wing, 2001

Readiness to Change

- Percentage of employees ready to change?
  - (i.e., in implementing short term treatment interventions?)
    - 20 to 30%
      - Proshanska, Levesque, Prochaska, Dewart & Wing, 2001

Complexity of Competence: Knowledge: Half life

What is the half-life of a doctoral psychologist's knowledge?

- 10-12 years (Dubin, 1972)
- 5 years (Hebb, 1975)
- "Half of the facts" are replaced within a typical span of graduate school

Knowledge Explosion

Biomedical literature (40,000 journals in 1991) doubles every 20 years.

1993: 130 websites
2002: 36 million

It takes an estimated 17 years for randomized trial results to be incorporated in the practice community from academia **(Balas & Boren, 2000)**

Statistically Illiterate practitioners

(Gigerenzer et al., 2008)

New Views of Supervision

- Enhancing Competence
- Key to Lifelong learning
- Critical role of Self-assessment
- Metacompetence

Professional Competence

- Professional competence is the 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 community being served”
  - Epstein & Hundert, 2002, p. 226
- “Competence depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence”
  - Epstein & Hundert, 2002, p. 226

Competence

As Roberts, Borden, Christiansen, & Lopez (2005) suggest, unlike other professionals such as basketball players (who measure success by balls dropped through the hoop), the obligations and standards of psychologists are more complicated to define and measure, in light of the complexity of the tasks involved and ever-present changes in healthcare (Falender & Shafranske, 2007).

Competence

Kitchener: It may be easier to require psychologists [and supervisees] to be competent than it is to define what competence means [and] competence is sometimes easier to identify in its absence than it is to specify what a proficient level of practice or scientific expertise involves (2000)

As applied to psychology, competence involves understanding and performing tasks consistent with one's professional qualifications
(often having involved specialized training), sensitive to cultural and individual differences, and anchored to evidence based practices
(APA Presidential Task Force on Evidence-Based Practice, 2006).

Competence Involves:

- “Judgement (ability to assess when to apply particular knowledge or skills—e.g., with which client, under which circumstances, focused on which particular presenting concern) and diligence (consistent self-reflection and attention to both one’s own level of multicultural competence and the appropriate application of the multicultural competencies in all areas of practice”
  - Collins & Arthur, 2005, p. 48; cited in Collins & Arthur, 2007 and derived from College of Albert Psychologists’ Bylaws (2003)

- As assembled knowledge, skills, and values (attitudes) assembled in work performance (Falender & Shafranske, 2004)

Foundational competencies reflect the knowledge, skills, attitudes, and values that serve as the basis for how or why psychologists (do) what they do, *i.e.*, they are foundational to professional functions.
This category of competencies includes:

a) **reflective practice/self-assessment;**
b) **scientific knowledge/methods;**
c) **relationships;**
d) **ethical/legal standards/policy;**
e) **individual/cultural diversity; and**
f) **interdisciplinary systems.**

http://www.appic.org/downloads/CompetenciesCombinedWorkgroupSummaries.DOC

Benchmarks added Professionalism

Functional competencies reflect what psychologists do,
***i.e.*., their professional activities or functions.**
This category of competencies includes:
a) assessment/diagnosis/case conceptualization;
b) intervention;
c) consultation;
d) research/evaluation;
e) supervision/teaching; and
f) management/administration.

From Competencies Conference Report,
http://www.appic.org/downloads/CompetenciesCombinedWorkgroupSummaries.DOC

Benchmarks separated Supervision and Teaching; added Advocacy

Competencies in Psychology

- **Benchmarks**
  - **http://www.apa.org/ed/graduate/competency.html**
  - **Other resources**
    www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

    http://www.psychtrainingcouncils.org/pubs/Comptency%20Benchmarks.pdf
- **Practicum Competencies**
  http://www.adptc.org/public_files/Practicum%20Competencies%20FINAL%20(Oct%20'06%20Version).pdf
  - CCTC http://www.psychtrainingcouncils.org/pubs/NCSPP-%20CCTC%20model%20Student%20Competency.pdf
  - NCSPP http://www.ncspp.info/DALof%20NCSPP%209-21-07.pdf
  - APPIC http://www.appic.org/training/7_1_training_subject_rev_1_08.htm
  - ASPPB:

Other Competencies Documents

- School Psychology
  - http://www.nasponline.org/standards/FinalStandards.pdf
  - Also Tharinger, Pryzwansky, & Miller, 2008
- Canada—Mutual Recognition Agreement of the Regulatory Bodies for Professional Psychologists in Canada
  - http://www.cpa.ca/documents/MRA.pdf
    - Appendix on Core Competencies
- Core Competencies for Clergy and Other Pastoral Ministers in Addressing Alcohol and Drug Dependence and the Impact on Family Members at:
  - http://www.SAMHSA.gov/grants/competency/competency.pdf
- **TAP 21A Competencies for Substance Abuse Treatment Clinical Supervisors**
  - **http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17601**
- Health Psychology: France, Masters, Belar, et al., 2008; Kaslow, Dunn, Smith, 2008

Documents on Competencies

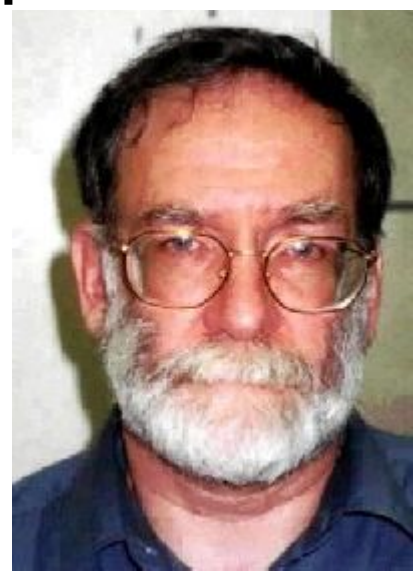
- CalSWECII Competencies for Social Work
  - http://calswec.berkeley.edu/MH_competencies_Adv_Specializn_year.pdf (foundational and advanced)
- CASW Code of Ethics and Guidelines for Ethical Practice
  - http://www.casw-acts.ca/practice/guidelines_e.pdf
- Saskatchewan Association of Social Work Standards
  - www.sasw.ca/standards_of_practice.html
- Registered Psychiatric Nurses Association of Saskatchewan
  - www.rpnas.com/public/jsp/content/documentation/documentation.jsp
- Physician competencies—psychiatry
  - Andrews & Burruss (2004)
  - www.cma.ca or www.quadrant.net/cpss/

Metacompetence

- Ability to assess what one knows and what one doesn't know
  - Introspection about one's personal cognitive processes and products
    - Dependent on self-awareness, self-reflection, and self-assessment
      - Weinert, 2001
- Supervision guides development of metacompetence through encouraging and reinforcing supervisee's development of skills in self-assessment
  - Falender & Shafranske, 2007

Self-Assessment

- Accuracy
  - Davis, Mazmanian, Fordis, VanHarrison, Thorpe, & Perrier, 2006
- Competency including values and attitudes of those trained pre-EBP
- As a part of re-licensure
  - Shipman White Paper from U.K.



