



Towards Best Practice Supervision of Clinical Psychology Trainees

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Supervision of professional practice is mandated in the training of clinical psychologists and consensually agreed to be central in such training. Supervision is intended to serve three related, but somewhat conflicting, functions: (1) normative functions of monitoring and ensuring client well-being, and monitoring and evaluating supervisee competence; (2), restorative functions of supporting supervisee personal and professional well-being; and (3) formative functions of educating and guiding supervisee's professional practice. Research suggests supervision as currently practised can achieve the restorative—and to some extent, the formative—functions of supervision. However, current supervision practice has not been demonstrated to be effective in its normative functions. Recommendations on how to enhance supervision practice are described, which include systematic assessment of supervisee competence and client outcome and options for reconciling the normative function of supervision with the other functions.

Key words: clinical training; positive psychology; psychotherapy process; supervision; treatment feedback.

What is already known on this topic

1 The main functions of supervision, and largely, how to achieve the restorative function and to some extent, the formative function.

What this paper adds

1 Suggestions for effective practice in particularly the normative functions of supervision.

Despite the divergence in systems of psychotherapy, their goals and varied training practices, supervision remains the one component considered essential to all. (Lambert & Ogles, 1997, p. 421)

As documented in this article, supervised clinical psychology practice is consensually viewed by accrediting bodies, those who provide clinical psychology training, and trainees, as central to effective clinical psychology training. Given this consensus, it is surprising that there is very little research on the extent to which supervision achieves its ultimate aims of ensuring supervisees are clinically competent, and that clients benefit from supervisees' professional services. This article is a critical examination of the functions of supervision, the processes used in supervision, and the evidence on the efficacy of supervisory processes. We also provide recommendations for best practice of clinical psychology supervision.

The Importance of Supervision

There is an international professional consensus that supervision of clinical psychology practice should be a central

component of the training and accreditation processes for clinical psychologists (Lambert & Ogles, 1997; Roth & Pilling, 2007; Watkins, 1997). In North America, Western Europe, and Australia, professional bodies and registration authorities specify minimum requirements of the hours of supervision of professional experience that clinical psychologists must attain before being eligible for independent practice (e.g., Australian Psychological Society, 2003; Lambert & Ogles, 1997; Ogren, Jonnson, & Sundin, 2005; The British Psychological Society, 2006). As a recent example, in July 2010, Australia moved to a national registration system. Registration as a psychologist with approval to identify clinical psychology as an area of endorsed practice in Australia requires completion of an accredited postgraduate degree in clinical psychology, which must include specified minimum amounts of supervision of clinical practice (Psychology Board of Australia, 2010). In addition, graduates must then complete further supervised practice (1 year for professional doctorate graduates and 2 years full time for master's degree graduates). Not only is supervision mandated in the training of clinical psychologists but also is increasingly being viewed as an important process for maintaining practice standards and enhancing professional development for qualified psychologists (Roth & Pilling, 2007; Westefeld, 2009).

Clinical psychology trainers and trainees agree that supervised practice is a vital component of clinical psychology training. In recent surveys of clinical program directors and postgraduate clinical psychology students from universities around Australia, both program directors and students rated individual clinical supervision as essential top training, and

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students rated it as the most effective form of training they were receiving (Scott *et al.*, 2011).

At the same time as regarding supervised clinical practice as crucial to effective training, it is also widely recognised that supervision is challenging to do well. Supervisors vary considerably in their ability to provide effective supervision (Russell & Petrie, 1994; Scott, Ingram, Vitanza, & Smith, 2000), and many professional societies and accreditation bodies specify requirements for people to be accredited to provide supervision. For example, under the Australian national registration guidelines, to become an accredited supervisor, clinical psychologists must have a minimum of 3 years professional experience and complete a supervisor training program that involves demonstration of key supervision knowledge and competencies (Psychology Board of Australia, 2010). Furthermore, supervisors must complete further training at least once every 5 years to retain their supervisor accreditation.

Functions of Supervision

There have been numerous definitions offered of supervision, which specify a range of functions of supervision (e.g., Bernard & Goodyear, 2009; Bordin, 1983; Holloway, 1995). Milne (2009, p. 15) provided a recent and clear definition that captures the key elements of previous definitions and provides a useful description of the key function of supervision.

[Supervision is] the formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching, and collaborative goal-setting. The objectives of supervision are "normative" (e.g., case management and quality control issues), "restorative" (e.g., encouraging emotional experiencing and process-

ing) and "formative" (e.g., maintaining and facilitating the supervisees' competence, capability and general effectiveness). (Milne 2009, p. 15)

Table 1 presents an elaborated model of the tasks and goals of supervision based on Milne's (2009) definition. The ultimate goal of supervision is to enhance clients' positive outcomes from clinical psychology services. To that end, supervision must ensure that clinical psychology trainees can practise safely and effectively. In addition, there is also an aspiration for most supervisors to build on the strengths that supervisees bring to the process. This normative role of supervision is a key one enshrined in statements by professional and registration bodies. The normative role includes two related aspects. First, as stated in the Australian Psychological Society's (2003) ethical guidelines, supervisors have a responsibility to ensure that the practice by their supervisees during training is conducted so as to benefit the clients of the psychological service, and that accepted standards of professional practice are adhered to. If supervisors have a reason to believe that their supervisee is breaching professional or ethical standards, the national registration guidelines state that supervisors must contact the registration board with their concerns.

