Clinical Supervision—The Missing Ingredient

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Abstract

Clinical supervision is acknowledged as a distinct professional competence that requires specific education and training. However, it is all too often an inadequately addressed or an entirely missing ingredient in psychology curricula and clinical research including, for example, clinical trial protocols and evidence-based treatment implementation. It is proposed that clinical supervision training follow the shift to the competence movement that has occurred in psychology education, training, and regulation generally, and embrace a systematic and intentional competence model. Groundwork for such a competence model for supervision has been laid in the supervision guidelines from the American Psychological Association (APA, 2014; 2015) and the Association of State and Provincial Psychology Boards (ASPPB, 2015) defining parameters for clinical supervision and the requisite supervisor competencies. This article discusses these inadequately addressed or missing ingredients, the insufficiently organized approach to supervision as a distinct competency at the present time, and the assumptions that are obstacles to progress. Strategies are proposed to overcome these obstacles; for example, methods of infusing supervision into existing curricula, the hidden curriculum, and transformational leadership that would guide its implementation. Knowledge, skills, and attitudes would be systematically developed as a critical component of self-reflective competency-based education, a portal to life-long learning, and an essential part of research and implementation.

Keywords: clinical supervision, supervision training, competency-based supervision, supervision, reflective supervision

Clinical Supervision: The Missing Ingredient

The competency-based approach to clinical supervision is representative of the shift generally to competence-based approaches to education, training, and regulation in psychology (Falender & Shafranske, 2004; Kaslow, 2004). Clinical supervision has been designated as a distinct professional competence requiring specific education and training since the 2002 American Psychological Association (APA) Competencies Conference (Falender et al., 2004; Kaslow et al., 2004) and by the National Council of Schools of Professional Psychology Mission Bay Conference (Bourg, Bent, McHolland, & Striker, 1989). It has been an accreditation requirement (APA Committee on Accreditation [CoA]) since 1996. While it has gained some momentum, clinical supervision generally remains a missing ingredient in training, research, and practice and its implementation has been uneven. Many clinical supervisors have not received formal training. Psychology doctoral candidates are receiving inconsistent levels of training during their health service psychology graduate trajectory (inclusive of clinical, school, and counseling). Supervisors do not consistently model essential components of supervision practice including ethical adherence (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Wall, 2009), multicultural competence (Furr & Brown-Rice, 2016; Kakavand, 2014; Ladany, 2014) and use of a supervision contract (Ellis et al., 2014). These omissions pose significant risk, foremost to the client, but also to the supervisee because of the failure to articulate and adhere to the requirements of the training sequence or standards of competent, ethical clinical supervision. Furthermore, clinical research generally, including that on evidence-based practice, neglects the role of clinical supervision. All of this is paradoxical in light of the fact that clinical supervisors provide the foundation of training towards competence and serve as evaluators and gatekeepers for the profession, ensuring that unsuitable, unqualified individuals do not enter (ASPPB, 2015).

Strategies are needed to enhance training, research, and practice to ensure a systematic and intentional approach to clinical supervision (Falender & Shafranske, 2017).

This article begins by describing the clinical supervision guidelines and accreditation standards and their historical context. Specific competencies distinct to supervision training, the current status of supervision training, and assumptions of many current supervisors are identified and discussed. Competencies and competency-based supervision are then detailed and distinguished from some common legacy practices. Emphasis is on the missing or insufficiently addressed ingredients, contrasting actual practice with the standards and guidelines. Finally, the article proposes strategies for change to address the missing ingredients and lack of a systematic approach. Proposed strategies include a transformational leadership approach aimed at enhancing training and practice in competency-based supervision and a culture shift to infuse clinical supervision into the graduate curriculum. Essential are methods of motivating supervisor leadership to instill a culture of competence and life-long learning in which faculty, supervisors, and supervisees alike approach supervision in a reflective, self-assessing, proactive, and strengths-based manner.

Accreditation and Guidelines Regarding Clinical Supervision

Clinical supervision has been long acknowledged for its influential role in graduate training. It is psychologists' third most frequent professional activity (outranked only by psychotherapy and assessment/diagnosis, [Norcross & Rogan, 2013]). It is responsible for about one-half of a professional psychologist's formal training (Bent, Schindler, and Dobbins, 1992), and credited as the most important influence on clinical practice (Orlinsky & Ronnestad, 2005). It is an activity most psychologists perform during their career (Ronnestad, Orlinsky, Parks, & Davis, 1997).