Toolkit to Assess Competence

- Rating of Live or Recorded Performance
- Objective Structured Clinical Examination
- Portfolio Review
- Record Review
- Simulations/Role Plays
- Self-assessment
- Structured Oral Exams
- Standardized Patient/Client Interviews
- Written Exams
- 360 Degree “Evaluations” (quotes are mine—CF)

- http://www.apa.org/ed/graduate/combined%20fact%20sheets.pdf

APA Policy Statement on Evidence-Based Practice in Psychology

Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.[2] This definition of EBPP closely parallels the definition of evidence-based practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values." The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. (APA Presidential Task Force, 2005)

Evidence-based Practice

- EBP is not static but is dynamic and requires both Continuing Education and CQA from practitioners
  - Hunsley, 2007
- This is especially important to supervisors to instill “self-critical professional stance”—which can be unsettling—balance of awareness of one’s competence and constantly evolving nature of what constitutes competent health care (Hunsley, 2007, p. 119)

EST Training Across Disciplines

- Programs requiring the gold standard of training in any EST
  - 95.7% of psychiatry programs*
  - 46.2% of psychology Ph.D. programs
  - 32.7% of Psy.D. programs
  - 38.3% of social work programs
    - Bledsoe, Weissman, Mullen, Ponniah, Gameroff, Verdeli, et al., 2007.

*This may be responsive to recent mandate of psychiatry accreditation board that all psychiatry residents receive training in CBT

Differential Training by Practitioners and Supervisors

- Significant limitation to fidelity of EBTs (and ESTs) is that supervisors are not trained in model, and that supervision may be distance, infrequent, and not specific to needs of clients/supervisees
    - Baer et al., 2006

Competency-based Supervision

- **Competency-based supervision** is an approach that explicitly identifies the knowledge, skills and values that are assembled to form a clinical competency and develop learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and the requirements of the local clinical setting
  - (Falender & Shafranske, 2007)

Steps in Competency-based Implementation

1. Orientation to the competency-based approach
2. Collaborative identification of competencies which will be training focus
3. Collaborative identification of requisite knowledge, skills, and values to define focus of supervision
4. Collaborative identification of individual areas of strength and areas for enhancing knowledge and skills
5. Development of supervision contract

Note: Developmental levels should not be assumed (Self-assessment, self-report, and observation should be used)

Task

- Select a partner
- Select clinical competences associated with Crisis Intervention and Self-Harm Assessment
- For each competence identify
  - Knowledge
  - Skills
  - Attitudes/Values
- Identify learning and evaluation processes
  - Supervisee activities
  - Supervisor activities
  - Mode of evaluation: Formative ➪ Summative

Quick Exercise: Competencies

Crisis Intervention and Self-Harm Assessment

Identify the

- Knowledge
- Skills
- Values

which are assembled to form competence.

Development of Core Competencies—

- Competencies in Suicide risk assessment
- Managing one's reactions to suicide
- Reconcile the difference (and potential conflict) between the clinician's goal to prevent suicide and the client's goal to eliminate psychological pain via suicidal behavior
- Maintain a collaborative non-adversarial stance
- Make a realistic assessment of one's ability and time to assess and care for a suicidal client as well as for what role the clinician is best suited
  - Rudd et al., 2008

Best Practices of Supervision

(a) The supervisor examines his or her own clinical and supervision expertise and competency;

(b) the supervisor delineates supervisory expectations, including standards, rules, and general practice;

(c) the supervisor identifies setting-specific competencies the trainee must attain for successful completion of the supervised experience;

(d) the supervisor collaborates with the trainee in developing a supervisory agreement or contract for informed consent, ensuring clear communication in establishing competencies and goals, tasks to achieve them, and logistics; and

(e) the supervisor models and engages the trainee in self-assessment and development of metacompetence (i.e., self-awareness of competencies) from the onset of supervision and throughout.

Falender & Shafranske, 2007, p. 238

Supervisory Contract

- Development of the supervision contract is an essential component of the supervisory process and serves as the basis for the supervisory alliance, enhanced articulation of expectations, informed consent, and definition of parameters of the relationship and the process.

Supervisory Contract

- Content and Context of Supervision
  - Scope of practice under supervision
  - Length of contract period
- Roles and Expectations of Supervisee and Supervisor
  - Learning activities, processes, supervisor and supervisee responsibilities, feedback, mutually defined goals and tasks
- Legal/Ethical Parameters
  - Informed consent; Confidentiality
  - Adherence to agency/practice requirements and rules
  - Include specific reference to ethical codes, licensing statutes, and laws
  - Reference to agency/site personnel practices
- Performance Expectations
  - Specific knowledge, skills, values (from Benchmarks or Competency doc)
  - Modes of formative and summative evaluation

Supervisory Contract: Informed Consent

- Supervisor and supervisee rights and responsibilities
- Context in which services/supervision occur; ethical and legal compliance
- Supervisor-supervisee-client boundaries
- Expectation that personal factors will be addressed in supervision
- Documentation of supervision, access, maintenance of log
- Expectation of self-assessment
- Possibility that cases will be transferred or supervisor will join supervisee as co-therapist if it is beyond supervisee competence
- Possibility that supervisee will be referred for personal therapy
- Description of processes for evaluation, timing and frequency
- Parameters of Supervisee Confidentiality including limits of confidentiality
- Complaint processes
    - Falender & Shafranske, 2004; Thomas, 2007

Supervision Contract Examples

- www.cfalender.com
- Falender & Shafranske, 2004 (Appendix)
- Falvey, 2001

Alliance and the Supervision Contract

- The mutually defined goals and tasks of clinical training, and the ensuing emotional bond
- the knowledge, skills, and values, which will be assembled to form specific clinical competencies, and
- the learning strategies and evaluation procedures involved in developing the competencies should be articulated in the supervision contract.

Clarity in the training goals and the collaborative identification of the means to achieve the goals establish a context for the development of an alliance out of which an emotional bond will develop and the training goals will be achieved.