Second, the Australian Psychological Society (2003, p. 4) states that the ultimate responsibility of supervisors is "to make a judgement about the competence of their supervisee, . . . and whether they believe this person is sufficiently prepared to enter the profession as a colleague." The new national registration guidelines stipulate that supervisors hold ultimate responsibility for determining whether their supervisee has demonstrated the required core competencies to be registered as a psychologist. In other words, supervisors are gatekeepers ensuring that trainees can practise the profession of clinical psychology competently.

Supervisors do sometimes judge supervisees as incompetent. Surveys of clinical psychology training programs suggest that almost all programs have failed some students undertaking supervised placements, almost always on the basis of the supervisor's judgment (Biaggio, Gasparikova-Krasnec, & Bauer, 1983;

Table 1 Task and Goals of Supervision

Tasks	Immediate goals	Ultimate goals
Normative		
Case management, monitoring, and quality control	Trainee's therapy delivery is safe, ethical, and effective	Determine the supervisee's fitness for practice
Evaluate supervisee's performance	Enhance current clients' benefits Evaluate adequacy of supervisee's competence	Ensure that the supervisee can independently practice safe and effective therapy
Restorative		
Emotional support and processing	Develop supervisee's professional identity	Enhance supervisee's capacity to practice in ways that enhance his or her own health and prevent burnout
Enhancing effective professional self-care	Enhance supervisee's professional resilience	
Formative		
Develop supervisee's skills and knowledge	Develop adequate repertoire of clinical knowledge and skills	Develop long-term commitment and self-educational strategies to promote effective and evidence-based practice
Assist clinical decision-making		
Promote supervisee's self-evaluation	Enhance self-reflection skills	

Gallessich & Olmstead, 1987; Gonsalvez & Freestone, 2007; Vacha-Haase, Davenport, & Kerewsky, 2004). However, rates of failure of postgraduate clinical psychology students in supervised practice tend to be extremely low—usually only 2% or 3% of students are ever failed (Gonsalvez & Freestone, 2007). As there is almost never any external validation of supervisors' judgements about supervisees' competence, it is unclear if these failure rates are appropriate.

There has been some discussion in the literature regarding a "leniency bias" on the part of supervisors when evaluating supervisees (Gonsalvez & Freestone, 2007). We suggest two contextual issues that may influence supervisors' judgments regarding supervisee competence, particularly when failure of the student is being considered. First, many supervisors of postgraduate students on placement have complex lines of accountability when undertaking supervision. The supervisor usually undertakes supervision at the invitation of the university at which the student is being trained, and often that university makes specific requests of the supervisor in terms of the nature of supervised practice (e.g., hours of client contact and hours of supervision in the placement, criteria and timing of evaluation of the student's competence). The supervisor often works in an organisation that has specific codes of practice it requires of its employees (e.g., medical record-keeping requirements and emergency procedures). The supervisor also has responsibility for the development of the supervisee's professional knowledge and skills and finally for the clients being seen by the supervisee. The Australian Psychological Society's Code of Ethics clearly indicates that the welfare of clients takes precedence over psychologist "self-interest" or the interests of other stakeholders. However, the supervisor has the most immediate personal contact with the supervisee, and in a complex situation of multiple accountabilities, supervisors might err on the side of giving supervisees the benefit of any doubts they have about accurate assessment of competence.

The second potential problem for supervisors is that field supervisors often supervise only one or two students per year. Making judgments about professional competence with limited normative referents about what is reasonable to regard as competent practice in a trainee clinical psychologist is potentially daunting. In the context of having limited contact with universities that might provide such normative information and of recognising the substantial negative consequences for supervisees of failing a supervised practicum experience, supervisors might understandably err on the side of passing supervisees with questionable levels of competence.

Clinical psychology trainees often report high levels of concern about their capacity to be effective therapists and high levels of stress during their clinical training (Scott *et al.*, 2011). For example, 70% of a sample of postgraduate clinical psychology students across three universities in Australia had scores on the General Health Questionnaire exceeding the suggested cut-off for identifying caseness for psychological disorder (Stafford-Brown, 2010). The restorative function of supervision focuses upon the support of the trainee by the supervisor and is argued by most writers in the supervision field as crucial to effective supervision (Bambling, King, Raue, Schweitzer, & Lambert, 2006; Friedlander, Keller, Peca-Baker, & Olk, 1986; Kennard, Stewart, & Gluck, 1987). It has been suggested that the field of

positive psychology may be helpful in the restoration of well-being of supervisees (Howard, 2008). Some areas where positive psychology may contribute include assisting supervisees with increasing self-efficacy, engagement with their work, and enhancing resilience (Howard, 2008).

Finally, the formative function of supervision is the teaching role of enhancing the supervisees' knowledge and skills in the practice of clinical psychology. As noted earlier, students view the learning gained through supervision as the most helpful mode of learning in their development as clinical psychologists (Scott *et al.*, 2011).