APA Accreditation requires training in supervision and considers it a profession-wide competency. The APA Committee on Accreditation Implementation Standards state:

> VIII. Supervision (This competency is required at the doctoral and internship level.) The CoA views supervision as grounded in science and integral to the activities of health service psychology. Supervision involves the mentoring and monitoring of trainees and others in the development of competence and skill in professional practice and the effective evaluation of those skills. Supervisors act as role models and maintain responsibility for the activities they oversee. Trainees are expected to:
>
> ***Doctoral students:*** Demonstrate knowledge of supervision models and practices.
>
> ***Interns:*** Apply this knowledge in direct or simulated practice with psychology trainees, or other health professionals. Examples of direct or simulated practice examples of supervision include, but are not limited to, role-played supervision with others, and peer supervision with other trainees. (APA, CoA, Implementing Regulations, n.d., C-8 D Profession-Wide Competencies).

In 2014, the APA Council approved *Guidelines for Clinical Supervision in Health Service Psychology* (APA, 2014, 2015). In 2015, the ASPPB adopted *Supervision Guidelines for Education and Training Leading to Licensure as a Health Service Psychologist* (ASPPB, 2015). Both are reflective of the infusion of competence into both the role of the supervisor and the planful development, training, and monitoring of the supervisee.

Competency-based clinical supervision provides the means to instill and monitor competence development. In the *Guidelines for Clinical Supervision in Health Service Psychology* (APA, 2014; 2015) competency-based supervision was defined as:

> a metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/cultural clinical setting (adapted from Falender & Shafranske, 2007). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision (APA, 2014, p. 5).

The APA guidelines defined seven domains: supervisor competence, diversity, supervisory relationship, professionalism, assessment/evaluation/feedback, problems of supervisee professional competence, and ethical, legal, and regulatory considerations (APA, 2014). Good quality supervision entails supervisor competence in developing and maintaining a collaborative and respectful supervisory relationship within the parameters of the power differential. It entails shared responsibility for competence enhancement, attending to and infusing focus on multicultural dimensions, intersections, and biases/predilections of client(s), supervisee, and supervisor, ensuring ongoing routine outcome and therapeutic alliance monitoring as well as general monitoring of interventions with the client, attending to emotional responses and reactivity as well as self-care of the supervisee, while modeling and ensuring professionalism and adherence to ethical, legal, and regulatory standards (APA, 2014; 2015).

Historical Context and Realities of Supervision

Supervision practice evolved from an apprenticeship model and psychotherapy theory. In part, this was based on the unexamined assumption that clinical knowledge and skills from psychotherapy models were directly transferable to supervision practice (Falender & Shafranske, 2004). The missing ingredient has been a systematic, intentional process that directly addresses

the factors that differentiate the practice of supervision from clinical practice and psychotherapy. A factor contributing to the lack of attention may be that the mean age of the active psychology workforce in 2016 was 50 (APA, 2016), and thus many supervisors completed graduate training prior to the shift to competencies. Recognition is required of the factors that distinguish clinical supervision from clinical practice including the power differential, evaluation, and systematic attention to the multiple clinical supervision competency areas (Falender & Shafranske, 2010).

An even more pessimistic view is that progress in supervisory training has not merely been slow, but has actually been reversed due to financial and time constraints. Hoge, Migdole, Cannata, and Powell (2014) bemoan the demise of supervision across mental health in the U.S., its diminishing presence in training and in work settings generally, driven by financial and time constraints. This perspective is supported by Norcross and Rogan's (2013) data: although supervision was still the third most frequent activity by psychologists, diminishing time is devoted to providing it. Hoge and colleagues argue that supervision provides an effective implementation science approach to support evidence-based treatments, enhance supervisory relationships, job performance, and professional development.

Faulty Assumptions Deterring Supervision Training

Until the past decade and into the current one, several prevailing assumptions have presented barriers to the acceptance of supervision as a distinct professional practice. The first faulty assumption is that clinical supervision is learned primarily through absorption or osmosis: the mere experience of having been supervised or supervising (Falender & Shafranske, 2004; Kaslow, 2014) regardless of whether there was a systemic, organized, or intentional framework, benchmarks, goals and evaluations. Osmosis is particularly apt because it refers to "the process of gradual or unconscious assimilation of ideas, knowledge, etc." (Oxford Living Dictionaries,