Alliance

- An emotional bond, characterized by trust, respect and caring, develops through a confluence of factors as the process of supervision unfolds. In our view, the development of the bond and the effectiveness of supervision, more generally, will be shaped by the degree to which the superordinate values are expressed . . .

Keys to Alliance

- Clarity
- Transparency and No Surprises
- Definition of All Power Differentials Including Administrative
- Integrity
- Continuous Constructive Feedback Given Sensitively and Welcomed as well

Alliance Strains

- Strains can be brought about by the challenges inherent in clinical practice/clinical training, conflicts in the goals and/or tasks, inadequate attention to the superordinate values, inadequacies in technical competence (inquiry & educational praxis), and particularly, in boundary crossings and violations, in problematic supervisee behavior, and through negative reactions and the enactment of transference, countertransference and parallel process phenomena.
- Think of strains that might occur or have occurred in your setting

Alliance Strains

- Frustrations in treatment/supervision process and outcome may activate negative personal reactions and defensives, e.g., increasingly controlling, rigid, critical, etc., further straining the collaboration.

Indicators of Strain

- Withdrawal
- Paucity of disclosure
- Direct expression of criticism/hostility
- Noncompliance/passive responding
- Acting in/acting out

Leading to Double or Triple Traumatization

- Presence of previous exposure to trauma
- Strains
- Ruptures

- Resulting in:
  - Failure to Disclose
  - Spurious Compliance
- When conflict arises between supervisor and supervisee and is not resolved, it compounds supervisee exposure to trauma from clients

High Risk Areas

- Supervisees and suicide of clients
  - Rates—
    - 40% of psych trainees experienced client suicide or serious attempt (Kleespies et al., 1993)
    - The earlier in training, the more severe impact, enduring consequences
- Other risks
  - Half of all psychotherapists are threatened, harassed or physically attached by a client at some point in one's career
    - Leading to greater vulnerability, decrease in emotional well-being
      - Summarized in Norcross & Guy, 2007

Nondisclosure: Is it Related to Strain?

- Positive correlation between positive supervisory alliance and supervisee disclosure
- Nondisclosure occurs in supervision
  - Negative reactions to supervisor (90% who failed to disclose)
  - Personal issues (60%)
  - Clinical mistakes (44%)
  - Evaluation concerns (44%)
  - General observations about client (43%)
  - Negative (critical, disapproving, unpleasant) reactions to client (36%)
    - Ladany, Hill et al. 1996

Counterproductive Supervision Events

- Dual/Multiple role relationships
- Supervisor's lack of openness or competence
  - Reichelt & Skjerve, 2002
- Negative supervision erodes supervisee professional self-confidence, increases self-doubt, and invites negative countertransference reactions to clients, increases performance anxiety and exacerbates supervisee self-criticism
  - Orlinsky & Ronnestad, 2005

Supervisor Self-disclosures

- Supervisor Self-disclosure
  - Pathway:
    - Supervision Relationship
    - Precipitant/Stimulus for Supervisor Self-disclosure
      - Supervisee struggling
    - Intent of Self-disclosure
      - Teaching/improving clinical work
      - Normalizing
    - Content of Self-disclosure
      - Supervisor's response to own or supervisee client
    - Effect of Self-disclosure
      - Knox, Burkard, Edwards, Smith, & Schlosser, 2008-small n

Ruptures

- Personal values/attitudes limiting ability to empathically attune
- Misattunement—for sociocultural or person reasons-- leading to perception of supervisor as not understanding
- Negative reactions to clients—supervisory task to teach and model management rather than responding personally

Negative Factors (Adapted from Ackerman & Hilsenroth, 2001)

- Rigid - Over structuring the therapy/supervision
- Uncertain - Failure to structure the therapy/supervision
- Exploitive - Inappropriate self-disclosure/supervision
- Critical – Managing
- Distant - Unyielding transference interpretation
- Tense - Inappropriate use of silence
- Aloof - Belittling
- Distracted - Superficial interventions

Proceeding

- Negative reactions to clients, supervisee, or supervisor interfere with working alliance and client outcome
  - They need to be dealt with and contained
  - Relationship must be safe
  - Disclosures must be accepted, not ridiculed

Proceeding

- Supervisee reinforces negative patterns of interaction with little awareness of personal involvement
  - Adopting stance of inquiry, stepping back from defensive mode of reacting interrupts cycle of misattunement
    - Frame feeling states and attributions being made
    - Attempting to gain insight through understanding what feelings are being warded off

Metacommunication

(Safran in Falender & Shafranske, 2008)

- Stage 1: Attend to Rupture Marker
- Stage 2: Exploration of Rupture Experience
- Stage 3: Exploration of Avoidance
- Stage 4: Supervisee Asserts and Supervisor Validates Assertion
- Outcome: Increased Collaboration and Enhancement of the Alliance or Increased Strain and Threats to the Alliance (acting out/non-compliance/distrust)

Recognition of Parallel Process

- Upward and downward parallel process in supervision
  - Complexity of supervisee/therapist, supervisor, and client/client family in parallel processes in supervision
- Evidence supports existence of parallel process or isomorphism
- Critical to consider power of supervisor through role, legality, privilege and other factors

Knowledge of Self

- “Competent caring for the well-being of persons and peoples involves… self-knowledge regarding how their own values, attitudes, experiences, and social context influence their actions, interpretations, choices, and recommendations”
  - Principle II of the 3rd draft *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Science, 2008; http://www.sipsych.org/Universal_Declaration_Draft3_2008-04-10.pdf

Initiation into Role of Personal Factors

- Personal and professional sources influence conduct of psychological treatment and become intertwined
  - Conscious beliefs
  - Culturally-embedded values reflecting individual differences and diversity
  - Unresolved conflicts
- Supervision is subject to these influences as well

Role of Personal Influence

- Countertransference
  - Supervisor and clinician's understanding is always perspectival: influenced by personal interests, commitments, and cultures out of which personal meanings are constructed
  - Countertransference in the broadest sense takes into consideration that "in the final analysis *all* understanding is self understanding" (Gadamer, 1962).