Numerous writers have noted the dialectic of, on the one hand, the restorative and formative functions of supervision, and on the other hand, the normative function of deciding whether supervisees are competent to practise. The restorative and formative functions require that supervisors be an empathic advocate for their supervisees, as well as an understanding educator (Bogo, Regehr, Power, & Regehr, 2007; Gizara & Forrest, 2004; Proctor, 2000). The normative function requires that supervisors enforce the required professional standards, which can mean failing some supervisees. The tension between these functions creates dilemmas for trainees and supervisors. For example, if a supervisee is anxious about clinical work, disclosing that anxiety might lead the supervisor to offer support and suggest helpful coping strategies (restorative function) and/or to help the supervisee develop clinical knowledge and skills that enhance therapeutic self-efficacy (formative function). At the same time, the supervisee might be concerned that the supervisor could form a negative appraisal of the trainee's capacity to cope with clinical work based on a disclosure of supervisee anxiety. For supervisors, knowing that supervisees are aware that supervisors can fail them might lead supervisors to be sceptical about the veracity of what supervisees' self-reports of their clinical work, which could undermine the restorative and formative functions of supervision.

Supervisors often resolve the dialectic between normative and other functions of supervision by making unrealistically positive evaluations of their supervisee's performance (Gonsalvez & Freestone, 2007). Supervisees address the dialectic by being selective about what they disclose to supervisors about what happens in their therapy sessions (Bernard & Goodyear, 2009). Perhaps, these biases explain why supervisor's rating of supervisee competence is not correlated with objective ratings based on videotaped samples of professional practice (Borders & Fong, 1992) but are predicted by the quality of the supervisory relationship (Lazar & Mosek, 1993). In other words, supervisors and supervisees often behave in ways that compromises the normative role of supervision. Later in the article, we return to the issue of reconciling the normative and other functions of supervision.

Processes of Supervision

The research and writing on supervision processes have focused almost exclusively on the supervisory alliance and how the alliance affects the achievement of the restorative and formative goals of supervision (e.g., Beinar, 2004; Bernard & Goodyear, 2009). For example, there are a large number of studies on the association of the supervisory alliance with supervisee

well-being and satisfaction with supervision (see Bernard & Goodyear, 2009, for a review). In contrast, there is very little research or even description of the other processes in supervision that might achieve formative goals (e.g., supervisor instruction and modelling of therapeutic skills). Furthermore, almost no attention has been paid to how supervisors make evaluations of their supervisee's clinical competence or evaluate the outcome of the supervisees' clinical work with their clients (Bambling *et al.*, 2006). In what follows, we summarise what is known about the processes supervisors most often use in supervision.

A large scale survey of supervisors and supervisees found consensus that the practice of clinical supervision predominantly consists of supervisees verbally reporting to their supervisor on what they did in clinical sessions, how the client is responding in sessions, and discussing plans for future therapy sessions (Ellis & Ladany, 1997). Similarly, in a recent survey of Australian postgraduate clinical psychology students (Scott *et al.*, 2011), respondents reported that supervision time was most often focused on discussion with the supervisor about current and future client sessions based on the supervisees' report of (1) what was happening in sessions and (2) the outcomes thus far. Students report that supervision varies considerably between supervisors and can include different combinations of discussion of therapy content, therapy process, or therapy outcome; discussion of the supervisee–client therapeutic alliance or the supervisor–supervisee alliance; demonstration or practice of specific therapy skills; or reviewing audio-visual recording of supervisee therapy (Scott *et al.*, 2011).

Contracting for Supervision

Given the multiple functions of supervision, it is not surprising that the literature on effective supervision emphasises the importance of specifying the goals, tasks, and processes of supervision at the beginning of supervision (e.g., Bernard & Goodyear, 2009; Bordin, 1983). Most writers in the field recommend an explicit written contract be negotiated and signed by the supervisor and supervisee, and this has become a common practice. The use of a contract is associated with low supervisee anxiety in regard to the supervision process (Ellis, Ladany, Krenzel, & Schult, 1996) and is suggested to encourage supervisees to be more open in telling supervisors about their concerns in supervision (Bahrick, Russell, & Salmi, 1991). Green and Youngson (2003) propose that a supervisory relationship that has been established with clear contracting is likely to develop into one where appropriate challenging and disclosure of anxieties is acceptable, and goals are more likely to be met, though this proposition has not been formally tested in research.

Evaluating Therapy Outcomes for Supervisee's Clients

In the Scott *et al.* (2011) survey of postgraduate clinical psychology students, the students reported that their supervisors "occasionally" require them to conduct and report systematic assessment of client outcome to evaluate their therapeutic work. However, the outcome of therapy was primarily judged

by supervisors based on supervisees' report of their impressions of client progress and what the client reports to the supervisees on outcome.

Supervisees' reports of their impression of client outcome are inadequate as a means of evaluating the success of therapy. Averaged across presenting concerns and therapy approaches, approximately 60–70% of adults benefit from individual outpatient psychotherapy delivered in routine-care settings (Hansen, Lambert, & Forman, 2002). A non-trivial minority of clients (about 10%) deteriorates, and a further 20–30% show no improvement after individual therapy (Lambert & Ogles, 1997). Similarly to individual therapy, a substantial number of clients fail to respond to existing evidence-based couple-therapy approaches (Halford & Snyder, *in press*). About 10–15% of couples deteriorate, and another 15–20% show no reliable benefit from therapy (Snyder, Castellani, & Whisman, 2006). Research consistently shows that even the most experienced clinical psychologists are very poor at identifying the small but important minority of clients who are deteriorating across the course of individual therapy and also are poor at detecting those clients who are unlikely to benefit from the therapy they are receiving (Lambert, 2010). The ability of couple therapists to predict therapy failure has not been assessed, but it seems extremely unlikely that inexperienced therapists' clinical impressions could validly assess therapy outcome when experienced therapists cannot. Yet, supervisees' clinical impressions are the predominant method used to evaluate the outcome of supervisee-delivered therapy.