2018). Supervision experience was less a deliberate effort to instill and support designated competencies required by the profession, but more dependent on which clients and issues presented themselves for treatment during a supervisee's training. The significant limitations of the osmosis learning technique are highlighted by the important concept of metacompetence, or the difficult task of knowing what one knows and the even more difficult task of knowing what one does not know (Falender & Shafranske, 2007). Individuals who have not had formal training in supervision may not understand or appreciate the requisite competencies or their impact on clinical practice. Those who have only attended supervision workshops are significantly more inclined to disagree with the importance of such training (Rings, Genuchi, Hall, Angelo, & Cornish, 2009). Further, simply repeating performance without effective feedback and orientation does not necessarily lead to improved competence or outcomes (Goldberg et al., 2016). Enhanced supervision training will facilitate and systematize the natural process of osmosis to transmit effective supervision knowledge, skills, and attitudes to future generations.

The second faulty assumption is that most or all supervisors are competent. To the contrary, a high incidence of less than competent, inadequate, or harmful supervision has been reported in numerous studies (e.g., Ellis et al., 2014; Ellis, 2017; Ladany, 2014). Harmful supervision has been defined as "supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee" (Ellis et al., 2014, p. 7) while inadequate supervision refers to supervisors who are unable or unwilling to meet criteria for minimally adequate supervision: enhancing supervisee professional development, monitoring service quality, and serving as a gatekeeper to the profession (Ellis et al., 2014). Examples of harmful supervision include harm by the supervisor's actions or boundary violations. Examples of inadequate supervision include supervisees' perceptions that supervisors were oblivious to

cultural backgrounds, omitted evaluative feedback, or behaved unethically. Ellis and colleagues reported that over 90% of supervisees surveyed were currently receiving some inadequate supervision; and 35.3%, were receiving harmful supervision. In other surveys, 23 (Wall, 2009) to 50 percent (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999) of supervisees reported they believed their supervisors had engaged in unethical lapses. All of these studies indicate that the assumption of widespread competence is faulty, emphasizing the necessity for greater attention to ensure supervisors have adequate training for the responsibility entrusted to them.

Status of Training in Clinical Supervision

Clinical supervision is addressed generally in the clinical training trajectory, but when and how thoroughly it is addressed is variable. For example, in neuropsychology, over 84% of practicing neuropsychologists (the vast majority of whom were currently supervising) reported clinical supervision was discussed in graduate school only minimally or not at all (Schultz, Pedersen, Roper, & Rey-Casserly, 2014). In the U.S., surveys of supervision practice by training directors have not been conducted since 2000 when less than a third of training programs and internships included supervision training (Scott, Ingram, Vitanza, & Smith, 2000). In 2002, 39% of graduate students queried indicated their graduate program offered a course in clinical supervision, and most of those were in counseling, not clinical psychology. Forty-four percent of participants reported having supervised at least one student during their internship, but 51% of those had not taken a course in clinical supervision (Lyon, Heppler, Leavitt, & Fisher, 2008).

In Canada, 20 of the 28 accredited doctoral programs responded to a survey on supervision. Of those, seven offered no specific supervision training, six devoted less than 10 hours to clinical supervision, three offered 10 to 20 hours, while four devoted more than 20 hours to the topic. Only five of the 20 programs required supervised experience in clinical supervision,

and only four reviewed audio or video recordings of supervision (Hadjistavropoulos, Kehler, & Hadjistavropoulos, 2010).

Time constraints during the doctoral program, internship, postdoctoral year, and post-licensure present an issue for supervision training. Supervision training should not begin until the supervisee has achieved some clinical competence in keeping with the premise that little league baseball players should not coach in the major leagues (Stoltenberg & McNeil, 2010). Students should minimally be in their second or third practicum experience when they are trained in supervision. However, internship training directors ranked supervision training among the three *least* essential and one that they would urge APA to "throw overboard" (Stedman, Schoenfeld, & O'Donnell, 2013, p. 136). In a sample of Association of Psychology Postdoctoral and Internship Centers (APPIC) training directors and staff psychologists (perhaps a biased sample as 84% of those surveyed had personally completed a postdoctoral fellowship or worked at a site offering a postdoctoral fellowship), nearly half recommended both academic coursework and applied experience prior to doctoral internship and 75% recommended one or more applied clinical supervision experiences prior to or during doctoral internship. Ninety-nine percent endorsed some supervision training during the postdoctoral fellowship (Genuchi, Rings, Germek, & Erikson Cornish, 2014). However, only an estimated twenty percent of psychology doctoral graduates obtain formal postdoctoral training (Walton, 2014) and increasingly supervisees are seeking licensure post-internship. If supervision training is deferred to post-licensure, no formal vehicle exists beyond supervision workshops that are typically one or two-day sessions, highly variable in content, and lacking any assessment of impact on supervision practice. Gonsalvez and Calvert (2014) were likely correct when they observed that the size and magnitude of change brought to supervision by the competence era has taken many practitioners by surprise.