- *Objective* countertransference—reactions of psychotherapist induced by client's maladaptive perceptions, affects, and behavior which are consistent with the responses of significant others in the client's life
- *Subjective* countertransference—uncharacteristic, and at times, maladaptive reactions of the psychotherapist emanating from personal factors
    - Shafranske & Falender, 2008 (in Falender & Shafranske, 2008)

Countertransference: Therapist to Client (Betan et al., 2005)

- 1) overwhelmed/disorganized
  - Desire to flee or avoid and strong negative feelings (Axis II Cluster B clients)
- 2) helpless/inadequate
  - Hopelessness, anxiety, incompetence
- 3) positive
  - Close connection, good therapeutic relationship
- 4) special/ over-involved
  - Boundary, self-disclosure issues
- 5) sexualized
  - Sexual feelings toward client, sexual tension
- 6) disengaged
  - Distracted, withdrawn, annoyed, bored in session
- 7) parental/protective
  - Wish to protect client in parental way, above and beyond positive feelings
- 8) criticized/mistreated
  - Feelings of being dismissed, unappreciated, devalued by the patient

Supervisor Countertransference

- “…exaggerated reactions stemming from a supervisory interaction customarily related to the supervisor's unresolved personal issues or internal conflicts.” (Ladany et al., 2000)
  - Triggered by interpersonal style of supervisee
    - Defensiveness, guardedness, passivity, shyness, assertiveness, warmth
  - Stemming from aspect of supervisor’s own unresolved personal issues
    - Personal, family issues, competency concerns, need to be liked, work with previous supervisees
- Cultural issues (Vargas, unpublished)

Countertransference Management

- Relationship must exist before countertransference exploration
- Countertransference approached as important informers of the therapeutic process
- Countertransference includes both positive and negative forms of personal influence
- Countertransference informs the therapeutic process
- Countertransference may elicit positive and/or negative responses in the therapist and take forms of distinctly unusual, idiosyncratic, or uncharacteristic acts or patterns of therapist experience and/or actions towards clients, including enactments and parallel processes involving the supervisory relationship
    - Shafranske & Falender, 2008

Countertransference Management

- Inquiry into supervisee subjective states (boredom, confusion, irritation) when departures from usual clinical conduct arise or when treatment is not progressing
- Critical to maintain boundary between supervision and psychotherapy

Countertransference Management

- How supervisees treat countertransference and ruptures is more important than the fact they occur
- Clinical competence includes the awareness of personal factors which influence the therapeutic process as well as skills in effectively bringing countertransference reactions into the service of the treatment.

Stages in Addressing Personal Factors and Countertransference

- Preface
  - Supervisory contract
  - Explicit orientation to personal factors
  - Modeling
  - Exploration of positive contributions of personal factors and strength-based aspects
- Collaborative Identification of CT
- Reinforcement of Identification of CT as a Competency

Addressing Countertransference

(Derived from Gelso & Hayes, 2001)

- Self-insight
- Self-integration—(differentiation)
- Anxiety experience and management
- Empathy
- Conceptualization ability
  - Elaborated in Shafranske & Falender, 2008 (In Falender & Shafranske, 2008)

Parallel Process

- Upward and downward
- Isomorphism
- Recursive replication
- Syllogism
- Mirroring

Diversity Factors

- Gender
- Sexual orientation
- Culture
- Race
- Ethnicity
- Language
- Age
- SES
- Religion & spirituality
- Disability or Ableness
- Urban vs. rural/remote
- Body size
- Other factors including worldview

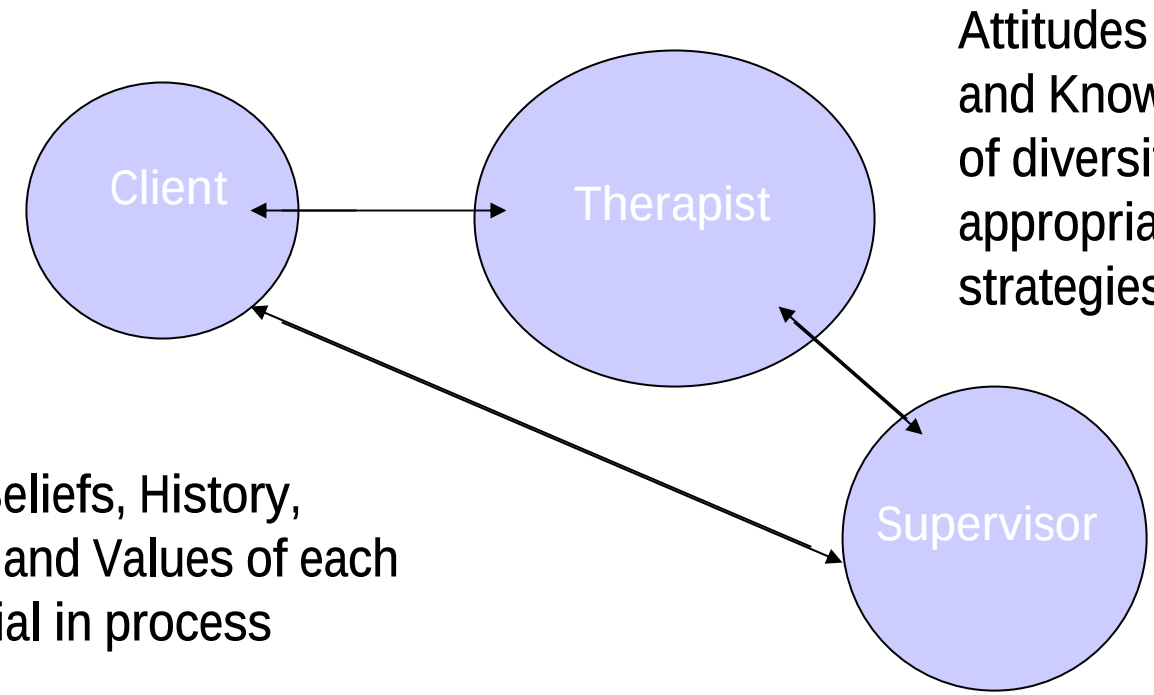
- Belief in importance of multicultural competence outpaces behavior (Hansen et al., 2006; McKitrick & Lee, 2008)

McKitrick, D.S., & Li, T.S. (2008). Multicultural treatment. In Handbook of Clinical Psychology, Vol. 1. Adults.