Even if therapy outcome is assessed using reliable measures at the end of therapy, this does little to assist the clients of supervisees. Simply knowing that clients did not benefit is not enough, supervision is intended to enhance the benefit clients receive from supervisee-delivered psychological services. There needs to be a much stronger emphasis in supervision on detecting poor client response to therapy and on adjusting what is being done by supervisees in sessions to enhance client outcomes.

Evaluating Supervisee Therapeutic Competence

How do supervisors determine the competence of their supervisees? As noted earlier, supervisors and supervisees agree that evaluation of supervisee competence primarily is based on supervisees' verbal report of what they did in clinical sessions (Ellis & Ladany, 1997). Similarly, Australian postgraduate clinical psychology students also say that their self-report of the content of therapy sessions was by far the most frequently used method to assess their clinical work (Scott *et al.*, 2011). In contrast, supervisor direct observation of clinical practice was used "never or rarely," and supervisor review of audio-visual recordings of therapy sessions was used only "occasionally," and only by some supervisors.

A key rationale for mandatory supervision is to ensure that supervisees practise safely as it is assumed the supervisee lacks the experience and skills to make effective judgments of their own competence. It seems paradoxical that supervisors then rely heavily on supervisees' self-reports of their therapy sessions to monitor and evaluate supervisees' therapeutic competence.

The Supervisory Relationship

The supervisory working alliance is widely seen as having a critical impact on whether supervision is effective (e.g., Bernard & Goodyear, 2009; Bordin, 1983; Roth & Pilling, 2007). The supervisory alliance is the context in which learning occurs (Carroll & Gilbert, 2006). The degree to which the participants have a good working relationship predicts how effectively problems will be resolved and the overall progress of the supervisee (Bernard & Goodyear, 2009; Bradley & Ladany, 2001; Holloway, 1995).

The supervisory alliance is described by many writers as particularly important in achieving the restorative and formative functions of supervision. With respect to the restorative function, the supervisory alliance—and particularly empathy by the supervisor—provides the context in which supervisee self-disclosure occurs. In addition, many argue that a strong supervisory alliance parallels, models, and promotes the crucial components of an effective therapeutic alliance between the supervisee and the client. For example, when a supervisor assists a supervisee to emotionally process their response to a client, this can be seen as essentially similar to the emotional processing the supervisee might need to offer the client. The supervisee's emotional processing in supervision might assist the supervisee to overcome barriers to effective empathy with the client and the supervisory process models for the supervisee on how to proceed in therapy.

One of the biggest risks of dual relationships in supervision is the potential for supervision to become blurred with therapy. Particularly when considering the restorative function of supervision, it can be difficult to decide when appropriate supervisor-facilitated exploration of therapy process variables in the supervisees' professional work can become an inappropriate personal therapy for the supervisee. It is the role of supervisors to indicate to supervisees how their practice may impact on client outcome, including issues such as how their personal characteristics may positively or negatively effect important treatment variables such as the alliance. On the other hand, a supervisor should not engage in therapy with a supervisee as this is clearly a dual relationship, particularly considering the tension with the normative function of supervision where a dual relationship is likely to impair a supervisor's judgment. It is suggested that supervisors clarify with supervisees that although it is the role of supervisors to provide feedback that at times may be quite personal regarding the supervisee's practice, if any personal issues are affecting the supervisee's practice, it is the supervisee's responsibility to find an appropriate person to assist them in resolving such personal issues.

Developing Supervisee Knowledge and Skills

The first two authors have run numerous workshops on supervision and discussed with supervisors the teaching processes they use. Some supervisors report focusing predominantly on the process in the supervisory alliance to facilitate supervisee professional development and state that they rarely, if ever, teach supervisees specific skills in supervision. Other supervisors report using a broad range of teaching strategies to enhance supervisee professional knowledge and skills including didactic

instruction, guided reading, skill demonstrations and practice, problem-solving discussions, and guided supervisee self-evaluation of therapy content and process.

Bambling *et al.* (2006) compared two supervision programmes that captured the different approaches to developing supervisee competence. The first programme focused on the supervisory alliance and process as the means of enhancing supervisee competence. The other supervision programme included a specific curriculum of therapeutic intervention strategies that were demonstrated and practised. Then, its application in supervisee-run therapy was sampled and critiqued. Interestingly, the two programmes produced similar enhancements of supervisee competence, suggesting that there are a variety of specific procedures within supervision that can enhance supervisee competence.

The Effectiveness of Supervision

Bambling *et al.* (2006), in an extensive review of research, concluded that research on therapists in training has focused primarily on the process of supervision, while neglecting the impact of supervision on measurable outcomes relevant to both the client and the supervisee's competence. It has been suggested that this lack of empirical research on supervisee competence and client outcomes might have resulted from a pervasive assumption that supervision is effective (e.g., Bambling *et al.*, 2006; Bernard & Goodyear, 2009; Roth & Pilling, 2007). However, such effectiveness has to be demonstrated rather than presumed. What follows is a brief review of the existing empirical literature.