Competency-Based Clinical Supervision in Context

Competency-based clinical supervision has been described as the zeitgeist of contemporary supervision practice (Holloway, 2012). It provides an approach that identifies the knowledge, skills, and attitudes expected for supervisees at given stages of professional development in the competency domain(s) in which they are being supervised and assists supervisees in meeting competence standards (Falender & Shafranske, 2010). It is unique in its attention to the art of supervision, including emotional response, and personal factors.

Components of effective supervision in a competency-based, meta-theoretical frame include development of a supervisory relationship or alliance, a vehicle through which a trusting and collaborative process occurs that fosters reflective self-assessment. The supervision contract provides informed consent and provides supervisee role invocation by clarifying supervisee roles and responsibilities and supervisor contributions. Together the dyad collaboratively identifies areas of lesser competence including specific behaviorally-anchored competencies (e.g., Benchmarks), frames these as goals and tasks, and implements the learning cycle to engage in reflective practice through the lens of multicultural and diversity competence, anchored in the worldview of the client and considering perspectives of the supervisee-therapist and supervisor.

Attention in a competency-based, meta-theoretical frame is directed to identification and management of personal factors, emotional reactivity and use of the self. Personal factors refer to fundamental assumptions about one's self and others, ethical values, and the interface with influences of both professional training and the world. These include how one experiences and processes emotions that arise in clinical work, schemas to organize interpersonal relationships, and worldviews that inform beliefs, values, and assumptions. When the supervisee or supervisor identifies supervisee reactivity or countertransference, in supervision or through review of live or

video sessions, a planful approach to management is an essential supervisory competency. A reflective process, it involves collaborative identification of the marker, self-insight and differentiation, increasing empathy, anxiety management, and case conceptualization. If unaddressed, reactivity may result in empathic disengagement, turning inward towards one's personal experience, potentially emotionally withdrawing from the client (Falender & Shafranske, 2017).

In the evaluative realm, ongoing assessment of client outcomes is essential. Although described as the acid test of clinical supervision (Stein & Lambert, 1995), routine outcome monitoring, a system that tracks client improvements and issues off-track alerts as well, is often missing from supervision practice: only one-fourth of training sites surveyed currently used it (Overington, Fitzpatrick, Drapeau, & Hunsley, 2016). Clinicians are generally inaccurate in their assessments and believe almost all their clients are improving (85% in Walfish, McAlister, O'Donnell, and Lambert [2012]), making routine outcome monitoring essential. When therapists received feedback that their client was identified to be at risk based on client outcome data, those clients' outcomes were improved over those whose therapists did not receive such feedback (Boswell, Kraus, Miller & Lambert, 2015). Client outcome data can be collected weekly and used in supervision with therapeutic alliance monitoring to inform planning, conceptualization, and supervisee interventions (e.g., Lambert & Hawkins, 2007).

Additional components of the competency-based approach include systematic and ongoing feedback to the supervisee anchored to goals, assessment, and evaluation, attention to legal, ethical, and regulatory standards, ethical problem solving, professionalism, and self-care. A systematic, intentional approach to these components in supervision comprises competency-based supervision (Falender & Shafranske, 2012).

Supervisors are called upon to formally evaluate and attest to each supervisee's demonstration of competence to enter the profession of psychology (i.e., board of psychology verification of experience). A consequence of failure to engage in direct observation with live or video review of supervisee clinical work places strict reliance on supervisee self-report, a process subject to metacompetence and omissions (e.g., perceived errors, personal reactions to client or supervisor, or strains in the supervisory or therapy relationship [Knox, 2015]) that impact client care with a likely outcome that errors, empathic disengagements, and supervisee reactivity go unaddressed. More accurate assessment of competence should occur due to the direct observation requirements by the CoA (C-14.D. n.d.), and the use of a competency-based model.