Intersecting Factors

Awareness of own cultural biases/assumptions

Level of racial identity development



Attitudes toward and Knowledge of diversity appropriate strategies

Attitudes, Beliefs, History, Prejudices, and Values of each are influential in process

Diversity in Supervision

- **Low rates of actual discussion of ethnicity, gender and sexual orientation in supervision**
- **Lack of initiation of these by supervisors**
  - **Gatmon, Jackson, Koshkarian, Martos-Perry, Molina, Patel & Rodolfa, 2001**
- **Perceptions may vary between supervisees and supervisors on initiation and on supervisory prior experience**
  - **Duan and Roehlke, 2001**
- **Supervisors did not view exposure to cultural differences as influential in supervisee's development while supervisees do**
  - **Toporek, Ortega-Villalobos, & Pope-Davis, 2004**
- **Both white and supervisees of color found supervisors sometimes unresponsive to cultural issue**
  - **Burkard, Johnson, Madson, Pruitt, Contreras-Tadych, et al., 2006**
- **Many topics simply do not come up i.e., religion**
  - **Rusell & Yarhouse, 2006; Shafranske, 2005**

Opportunities

- Supervisor can infuse and model multiculturalism in supervision
  - **Ideally, racial identity development of supervisor is equal or greater than supervisee**
    - Ladany et al., 1997
  - Attending to cultural dynamics—and individual racial, ethnic, spiritual, sexual orientation, and gender identity
  - Enhances awareness of racial-cultural dynamics in vivo
  - Enhances relationship and client outcomes
    - Burkard et al., 2006
- Attention to multicultural phenomena associated with stronger supervisory alliance
  - Gatmon et al., 2001; Nilsson & Alexander, 2004
- When multicultural dynamics are introduced it is associated with a increases in personal awareness of culture
  - Toporek et al., 2004
- Creation of culturally sensitive ambiance and climate
  - Dickson, Jepsen, & Barbee, 2008

Facilitative Supervision Strategies

- Asking questions about cultural issues
- Encouraging supervisees to elaborate on conceptualizations that include cultural issues
- Challenging supervisees to consider how the client's cultural background may be influencing her or his current situation or problem.
  - Burkhard et al., 2006
- Identify your own level of racial identity development and consider that of supervisee
  - Helms (1995); Ponterotto & Pedersen (1993);
  - Bhat & Davis, 2007

Diversity Not Addressed

- Bringing up discussion at all
- Neglected in graduate training
- Asking about disabilities during intake—as they may be invisible
- Use of pejorative language regarding handicapping conditions
  - (Cornish, Gorgens, & Monson, 2008 in Cornish et al., 2008))

Microaggressions

- Cumulative effect of Invalidating racial-cultural issues
  - Making stereotypic assumptions about Black clients and/or Black supervisees
  - Blaming clients of color for problems that stem from oppression
  - Offering culturally insensitive treatment recommendations
    - Constantine & Sue, 2007, Sue et al., 2007

Culture in Supervision

- **Family/therapist (supervisee) and supervisor maps**
  - **Ecological context**
  - **Family life cycle**
  - **Migration/acculturation**
  - **Family organization**
  - **Health/ spirituality/ religion/ faith**
  - **Happiness/ optimism**
    - **Derived from Falicov (1998), modified by Falender & Wisnia (2001)**

Group Exercise

Identify and discuss the issues related to diversity competence in the vignette.

- What would be your focus in supervising the supervisor and what technical approaches would you take to enhancing his/her competence in addressing diversity issues and individual differences in clinical supervision?
- How might you assess the effectiveness of your interventions and consultation?

Assessment of Client or Supervision Outcome

- Client outcome
  - Feedback loop with client to supervision
  - Lambert OQ or other behavioral checklist
- Complexity
  - Unclear relationship of competence to client outcome (dependent on measures, definitions)
    - Barber, Sharpless, Klostermann, & McCarthy, 2007
- Only a minority of psychologists use a measure to assess outcome—but those who did were trained to do so (!!)
    - Results summarized in Hunsley, 2007b

SUCCESSFUL SUPERVISION

Factors Associated with Successful Supervision

- Rapport building
- Supervisor fund of knowledge
- Encouraging supervisee active role
- Mutuality in process as developmentally appropriate
- Development of shared goals
- Role definition or invocation for supervisee and supervisor
  - Involves the identification of means to achieve the shared goals
  - Use of a formal contract articulates the goals, means and the expectations and responsibilities - establishes the “ground rules”
- Meta-communication on the process of supervision

Lousy Supervision

- Overarching principles
  - Unbalanced
  - Developmentally inappropriate
  - Intolerant of differences
  - Poor model of professional/personal attributes
  - Untrained
  - Professionally apathetic
    - Magnuson, Wilcoxon, & Norem, 2000

Contributions of Supervisees to Lousy Supervision

- Supervisee factors
  - Unwilling to grow and change*
  - Psychological limitations
  - Unresolved issues
  - Fearful of change
  - Unwilling/unable to examine self
  - Social limitations
  - Lack of sensitivity/respect
  - Distrustful/defensive
  - Unwilling/unable to accept feedback
  - Defiant/avoidant in supervision
  - Limited skills and knowledge base
  - Limited motivation for learning
  - Inadequate understanding of counseling process
    - Wilcoxon, Norem, & Magnuson, 2005

Most Effective Supervision Formats

- Joint review of videotapes of sessions; live supervision/feedback
- Supervisees participate on a treatment team behind one-way mirror
- Group supervision
- Supervisor demonstrates specific therapy skills
- Individual case consultation

(Goodyear & Nelson, 1997)

Professional Practice, Ethics and Law

Ethical Standards

- CPA Ethical Standards
- **Canadian Psychological Association (CPA) Ethical Guidelines for Supervision in Psychology**
  - **http://www.cpa.ca/cpasite/userfiles/Documents/COESupGuideRevApproved7Feb09revisedfinal.pdf /**
- Universal Declaration of Ethical Principles for Psychologists
  - http://www.cpa.ca/cpasite/userfiles/Documents/Universal_Declaration_asADOPTEDbyIUPsySIAAP_July2008.pdf

Promoting Ethical Sensitivity

- Awareness of how supervisee's actions affect others and to anticipate reactions of others (clients, supervisors, etc.
- Ability to construct possible scenarios, with knowledge of cause – consequence chains of events in clinical setting
- Empathy and role-taking
- Ability to take perspective of others from other ethnic, cultural, diversity backgrounds
  - (Bebeau, 2002)

Negligence…in Canada

- Negligence—conduct that fails to meet the standard required of society
  - Duty of care owed the defendant to the plaintiff
    - Professional relationship
    - Broader duties owed to members of more general public
  - Failure to provide reasonable care
  - Causation between conduct and injury—proximate cause
  - Damage or injury to plaintiff
  - No conduct by the injured party that would preclude recovery
    - Truscott & Crook, 2004

Forms of Liability

- Direct Liability—supervisor him/herself was cause of harm
  - Negligent supervision
    - Failure to comply with accepted standards of supervision
    - Acts or omissions of the supervisor with the supervisee
- As supervision practice standards are articulated, defining negligence is clearer