Supervision and Client Outcomes

A critical test of whether supervision (and therapy) is effective is its impact on client outcomes. The pervasiveness of the assumption that supervision enhances outcome is reflected in the fact that supervision of therapists delivering the psychotherapy is a standard requirement for conducting psychotherapy outcome research (Waltz, Addis, Koerner, & Jacobson, 1993). In fact, almost all evidence collected in the last 25 years on the efficacy of psychotherapy has been conducted in trials in which there was close supervision of the therapists (see Nathan & Gorman, 2007, for a review of this evidence). Yet there is relatively little research directly assessing whether supervision does actually enhance client outcomes.

There is a small but growing body of literature showing that the clients of therapists receiving supervision have more positive outcomes in therapy. Bambling *et al.* (2006) found that depressed clients whose therapists were receiving supervision were less likely to drop out of therapy, reported significantly higher satisfaction with therapy, and had greater reductions in depression than clients of unsupervised therapists. However, Harkness and Hensley (1991) found the benefits of supervision for client outcomes were only evident when supervision focused on reviewing specific aspects of the clinical work with clients. How supervisors access supervisee in-session behaviour moderates the benefits of supervision. Kivlighan, Angelone, and Swafford (1991) found that clients whose therapists were being observed live by their supervisor (as opposed to therapists

reviewing recordings of their sessions with a supervisor at a later time) had stronger working alliances with their therapists and better perceptions of the therapy. Therapists in the live supervision condition gave more support (e.g., in the form of hope and reinforcement of change) than those in the recorded sessions, possibly because the immediacy of feedback in the live supervision enhanced therapy effects. Alternatively, perhaps the most dedicated supervisors make themselves available to watch their supervisees' therapy live, and this self-selection accounts for the benefits of watching live therapy. The potentially important finding that watching therapy live is particularly beneficial needs replication within a more rigorous research design.

One aspect of supervision that is reliably associated with better client outcomes is when supervision alerts supervisees to poor client progress (Harkness & Hensley, 1991; Lambert, Hansen, & Finch, 2001). As noted earlier, even experienced therapists are poor at detecting poor client response to therapy, and assisting supervisees to identify clients not making progress can help the supervisee to modify what is happening in therapy.

It is a well-replicated finding that supervision improves supervisee emotional well-being, awareness of therapeutic process, and confidence in their therapeutic ability (De Stefano *et al.*, 2007; Vallance, 2004). These improvements are positively correlated with supervisees' perceptions of therapeutic progress (De Stefano *et al.*, 2007; Vallance, 2004). However, given the doubt about the validity of supervisees' judgements of therapeutic outcomes, future research needs to relate supervisory processes to independent assessment of client outcomes.

Supervision and Supervisee Therapeutic Skills

Positive supervision is reliably associated with supervisees' perceptions of their clinical skills and self-efficacy as therapists (Borders, 1990; Cashwell & Dooley, 2001; Lobban *et al.*, 2009; Ogren *et al.*, 2005). However, perception of skill level is not an indicator of supervisee competence. Supervision impacts supervisees' skills through both modelling by the supervisor and by the incorporation of explicit supervisor advice into the supervisee's practice (Ladany, Inman, Constantine, & Hofheinz, 1997; Milne, Pilkington, Gracie, & James, 2003). However, as noted by Gray, Ladany, Walker, and Ancis (2001), supervision has the potential to be either a positive or a negative influence on supervisee practice. Supervisors can model both positive and negative behaviours, and supervisees can incorporate both good and bad advice into their practice. Brosan, Reynolds, and Moore (2006) and Gray *et al.* (2001) both found that when supervision is experienced negatively by the supervisee, supervision was associated with erosion of supervisees' therapeutic skills.

Supervision has been suggested to be particularly effective when it is received in the context of a curriculum-based training setting, such as clinical coursework (Berg & Stone, 1980). This suggestion seems reasonable in that consistency between the content of coursework (i.e., explicit instruction about therapy and modelling of skills) and the content of supervision would likely reinforce the supervisee's learning, while inconsistency might be confusing for supervisees. However, there is no systematic research on how the content of supervision is best coordinated with other training components.

There are some pragmatic reasons for mapping curriculum content so that some content is covered in coursework and some in supervision. One-to-one supervision is a particularly costly method of providing information to trainees relative to providing lectures or guided reading to groups of trainees. Similarly, demonstrations of therapy procedures likely could be provided more cost-effectively in small-group sessions rather than in individual supervision. On the other hand, providing detailed feedback on the content and process of therapy being conducted by trainees might be more effective within the context of supervision than in classes.

Supervisory Relationship and Supervisee Well-being and Satisfaction

Psychological therapy involves prolonged exposure to emotionally arousing material, and therapists are at high risk of burn-out (Canfield, 2005; Weiss, 2004). A supportive experience in supervision reduces supervisee anxiety, enhances their confidence in their clinical practice (see Bambling *et al.*, 2006; Friedlander *et al.*, 1986; Kennard *et al.*, 1987), and enhances job commitment (Eby, McCleese, Owen, Baranik, & Lance, 2007). However, multiple studies in the nursing field show that for supervision to have a positive effect on the well-being of supervisees, supervisees must feel supported by their supervisor and feel comfortable discussing sensitive issues (e.g., Eby *et al.*, 2007; Edwards *et al.*, 2005).