Competence: Knowledge, Skills, and Attitudes in Supervision Training

The competency-based initiative has brought organization and discipline to the process of training. It affords the opportunity to identify, monitor, enhance, and evaluate competencies as a supervisee progresses through training toward the goal of independent practice with demonstrable competence. The movement intended to shift focus to emphasis on learning outcomes and attention to instilling lifelong learning beyond initial competence (Nelson, 2007). This initiative has been described as "a shift to a culture that emphasizes acquisition and maintenance of competence as a primary objective and a shift to a culture that promotes assessment of that competence at all levels over time …and a call for valid assessment of competence" (Roberts, Borden, Christiansen, & Lopez, 2005, p. 356). Supervisors are at the forefront of the process because of their roles as evaluators and gatekeepers. Supervisors engage in ongoing assessment, monitoring, evaluation and feedback, but with the added purpose of ensuring supervisees are aware of their competence development and are planfully accruing greater competence. Implicit in the competence movement is supervisee self-assessment and

identification of competencies. Although significant supervisor competence is necessary to fulfill these designated roles, ironically, supervision has been generally missing from the discussion. Supervision guides supervisees from reflection-on-action to reflection-in-action. Supervisors guide supervisees towards self-reflective practices, attending to personal responses, self-questioning, attending to beliefs and biases, all influencing the clinical process. Competence is not an end point but an entry into reflective practice.

Thematic analyses of international supervision competency frameworks have displayed marked consistency (e.g., Olds & Hawkins, 2014). Direct support has been provided for the validity of the Benchmarks competence framework for the practicum supervisee development progression (Price, Callahan, & Cox, 2017; Gonsalvez et al., 2016) and the usefulness of competence frameworks in training (Grus, Falender, Fouad, & Lavelle, 2016). Use of competency frameworks is essential to competency-based education (Hatcher et al., 2013). Competency-based supervision is the means to implement competency-based education (Falender & Shafranske, 2007), in order to monitor the acquisition of competence. Both increased specificity of behavioral anchors (e.g., pediatrics, Piazza-Waggoner, Karazsia, Hommel, & Modi, 2015) and a safe supervisory relationship that fosters an attitude of openness to external assessment and feedback (Eva & Regehr, 2008) appear to provide means to increase supervisee reflective practice.

Other Clinical Supervision Models

Among the other models of clinical supervision are psychotherapy-based approaches, including evidence-based supervision, a cognitive-behavioral approach supplemented by experiential rehearsals and role-play practices (Milne & Reiser, 2017), cognitive, psychodynamic, and family therapy (e.g., Beck, Sarnat, & Barenstein, 2008), and developmental

models (Stoltenberg & McNeil, 2010). Such models alone may not direct systematic attention to development and monitoring of the supervisee by omitting supervisory relationship, multicultural diversity of client(s), supervisee/therapist, and supervisor; emotional response of the therapist (e.g., reactivity and countertransference); ethical and legal principles and standards, and self-care.

Clinical Supervision in Implementation Research

Clinical supervision has also been a neglected, missing part of evidence-based treatment implementation (Bearman, Schneiderman, & Zoloth, 2017). Although supervision may be a key to prevent implementation drift, or loss of fidelity to evidence-based treatment models in community settings (Bearman et al., 2013), clinical supervision in evidence-based treatments is often limited, overshadowed by administrative supervision (Bearman et al., 2017; Hoge, Migdole, Cannata, & Powell, 2014). When supervision occurs it may be described as mentoring, teaching, coaching, consultation, and is primarily focused on enhancing fidelity. All of this leads to confusion about supervisor responsibility, evaluation, and liability. Further, use of video review or live observation, essential components of model implementation monitoring, was relatively rare (Accurso, Taylor, & Garland, 2011).

Clinical supervision has been missing as the subject of clinical trials (Schoenwald, Mehta, Frazier, & Shernoff, 2013), and is often not described in clinical trial protocols (Roth, Pilling, & Turner, 2010). When studies of clinical supervision efficacy are conducted, they typically do not assess the training or competence of the clinical supervisors. Watkins (2012) concluded that although the (experiential) validity of supervisor training is strong, a significant challenge is confronting the imbalance between clinical experience and empirical validity.