Vicarious Liability: Respondeat Superior

Supervisor is liable by virtue of relationship with supervisee

- Three Conditions that must be met:
- Supervisees voluntarily agree to work under direction and control of supervisor and act in ways that benefit the supervisor
- Supervisees must be acting within the defined scope of tasks permitted by supervisor
- Supervisor must have power to control and direct the supervisee's work
    - Disney & Stephens, 1994

Additional factors

- Establish whether an action fell within scope of supervisory relationship
  - Time, Place, Purpose of the act
  - Motivation of supervisee
  - Whether supervisor could have reasonably expected the supervisee to commit the act
    - Disney & Stephens, 1994

Malpractice elements

- Fiduciary relationship with therapist or supervisor—supervisor is working in best interests of supervisee and clients
- Supervisor's (or therapist's) conduct was improper or negligent and fell below standard of care
- Supervisee (or client) suffered harm or injury which is demonstrated
- Causal relationship demonstrated between injury and negligence or improper conduct
  - Disney & Stephens, 1994

- Premise is that supervisor will remedy all deficiencies of supervisee

Canadian Code of Ethics for Psychologists, 3rd edition

- *Minimize harm*
  - II.27 Be acutely aware of the power relationship in therapy and, therefore, not encourage or engage in sexual intimacy with therapy clients, neither during therapy, nor for that period of time following therapy during which the power relationship reasonably could be expected to influence the client's personal decision making. (Also see Standard III.31.)
  - II.28 Not encourage or engage in sexual intimacy with students or trainees with whom the psychologist has an evaluative or other relationship of direct authority. (Also see Standard III.31.)

Canadian Code of Ethics for Psychologists, 3rd edition

- Avoidance of Conflict of Interest.
  - III.31 Not exploit any relationship established as a psychologist to further personal, political, or business interests at the expense of the best interests of their clients, research participants, students, employers, or others. This includes, but is not limited to: soliciting clients of one's employing agency for private practice; taking advantage of trust or dependency to encourage or engage in sexual intimacies (e.g., with clients not included in Standard II.27, with clients' partners or relatives, with students or trainees not included in Standard II.28, or with research participants); taking advantage of trust or dependency to frighten clients into receiving services; misappropriating students' ideas, research or work; using the resources of one's employing institution for purposes not agreed to; giving or receiving kickbacks or bonuses for referrals; seeking or accepting loans or investments from clients; and, prejudicing others against a colleague for reasons of personal gain.

Risk Management in Supervision

1. Know your supervisee's competence—and your own. Question your own competence and consult.
2. Evaluate all cases, document evaluation and your supervision
3. Use live or videotape supervision or see the patient periodically
4. Supervise all major decisions by the supervisee and make sure supervisee keeps records.
5. Ensure adequate coverage when supervisee unavailable
6. Provide periodic written evaluations to supervisee. Give negative evaluation when indicated.
7. Know the legal rules about supervision including state regulations for your discipline and regulations of your setting.
8. Have a clear understanding with supervisee of mutual goals and expectations. Arrange for emergency and out-of-town coverage.
9. Investigate complaints by clients of supervisory misconduct.
    1. (Adapted from NASW, 1994; Stone, 1994, Falender & Shafranske, 2004))

Lawsuits brought by Clients

- Sexual misconduct
  - Negligent supervision in mishandling of transference/countertransference
    - Sexual relations between psychologist and client is a well-known hazard—prudent supervisor watches carefully for signs of boundary issues (Minn.Supreme Ct.)
  - 9th Circuit: Simmons vs. U.S.—social worker mishandled transference
    - Failure to instruct on treatment boundaries
    - Monitor for warning signs of sexualized transference
      - Recupero & Rainy, 2007
  - Failure to provide feedback to training program
    - Garamella v. New York Medical College
  - Boundary violations

Sexual Feelings

- Feeling sexual attraction to client is normative: 88% of psychologists reported feeling at least once in their career Rodolfa et al., 1994; Pope, Sonne, & Greene. 2006
- However, training or supervision not adequate 9%
  - Pope, Keith-Spiegel & Tabachnick, 1986
- Sexual attraction manifested in greater attention to client, distance, distraction, and loss of objectivity
- Only half of supervisees discussed with supervisors; supervisors did not raise
  - Ladany, O'Brien, Hill, Melincoff, Knox, & Petersen, 1997
- Is it "developmentally inappropriate" to discuss countertransference and transference with beginning supervisees?
- What about reactivity of supervisee/supervisor?

High Risk Behaviors

- Therapist response to client
- Therapist needs
- Session characteristics
- Accountability

Hamilton & Spruill, 1999

Sexual Behavior

- Sexual advances, seductions, and/or harassment experienced by 3.6 to 48% of psychology and mental health-related students
- 80% or more of mental health educators believe it is unethical/poor practice to engage in sexual contact with a supervisee or student, especially during the working relationship
- 13% of all participants said they would engage in sexual conduct if they knew no one would find out
    - Zakrzewski, 2006

Survey of Students and Ethics

- Many students (53% --n of 223) would not feel safe to pursue action if they had firsthand knowledge of a sexual contact occurring
  - Feared anonymity would not be protected
  - Concerned about repercussions
    - Zakrzewski, 2006

Dealing with Sexually Inappropriate Behavior

- What to do if supervisee tells you client asked her for a date?
- What if supervisee tells you client told her she was “hot”?
- What if supervisee tells you client told him he wanted to “hook up”?
  - Hartl, Zeiss, Marino, Zeiss, Regev, & Leontis, 2007

Response to Sexually Inappropriate Behaviors Hartl et al., 2007

- Discussion with supervisor
- Internal emotional response
- Responses when risk is involved
- Direct responses
  - Conceptualize as
    - Lack of awareness of appropriate social interaction
  - **Teach supervisee to respond in ways to teach or shape more appropriate behavior, maintaining collaborative working alliance, responding in a way that does not shame client but encourages more appropriate interactions and reaffirms therapeutic boundaries and is proportionate to the risk represented by the behavior**

Management of Sexual Attraction

- Identification of markers of sexual attraction
- Task environment and resolution
  - Exploration of feelings
  - Assessing knowledge
  - Normalizing experience
  - Focus on countertransference {transference}
  - Focus on therapeutic process
    - Ladany, Friedlander, & Nelson, 2005