There is a well-replicated finding that the quality of the supervisory alliance is associated with supervisee satisfaction with supervision (Bernard & Goodyear, 2009; Ladany, Ellis, & Friedlander, 1999). Specifically, the extent to which the supervisor is perceived by the supervisee as empathic and supportive is associated with supervisee satisfaction, and this effect is independent of the match between contextual variables (e.g., age, gender, and theoretical orientation) of the supervisor and supervisee (Cheon, Blumer, Shih, Murphy, & Sato, 2009; Gray *et al.*, 2001; Riess & Herman, 2008). However, the association of satisfaction and supervisory alliance is a correlation, and it is unclear if this association is causal. Moreover, supervisee satisfaction with supervision does not in any way show that supervisees are competent (Milne & James, 2002). It is easy to imagine that telling a supervisee that their clinical work is unsatisfactory could undermine the therapeutic alliance and satisfaction with supervision. In surveys, supervisors report that they see multiple barriers to judging a student as incompetent including lack of systemic support for the evaluation processes; the personal impact of telling a student that they do not feel the supervisee is fit or competent to work with clients; and concerns that such negative feedback would undermine the supervisory relationship (Gizara & Forrest, 2004; Vacha-Haase *et al.*, 2004). In the context of these challenges, it is possible to imagine that at least some supervisors avoid making a difficult decision to fail an incompetent supervisee, which avoids a potentially difficult challenge for the supervisory alliance. As noted earlier, the contextual factors of competing lines of accountability, and the lack of normative referents on competent practice, might influence supervisors to be reluctant to fail supervisees.

Poor supervision can be harmful to supervisees. In a study by Gray *et al.* (2001), supervisees reported numerous harmful

experiences such as supervisors violating ethical standards, including dual relationships; supervisors being demeaning, overly critical, and even vindictive: using their power for gain at the supervisee's expense; publicly humiliating supervisees; or even being blatantly sexist, racist, ageist, or homophobic towards the supervisee. Consequences of harmful supervision were reported to include excessive shame and self-derogation, notable loss of self-confidence, and generally functional impairment in both the personal and professional lives of supervisees. Nelson and Friedlander (2001) found that in a sample of supervisees who had experienced harmful supervision, between a third to a half of the supervisees reported developing health problems, and 8% left the profession.

One aspect of the supervision relationship that may enhance or detract from the alliance is the concept of parallel process, the phenomenon whereby supervisees re-enact or replicate in supervision what has occurred in therapy by presenting to their supervisor in a similar manner to how their client had presented to them in therapy. Conversely, supervisees can then behave towards their clients in a way that mirrors the perceived behaviours and attributes of their supervisor (Clarkson, 1994; Friedlander, Siegal, & Brenock, 1989). It has been proposed that this unconscious process is an attempt by the supervisee to manage their anxiety in supervision (Bromberg, 1982) and is particularly likely to occur when the supervisee is working with clients who provoke increased anxiety for the supervisee. Detecting the occurrence of parallel process is suggested to require awareness by supervisors of their own cognitive and emotional processes (Morrisey & Tribe, 2001). The risk of undetected parallel process may include abuse of power in supervision or simply not detecting situations involving conflict and anxiety that are troubling for the supervisee (Kaberry, 2000). On the other hand, a supervisor who is sensitive to any parallel processes can greatly assist supervisees to better understand what is occurring in their work with clients (Carroll, 1996).

Recommendations

As the preceding review of evidence highlights, there is much we do not know about supervision and a need for much more empirical research. At the same time, there is sufficient cumulative knowledge to provide some recommendations on the best practice of clinical psychology supervision. The guidelines offered below are almost certain to need revision as further evidence is gathered, but is based on what we currently know.

Contracting for Supervision

Given the diversity of functions of supervision, it is important to clarify and negotiate the goals and tasks of supervision, and the nature of the supervisory relationship. Supervision goals need to be negotiated in writing with the supervisee and based on supervisee self-reports of learning needs, developmental stage of supervisee, supervisor evaluation of supervisee strengths and learning needs, overall programme-learning objectives, and clinical context-specific learning needs. Setting up specific goals enhances self-reflection on the part of the supervisee, provides a clear agenda for supervision, increases the likelihood that supervision time will be focused and effective, and provides a

template for evaluating supervision. Supervision can be facilitated via regular discussion of progress towards the goals of supervision. The potential discrepancies between the supervisor's and supervisee's goals should be discussed openly. In addition, the Australian Psychological Society (2003, p. 4) suggests, "Supervisors should consider alerting supervisees to the difficulties supervisors may face in their dual roles of 'mentor' and 'evaluator'."

Collect and Use Data for the Normative and Formative Functions of Supervision

Systematic assessment of client outcomes is essential to protect clients, to provide supervisees with databased feedback on therapy progress, and to develop supervisees' skills in evidence-based practice. Furthermore, the assessment of client outcome needs to be performed regularly across the course of the therapy, with a particular focus on early response to failure to benefit from therapy. It is well established that if clients do not improve in the first few sessions of the therapy, then the probability of a positive therapy outcome is low (Brown, Dreis, & Nace, 1999; Harmon *et al.*, 2007; Lambert *et al.*, 2002). Systematic assessment of clients allows early identification of clients not benefiting from therapy and alerts their therapist in a timely manner, which significantly enhances therapy outcome (Lambert *et al.*, 2001, 2002).