Strategies to Infuse Competency-based Supervision

A Culture Shift

To be successful, the transformation of clinical supervision in the graduate school curriculum and into the training armamentarium must be infused in all aspects of vision, planning, curriculum, and general competence. The first step is creating a vision of life-long learning and competency-based clinical supervision infused in all aspects of training (Kaslow, Falender, & Grus, 2012). Transformational leadership provides a means to implement a culture change to competency-based supervision. The result of a transformational culture shift would be the development of momentum towards creation of a context that values a competency-based supervision approach. In contrast to transactional leaders who ensure given goals and targets are met, transformational leaders develop a vision: in this instance, a change to competency-based clinical supervision. This entails a process that is collegial, respectful, and collaborative, emphasizing both supervisee and supervisor self-reflection and self-assessment. Implicit in the approach is enhancing motivation to change with a goal of nurturing innovation, creativity, and growth through a vision of empowerment. Building on strong relationships with other supervisors and shared goals, the leader develops a small working group to create a charismatic vision that enhances growth and development for supervisees and supervisors alike (Kaslow et al., 2012).

Motivating Supervisor Involvement

A preliminary step is motivating training staff and supervisors to move towards a stance of life-long learning and strategic planning of ongoing goals for maintenance of competence—modeled by faculty and promoted in all aspects of clinical training. Self-assessment inaccuracy and inattention to the half-life of knowledge (and competence) have not been adequately recognized in training even though they have long been identified as ethical imperatives and

essential for psychologists engaged in graduate training, (Wise et al., 2010). Estimated current half-lives of specialties and proficiencies are variable. Examples are a half-life of 5.43 years for clinical neuropsychology and 10.43 for counseling psychology (Neimeyer, Taylor, & Rozensky, 2012). A goal is for faculty and supervisors alike to prioritize the lack of durability of knowledge and reinforce competence assessment, maintenance, and enhancement to monitor and increase competence (Wise et al., 2010). Further, clinical supervision may be a protective factor against emotional exhaustion, a precursor of burnout (Knudsen, Roman, & Abraham. 2013).

Another step towards achieving change is supervisors using their own self-assessment (Falender et al., 2016), sharing it with colleagues, and modeling both the process of self-assessment and goal setting. The small working group may identify "bright spots" (Heath & Heath, 2010, p. 27), areas in which supervisors and programs are demonstrating competency-based practices. Highlighting and honoring these will reinforce motivation for supervision practice change.

Addressing supervisor competence is essential. Conducting annual supervision workshops for all supervisors leads to changes in attitudes towards supervision and competence in supervision components. Essential components include introduction to goal and task setting in a competency frame, the supervision contract, training in direct observation and goal-targeted feedback, reflective practice, managing supervisor countertransference, routine outcome monitoring and its use in supervision, and identifying supervisee and supervisor ethical infractions through vignettes including multiple relationships, boundaries, informed consent, competence, and confidentiality. Such workshops should reference the APA supervision guidelines (APA, 2014, 2015) and use experiential exercises. For beginning supervisors, group supervision-of-supervision, conducted by an experienced, formally trained supervisor, ideally

once a week for at least a term is extremely valuable, with video review of client-supervisee and/or supervisee-supervisor videos and feedback. Group supervision-of-supervision could be supplemented with casebook readings on supervision (e.g., *Casebook for Clinical Supervision*, [Falender & Shafranske, 2008]; *Multiculturalism and Diversity in Clinical Supervision* [Falender, Shafranske, & Falicov, 2014]) and application to current supervision.

Infusion into Curriculum and Practice and the Hidden Curriculum

A challenge is to achieve increased competence in clinical supervision without adding additional courses to graduate programs. A first step is infusion into the existing coursework and educational structure. The Benchmarks competencies are relatively new (Fouad et al., 2009), so it is important to ensure that faculty and supervisors are fully aware of these and of their relevance, validity, and functions for training, clinical supervision, and monitoring of competence development. Ideally faculty should become very familiar with Benchmarks and use vignettes of supervisees to learn to convert more general or judgmental comments into specific competencies which are goals to attain (e.g., "rigid" into the goal of being "intellectually curious and flexible," Reflective practice/self-assessment, A. Willingness to consider one's own material; basic mindfulness and self-awareness [Fouad et al., 2009, p. S10.]). Group practice activities increase inter-rater reliability among faculty and supervisors. Next, supervisees will be assigned to self-assess using Benchmarks prior to beginning each training rotation, identifying particular foundational (e.g., professionalism; reflective practice, self-assessment, self-care; relationships; individual and cultural diversity; ethical legal standards and policies) and functional (e.g., assessment, intervention) competencies using measurable behavioral indicators (Fouad et al., 2009), or a setting-specific competencies document to provide the platform to identify goals and tasks for training. Ideally the supervisee's self-assessment is integrated into

the supervisory relationship formation from the onset of the supervision experience, providing a structure for supervisors and supervisees alike to track and monitor clinical progress and provide direct feedback. Supervisees identify preliminary goals from Benchmarks including those in development and collaborate with supervisors to develop tasks, one for the supervisee and the other for the supervisor. These are incorporated into the supervision contract, transforming it to a living supervision contract (Falender & Shafranske, 2017), with goals and tasks added as previous ones are achieved or as supervisee or supervisor perceive other goals to be more salient.