Boundary Crossings and Violations

- Boundary Crossings
  - “A non-pejorative term that describes departures from commonly accepted clinical practice that may or may not benefit the client” (Smith & Fitzpatrick, 1995, p. 500)
- Boundary Violations
  - Departure from accepted practice that places the client or the therapeutic process at serious risk (Gutheil & Gabbard, 1993)

Examples of Supervision Boundary Crossings

- Gifts
- Social events
- Lunch
- Multiple roles

Questions to Ask in Multiple Relationships in Supervision

- 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?
- Is there a risk the additional relationship could disrupt the supervisory relationship?
- Can the supervisor evaluate the matter objectively?
  - Adapted from Gottlieb, Robinson, & Younggren, 2007

Burian & Slimp, 2000

- Decision tree specific to internship
  - Professional benefit to each
  - Personal benefit to each
  - Present professional role
  - Location of social relationship
  - Intern's ability to leave social relationship/activity without repercussion
  - Probable impact on uninvolved interns
  - Probable impact on uninvolved staff members

Canadian Code of Ethics for Psychologists: Ethical Decision Making

- Identification of individuals and groups potentially affected by the decision
- Identification of ethically relevant issues and practices, including the interests, rights, and any relevant characteristics of the individuals and groups involved and of the system or circumstances in which the ethical problems arose
- Consideration of how personal biases, stresses or self-interest might influence the development of or choice between courses of action
- Development of alternative courses of action

Continued

- Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/ group(s) involved or likely to be affected (e.g., client, client's family or employees, employing institution, supervisee, research participants, colleagues, the discipline, society, self)
- Choice of course of action after conscientious application of existing principles, values, and standards.
- Action, with a commitment to assume responsibility for the consequences of the action

Continued

- Evaluation of the results of the course of action
- Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved.
- Appropriate action as warranted and feasible to prevent future occurrences of the dilemma (e.g., communication and problem solving with colleagues; changes in procedures and practices.
    - www.cpa.ca/cpasite/userfiles/documents/candian

Professionalism

- “is demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability, and altruism”
  - Stern, 2006

Unprofessional Behavior

- Unprofessional behavior in medical school related to subsequent disciplinary action by state medical boards
- 235 graduates of 3 medical schools disciplined by a state medical board between 1990 and 2003 and 469 control physicians matched by med school and graduation year
  - Use of drugs or alcohol (about 15% of violations)
  - Severe irresponsibility in 8.5% of physicians disciplined by medical boards (0.9 by controls)

- Disciplinary action by medical board was strongly associated with prior unprofessional behavior in medical school
  - **Severe irresponsibility**
    - Unreliable attendance at clinic
    - Not following up on activities related to patient care
  - **Severely diminished capacity for self improvement**
    - Failure to accept constructive criticism
    - Argumentativeness
    - Display of a poor attitude
    - (This and previous slide from Papadakis, Teherani, Banach, Knettler, Rattner, Stern, et al., 2005)

Second Study

- Two performance measures independently predicted disciplinary action:
  - Low professionalism on Residents' Annual Evaluation Summary
  - High performance on certification exam predicted decreased risk for disciplinary action
  - Both behavioral and cognitive measures during residency associated with greater risk for state licensing board actions
    - Papadakis, Arnold, Blank, Holmboe, & Lipner, 2008

Professional Competency Problems

- Ethical imperative to address them—
  - If because of their incompetence or lack of ethical sensitivity—they would inflict harm on consumers they have agreed to help
    - Kitchener, 1992
- Also Canadian Code of Ethics Third Edition:
  - Principle I: Respect for the Dignity of Persons
  - Principle II: Responsible Caring
  - Principle III: Integrity in Relationships
  - II.2 Avoid doing harm to clients, research participants, employees, supervisees, students, trainees, colleagues, and others.
  - II.7 Not delegate activities to persons not competent to carry them out to the benefit of others.
  - Also 11.25 –and the entire Code

How Many Performance Problems Are Addressed?

- 44% of counselor educators in Britain reported they passed students who would be unsuitable as counselors
  - Wheeler, 1996
- 93-95% of mental health faculty and staff observed supervisees with problematic behavior but only 66-76 actually remediated or dismissed
  - Gaubatz & Vera, 2002
- Issues of identification of students, remediation—and “gateslippers”

Feedback

Effective Feedback

- In the process of feedback the recipient implicitly compares the feedback to his/her own self-assessment
- There are factors which make feedback *more* – or less—easy to accept
  - More easy if it coincides with the supervisee's own impression of his/her behavior
  - If it is presented as a developmental goal, or part of a supervision plan
  - If it is behaviorally linked—very specific, and close in time to when observed
  - If the supervisor models reflective process regarding feedback

- Feedback perceived as negative may be hard to accept or integrate and can be de-motivational
- Improvement is most likely when recipients are positive about receiving feedback, believe change is possible and desirable (are motivated to change), use it to develop performance goals, and take action for improvement
- KEY: How does feedback inform recipient's self-assessment?

- Assessment of supervisee performance is subjective
  - Evidence that peer ratings provide excellent feedback, especially of professionalism
  - Self-assessment should be enhanced and tied to strategies to remediate or enhance competencies
  - Separate roles of mentor and evaluator
  - Increase transparency of performance evaluation and feedback

Enhancing Reflection and Self-Assessment

- Motivational interviewing derived technique
- Supervisees self assess their recordings and supervisors respond to enhance reflection and self-critiquing
  - Sobell, Manor, Sobell, & Dunn, 2008

Motivational Interviewing and Feedback

- Supervisor might say “Tell me a bit about what you heard on your tape and how might you phrase things differently in a similar situation next time?”
- “What other things might you do differently?” or “What do we need to work on in supervision to get you to a higher level?”).
- Open-ended questions allow trainees to reflect on their own progress, encourages trainees to decide to make changes (i.e., talk or interact differently with patients).
  - Sobell, Manor, Sobell, & Dunn, 2008

Evaluation

- How accurately can we evaluate supervisee competence if we have NEVER seen their clinical work?
- Much of current evaluation is of the supervisee's reconstruction of client behavior with less attention or information about supervisee behavior, conceptualization in vivo, or affective response.
- Gonsalvez & Freestone (2007) reported possibility that field supervisory assessments are not as reliable or valid as we assume
  - Affected by leniency bias
  - Low inter-rater reliability (except for proficiency in case and psychometry report-writing)
  - Strong alliance may introduce bias
  - Variation in structure and frequency of assessment, use of assessment methods