As an example of the above approach, the clinical psychology training programmes at Griffith University and the University of Queensland have used the Outcome Questionnaire 45 (OQ-45; Lambert, 2010) in their clinical training for the last 5 years. Students undertaking supervised practice in the Griffith University or University of Queensland Psychology Clinics are required to have their adult clients complete the OQ-45 before each therapy session. The OQ-45 is a brief measure of psychological distress, with well-established reliability and validity in detecting client well-being and response to therapy (Lambert, 2010). Each client's progress is compared by a computer programme with normative responses to therapy based on actuarial analysis of a large dataset collected by Lambert and colleagues. The OQ-45 programme generates a report on clients' response to therapy. Clients that are not showing expected positive change are identified, along with flagging of critical symptoms that might need attention (e.g., suicide risk and substance abuse), in a printable report. Supervisees take the OQ-45 reports on their clients to supervision, and the supervisor reviews the reports with the supervisee as a means of monitoring client outcomes and of ensuring supervision addresses the needs of clients not currently benefiting from therapy.

In addition to collecting data on client outcome, supervisors also need to collect data on supervisees' competence, which should include supervisors systematically sampling supervisees' in-session behaviour. As noted earlier, there is some evidence that direct live observation of supervisee sessions is particularly effective, but at the very least systematic reviewing of recordings of sessions is required to determine supervisees' clinical competence. The supervisee therapy sessions reviewed should systematically sample sessions across clients and stages of therapy.

Clients' subjective experience of a positive alliance with their therapist is a robust predictor of client therapy outcome (Haas,

Hill, Lambert, & Morrell, 2002; Martin, Garske, & Davis, 2000). Consequently, it is important that supervision address the competence of supervisees in forming such an alliance with their clients and that necessitates systematically assessing the therapeutic alliance forged by supervisees with their clients. Such an assessment is particularly important when therapy progress is poor. An additional element of the OQ-45 system is its clinical tools (Lambert, 2010). These are self-report measures completed by clients that report on their perception of the therapeutic alliance with their therapist. Clients may be identified by the OQ-45 system as not making the expected progress from therapy. In this case, their therapists have these clients complete the clinical tools. Supervisees can administer the clinical tools to clients and the results can be discussed in supervision to identify potential ways of enhancing client benefit from therapy. Use of clinical tools in this manner has been shown to substantially enhance therapy outcome for clients initially identified as not benefiting from therapy (Christensen, Russell, Miller, & Peterson, 1998; Harmon *et al.*, 2007).

Promote and Monitor the Quality of Supervision

There are a number of factors that contribute to establishing an effective supervisory process. One is to provide training in supervision for supervising clinical psychologists. The Psychology Board of Australia (2010) requires all supervisors of trainee psychologists to undertake a Board-approved training programme in supervision, and an update of supervisor training must be undertaken at least every 5 years. A currently approved programme is the Supervision Training and Accreditation Program (STAP). After completing STAP, which has been run in Queensland for the last 6 years, supervisors demonstrate increased knowledge of supervision processes, and they report increased use of written supervision contracts, objective measures of client change to evaluate supervisees, and reviews of audio-visual recordings of therapy sessions (O'Donovan, Dooley, & Kavanagh, 2009). Supervisors' self-reported changes were corroborated by supervisees' report of supervision (O'Donovan, Dooley, Kavanagh, & Melville, 2010).

Given the previously described association of a positive supervisory alliance with positive supervision outcomes, it is important to promote such a positive alliance. Just as systematic assessment of the therapeutic relationship can enhance therapy outcomes (Lambert, 2010), systematic monitoring of the supervisory relationship might also enhance supervisory outcomes. For example, recently, the first two authors of the current article have been pilot testing the supervision session report shown in Figure 1. The supervisor invites written feedback from the supervisee at the end of each supervision session, and that feedback is used to discuss and modify the approach being taken in supervision. This process is very similar to how the Session Rating Scale (SRS) has been used by Duncan *et al.* (2003) in therapy sessions.

There is no research to date on the effectiveness of these procedures in enhancing supervision outcome. However, given the observed benefits of such procedures in enhancing therapy outcome (Lambert, 2010), formal testing of the effects of supervision feedback systems is needed in future research. Finally, clinical psychology training programmes need to monitor the

quality of supervision carefully and keep supervisors and supervisees accountable for the supervisory processes used. For example, in many clinical training programmes, it has been routine practice for university staff to review supervisors' and supervisees' views of the progress of supervision at the mid-point of training placements. These reviews typically include both formal written feedback by supervisees and supervisors, as well as verbal review by a placement coordinator.

Communicate Formative Feedback and Promote Supervisee Self-evaluation

Giving feedback is central to the evaluative component of supervision (Hahn & Molnar, 1991). The Australian Psychological Society (2003) stresses that feedback should be provided in an ongoing manner and trainees should be given the opportunity to address problems or deficits as they arise. They state: "*As supervision progresses, responsibility for monitoring the performance of the supervisee lies with the supervisor. Supervisors should raise any queries of competence as they arise, and not wait until the end of the supervision period to discuss them*" (Australian Psychological Society, 2003, p. 4).

The adequacy of supervisors' provision of feedback to supervisees has multiple determinants. One influence is the content of the feedback. Supervisors find it more challenging to deliver feedback associated with the supervisee's personal characteristics, or with difficulties in the supervisory relationship, than with the supervisee's work with clients (Hoffman, Hill, Holmes, & Freitas, 2005). Supervisors' feedback is less likely to be provided to supervisees with low levels of openness to feedback, if supervisors perceive themselves as lacking competence in giving feedback, or if there is a difficult supervisory relationship (Hoffman *et al.*, 2005). In sum, these correlates of low levels of supervisor feedback, suggest that little feedback might be provided to supervisees when circumstances suggest it is most needed.