Supervision training can be integrated into practicum classes. Assigning beginning supervisees chapters from a text such as *Getting the Most Out of Clinical Supervision: A Guide for Practicum Students and Interns* (Falender & Shafranske, 2012) and discussing them in the context of their practicum experience will introduce students to the formal practice of clinical supervision, its components, and how to be most effective in the role of supervisee. They also will learn the expected parameters of supervision and what they should reasonably expect from the process. These include a formal process of role invocation or adopting the role of a supervisee, and clarifying expectations and processes in supervision. Elaboration of the proactive role for supervisees sets the tone for the importance of contributions of both supervisor and supervisee in the supervision process. Introduction to supervision contracts (ASPPB, 2015; Falender & Shafranske, 2017) provides clarity regarding the performance and general expectations for supervision. This includes an acknowledgement that the highest duty of the supervisor is protecting the client and that the contract is a translation or codification of the supervisory relationship into practice. It elaborates the role of the supervisor to maintain focus on client presenting problems and diagnoses, treatment protocols, and practice elements while enhancing and monitoring the development and practice of the supervisee.

During the second or third practicum course, in conjunction with targeted readings on supervision (e.g., *Casebook for Clinical Supervision: A Competency-based Approach*, [Falender & Shafranske, 2008]), strategic topics are identified for role-play. Using the components of competency-based supervision, supervisees are encouraged to identify pivotal interactions in supervision and role-play them with peers. Generally supervisees identify topics from their own personal experience: multiculturalism and worldviews, relationship strains, legal issues and ethical challenges, among others. Through role-play and role reversals (switching roles from supervisor to supervisee), and reflective comments from others, enhanced understanding of the competency-based supervision model and problem-solving is achieved.

It is extremely useful to the process of change to provide a supervision workshop for external supervisors from the practicum settings. The workshop addresses the components and structure of clinical supervision. Focus is on competency-based supervision, Benchmarks, and the didactic progression the students are receiving in their practicum sections to ensure continuity from university to placement. Learning can be enhanced and the material become much more accessible through the use of experiential activities, role-plays, and ethical problem solving.

Besides infusion into existing courses, the hidden curriculum is powerful. The hidden curriculum refers to how supervisors model essential elements of the competency-based approach through their behavior. For example, supervisors model professionalism through their comportment, demeanor, and generally respectful behavior as well as through acknowledging errors or misunderstandings and addressing them directly. They model specific factors through their own supervisor self-assessment, using and adhering to the supervision contract, approaching ethical dilemmas that arise in clinical practice or supervision through reflective

ethical problem-solving, modeling attention to and incorporation of multicultural perspectives of the client, supervisee-therapist, and supervisor, disclosing some aspects of personal perspective with respect to clients (e.g., reflecting on generational differences in perceptions between supervisor and supervisee) and generally modeling supervision practice conforming to and specifically noting supervision guidelines. Supervisors also model respect by reflecting on supervisee input and perspectives, acknowledging both their contributions and the importance of multiple frames of reference.

Dedicated Courses in Clinical Supervision

If it is possible to add dedicated courses to the curriculum, a proposed sequence of clinical supervision training could be accomplished through two or three academic courses (Falender, Ellis, and Burnes, 2013). One course, at the onset of clinical training would prepare the supervisee to be effective in that role, introducing the knowledge, skills, and attitudes of being a supervisee, laying groundwork of specific tenets of supervision structure, expectations, theory, current research, skills, and processes (Falender & Shafranske, 2012) including experiential learning and assisting the supervisee to be an active participant in the process. Techniques include client-therapist, therapist-supervisor role-plays with shifting role reversals, modeling, critical problem solving, and an interactive reflective process.