Remediation is *not* Disciplinary

- We need a new name for remediation as it has become punitive
- Remediation plans refer to specific competency-based plans to develop certain knowledge/skills/ or attitude/values
- Action plans should be normative
  - Falender & Shafranske, in preparation
- Negative evaluations are *not* defamatory
  - Papadakis & Loeser, 2006

Problems of Professional Competency

- Problems connected to insufficient training and supervision or difficulties with moral character or psychological fitness
  - Moral character: honesty and integrity a person deals with others—relevant to maintaining public trust—integrity, prudence, caring
  - Psychological fitness: emotional or mental stability of a professional—one's capacity to practice safely and effectively
- Creation of culture supporting self-assessment
  - Kaslow, Rubin, Forrest, Elman, Van Horne, Jacobs, et al., 2007
- Be sure process is in place *before* there is a problem with a specific supervisee
  - Forrest, Miller, & Elman, 2008

Definition Of Supervisee with Professional Competency Problems*— Post Remediation Plans

- Exhibit interference in their professional functioning as reflected in one or more of the following ways:
  - Inability or unwillingness to acquire and integrate professional standards into professional behavior
  - Inability to acquire professional skills to reach acceptable level of competence.
  - Inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning.
    - Lamb et al., 1987
    - * Elman & Forrest, 2007

Supervisees with Professional Competency Problems

- Does not acknowledge, understand, or address problem even when addressed
- Problem is not merely skill deficit rectifiable through academic/didactic training
- Quality of services delivered is adversely affected
- *F & S add that a critical dimension is how responsive supervisees are to feedback in general*

Supervisees with Professional Competency Problems**

- Problem not restricted to one area of functioning
- Disproportionate amount of attention by training personnel required
- Behavior does not change through feedback, remediation, or time
  - Lamb et al., 1987 (includes this and 2 previous slides)

**Trainees identified with professional competency problems (TIPPC)

- Forrest, Miller, & Elman, 2008

Failure to Meet Performance Criteria: Think Competency-frame

- Identify performance not meeting criteria
  - Knowledge
  - Skills
  - Values/Attitudes
  - Intersection of several

  - This will guide you in developing remediation plan
  - Remember that remediation/ actions plans can be a vital part of training

Possible Interventions

- Collaborate with graduate program
- Increase supervision with same or other supervisors
- Change format, emphasis and/or focus of supervision
- Recommend personal therapy
- Reduce or shift trainee workload
- Require academic coursework
- Recommend, if appropriate, leave of absence or second internship or traineeship

Remediation

- Strategies based on systematic evaluation balances in reliability and fidelity, maximizing learning, expanding on self-assessment capacity, utilizing gate-keeping functions
- Consider impact of beliefs, values, attitudes about individual and cultural differences on decisions of identification, assessment and intervention
- Maximize transparency—communicate limitations to rights to privacy and confidentiality
- Consider ethical, regulatory, and legal implications
  - Kaslow, Rubin, Forrest, et al., 2007

Next Steps

- **Probation (in writing)**
- **Stipulate how role/function changes during probation**
- **Review due process**
- **Formal Action**
- **Termination**
  - **Lamb et al., 1987**

Supervisor Log

- Date and session number of supervision
- Number of cases discussed
- Progress and problems
- Concerns/issues raised by supervisee
- Concerns/issues raised by supervisor
- Suggestions for future supervision
- Action plans for supervisee
- Follow-up on previous supervisory input
- Quality of care; i.e., ethical & legal issues, cultural impact

Self-Care as Ethical Imperative

- “Pursuit of technical competency has much to recommend it, but it might inadvertently subordinate the value of the personal formation and maturation of the psychologist”
  - Norcross, 2005; Norcross & Guy, 2007, p. 5

Self-Care

- Psychotherapists have high career satisfaction
- Promote positive self-care
  - Be proactive!! Living well!! Value and grow.
    - Norcross & Guy, 2007

Problems of MH Professionals Related to Self-Care Patterns

- Irritability or emotional exhaustion
- Insufficient or unsatisfactory sleep
- Doubts about one's own therapeutic effectiveness
- Concerns about size/severity of caseload
- Problems in intimate relationships
- Episodes of anxiety or depression
  - Mahoney, 1997

Spirals of positive and negative development

+

- Currently experienced growth
- Overall career development
- Healing involvement
  - Effective, constructive, affirming relationships
- Professional development resources

-

- Currently experienced depletion
- Limited overall career development
- Stressful Involvement
  - Difficulties in tx, avoidance coping, anxiety & boredom
- Lack of work setting support & satisfaction

Orlinsky & Ronnestad, 2005

+

- Breadth and Depth of case experience
- Continuous professional reflection
- Multiple theoretical perspectives
- Sense of assurance, resourcefulness, flexibility

-

- Narrow range of case experience
- Premature “closure” to experience
- Scant sense of therapeutic mastery
- Sense of awkwardness, insecurity, defensive rigidity

Orlinsky & Ronnestad, 2005

Most Important to “Well-Functioning”

- Self-awareness and self-monitoring
  - Meta-cognitive skills
    - If I had a client with symptoms like mine, what would I recommend?
    - If I am depressed is it related to the chronicity and severity of the clients I have recently taken on without thinking about impact?
  - Self-regulation
    - Correction of balance, interpersonal connections
    - Education, supervision resources
      - Coster & Schwebel, 1997; Howard, 2008

Psychotherapy Supervisors' Challenges

- Isolation
- Feeling undervalued
- Lacking information about supervision
- Not knowing where to turn when facing a supervisory dilemma

- Greatest joy: changing set from delivering client care; participating in supervisee growth
  - Riess & Fishel, 2000

Career-sustaining Strategies

- What activities do you engage in to enhance your career-satisfaction?
- What activities do you advocate for your supervisees to enhance their career-satisfaction?

Career-sustaining Strategies

- Higher satisfaction respondents
  - Vary work responsibility
  - Use positive self-talk
  - Maintain balance between personal and professional lives
  - Spend time with partner/family
  - Take regular vacations
  - Maintain professional identity
  - Turn to spiritual beliefs
  - Participate in CE activities
  - Read literature to keep up to date
  - Maintain sense of control over work responsibilities
    - Stevanovic & Rupert, 2004

Joys of Practice/Supervision

- Hitting a bulls-eye of success with supervisee/client
- Promoting growth in client/supervisee
- Enjoyment of work
- Challenge and continuing to learn
- Professional autonomy/independence
- Increased self-knowledge
- Personal growth
- Being a role model and mentor
  - Derived from Kramen-Kahn & Hansen, 1998; Skovolt, 2001

Review of Structure of Supervision