Ultimately, clinical psychology trainees are intended to be fit to practise independently. Towards achievement of that end, it is important that supervisees develop their skills in self-evaluation of their professional practice. Supervision needs to promote effective supervisee self-evaluation by prompting reflection on practice. This needs to include supervisees routinely assessing client outcomes, using that data to promote reflective practice and self-evaluation, and seeking supervision when needed. It is noteworthy that promotion of self-evaluation often serves to enhance openness of trainees to supervisor feedback (Lizzio & Wilson, 2004).

Separate Out Supervisory and Summative Evaluation Roles

The high perceived conflict between the normative supervision function of making the final determination of acceptable supervisee clinical practice, and the restorative and formative functions of supervision has led to three key suggestions on how to manage this tension. First, Proctor (2000) and Vacha-Haase *et al.* (2004) suggested that supervisors make clear at the beginning of supervision, the sorts of behaviours that they consider to be unethical or unprofessional and the steps that they would

Name of Supervisee: _____ Supervisor: _____

Date of Supervision: ____/____/____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about.

I-----I

We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The supervisor's approach is not a good fit for me.

I-----I

The supervisor's approach is a good fit for me.

Supervisory Alliance

I did not feel heard and understood.

I-----I

I felt heard and understood.

Overall

There was something missing in the session today.

I-----I

Overall, today's session was right for me.

Figure 1 Supervision Session Rating Scale.

This form is an adaptation of a therapy session rating form published in *Journal of Brief Therapy* by Duncan, Miller, Sparks, J. Reynolds, Brown, & Johnson (2003).

take if such behaviour occurred. This provides the supervisee with a clear understanding regarding the bounds of acceptable practice, which might reduce supervisee anxiety in relation to disclosing information that does *not* exceed these bounds.

Second, training institutions need to acknowledge explicitly the difficulties that field supervisors can experience in their normative function, and to ensure that appropriate frameworks are in place to support them in this function. For example, Bogo et al. (2007) recommend use of standardised evaluation tools, clear guidelines for dealing with students who are underperforming, and training in providing corrective feedback.

Third, and perhaps most importantly, we recommend the normative function should not be the sole responsibility of trainees' clinical supervisor. The need for assessment of supervisee competence independent of the supervisor is a well-established practice in assessing research competence. For example, the accreditation guidelines for postgraduate clinical psychology training programs in Australia mandate that, in the

examination of Master of Clinical Psychology, Professional Doctorate, and PhD research theses, final assessment of the adequacy of the research work must be conducted by at least two examiners other than the supervisor (Australian Psychology Accreditation Council, 2010). If these guidelines exist for the normative evaluation of research competencies to ensure standards and prevent conflict of interest for supervisors, why not have equivalent procedures for normative evaluation of clinical competencies?

There are numerous ways in which evaluation of trainee's clinical competence could be done independent of the supervisor. For example, the University of Queensland clinical psychology training programme incorporates a Multi-Station Assessment Test (MSAT) of clinical competence into evaluation of supervisees' clinical competence (Pachana, Sofranoff, Scott, & Helmes, 2011). MSATs are completed at the end of each of two supervised clinical training internships. The MSAT involves supervisees being presented sequentially with a set of clinical

scenarios. For each scenario, the student has to demonstrate key clinical skills and knowledge to different clinical staff. These procedures can be complemented by computer simulations of case work (Lambert & Meier, 1992) or a clinical viva based on supervised clinical work. A clinical viva could involve presentation of a clinical case series with outcome data to demonstrate capacity to produce client change, recordings of therapy session to demonstrate clinical competence, and self-reflection to demonstrate self-evaluation skills.

Much of the language of the body of supervision literature is framed in terms of preventing problems in practice and ensuring no notable deficits in supervisees' capabilities. Yet, much of our own experience in supervision has been a focus on encouraging and building on strengths. There is currently little in the literature which focuses on strengths-based supervision, and an increase in the discourse in this area would be useful. For example, future research could test what supervisory processes best enhance a supervisee's effective and accurate self-evaluation of professional behaviours and enable supervisees to accurately identify therapeutic strengths in their practice.

Conclusions

In summary, supervision is central to the process of training clinical psychologists, yet there is only limited evidence available on its effectiveness. The available research suggests that supervision of clinical psychologists might often compromise its normative function of protecting clients and determining supervisee competence to practise, to achieve its restorative and formative functions of supporting and educating supervisees. Enhancing the benefits of supervision can be achieved by increasing the use of systematic data collection, both to assess clinical outcomes for supervisees' clients and to assess trainee competencies through direct observation of supervisee therapy by supervisors. These data should be reviewed regularly in supervision and should be used to promote supervisee self-evaluation and supervisor-provided formative feedback. Positive supervisory processes should be promoted through supervisor training, use of supervisee feedback to guide supervisors, and external review of the supervisory processes. Finally, we suggest that the normative function of evaluating the competence of trainees should not be the exclusive province of supervisors, but rather systematic assessment by clinical psychologists other than the supervisor should be part of the basis on which supervisees are judged clinically competent to practise.

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