The second course would address the transition of supervisee to supervisor, and would require that the supervisee had completed a minimum of two to three practicum experiences. At that time, the supervisee would learn the perspective and role shifts of being a supervisor, including a significant cognitive shift and the requisite competencies associated with it. These include familiarity with the *Guidelines for Clinical Supervision in Health Service Psychology*, (APA, 2014), self-assessment of those competencies (Falender et al., 2016), and routine client

outcome monitoring as a supervision tool. In addition to the didactics, the students could conduct peer consultation with less advanced cohorts and role-play supervision with peers using topics related to supervisor competencies under the guidance and reflection of an experienced supervisor. For example, role-plays could focus on issues of shared cultural identities between client and therapist/supervisee, ethical dilemmas, relationship strains, or any supervision issues the group has experienced or heard about. After conducting role plays, the group processes their reactions, responses, and how they frame the process in terms of the supervision guidelines and competency-based framework.

In the third course, supervisees would receive supervision-of-supervision, supervising a less-experienced counselor or therapist under supervision of an experienced supervisor with supplemental reading and reflection. This experience would include systematic review of supervision session videos, and therapeutic alliance and client outcome measurement to direct intervention. Supervision-of-supervision would occur in individual or group format, and academic credit would be given to ensure it is a formal course, reflected on the supervisees' transcript. Summative assessment of competence of supervisor-in-training would be obtained by review either of clinical session recordings in supervision or *in vivo* observation and rating.

Next Steps

Optimism is warranted in that both the American Psychological Association and the Association for State and Provincial Psychology Boards have issued guidelines for clinical supervision. In addition, supervision is a topical area in the development of items for the EPPP2 (ASPPB, 2017). These significant developments support the practice of supervision and in the case of ASPPB, provide impetus to regulatory bodies and thus to training programs to require that supervisors have had explicit training in clinical supervision.

Clinical supervision needs to be promoted from its role as an often-missing ingredient to an essential one. It should be transformed into the basis for an attitude of life-long learning acknowledging that competence is not an end point, but instead merely the foundation and entry point into professional development that will continue throughout one's career. Infusing supervision didactics and training throughout the curriculum, eliciting and receiving feedback and deliberative practice, and monitoring and enhancing client improvement all lay that foundation for the continuing development of expertise (Tracey, Wampold, Lichtenberg, & Goodyear, 2014). Models for supervisor competence training and assessment as a life-long process come from Australia (Psychology Board of Australia, 2013), U.K. (Roth & Pilling, n.d.), and New Zealand (New Zealand Psychologists Board, 2013). For example, to become an accredited supervisor in Australia, clinical psychologists must have a minimum of three years professional experience and complete a supervisor-training program that includes review and assessment via a videoed supervision session of key supervision knowledge and competencies. Further, psychologists are required to update supervision skills every five years.

The competence movement has been adopted in the United States and internationally, with competency-based supervision as the vehicle for implementation (Gonsalvez & Calvert, 2014). A competency-based training paradigm (1) consistently provides clarity, specificity, and competence criteria (with behavioral indicators) for both supervisor and supervisee; (2) includes knowledge, skills, and attitudes that comprise specific competencies to assist the supervisor-supervisee in self-assessment and ongoing assessment and feedback to enhance metacompetence; (3) lays the groundwork for identification of supervision (and training) goals and tasks for supervisees based on the supervisee's self-assessment to be collaboratively monitored and amended when achieved; (4) provides for a durable supervisory relationship in which

collaboration can occur within the power differential that has been discussed with transparency of feedback promised; (5) provides a safe environment for the supervisee and supervisor to frame multicultural aspects of each in the context of the client; (6) provides an environment to collaboratively identify and manage reactivity to particular clients or triggers, identify deviations in practice and different emotional/affective responses; (7) identifies strains and ruptures in relationship, and provides a process for repairs; (8) provides competency-based ongoing clear feedback assessment, and evaluation, addressing strengths, and those in development using competence-based behavioral anchors with clarity about areas not achieving competence; (9) models life-long learning by identifying areas in the supervisor's developing competence; (10) ensures the supervisee is aware of the supervisor's highest duty to protect the client(s) and the public; (11) ensures the supervisee's awareness of the supervisor's role as gatekeeper ensuring that unsuitable individuals do not enter the profession.

As Watkins stated, "The press of and push toward competency-based, evidence-based, accountable supervision and training would…be the most readily evident, highly substantive change that would have occurred and that continues to occur in psychotherapy education" (Watkins, 2012, p. 288). I also concur with Milne and colleagues (2013) call to action: "It is time to move supervision towards its rightful place as a science-informed specialization within professional practice" (p. 218). We must take the next steps to provide the requisite training, competence tracking, accountability, and empirical support that are due to the clients, the profession, and the supervisees. It can no longer be the missing ingredient.

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