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PREFACE

Since the publication of the first edition of this book, we have seen remarkable advances in the development and understanding of supervision as a distinct professional practice. These advances have been reflected in the establishment of guidelines for the practice of clinical supervision (American Psychological Association [APA], 2015c) and the promulgation of local and international requirements and standards for education and training. More than 6,000 articles and books have been published on supervision since 2004, demonstrating a sixfold increase over the previous period.¹ The literature has expanded in both quantity and quality, and examines models and approaches to supervision, the impacts of relationship and alliance on its effectiveness, and the integral role of multicultural awareness and practice as well as many other features. The second edition of *Clinical Supervision: A Competency-Based Approach* builds on the contributions of many scholars, practitioners, and researchers in the field (many of whom we are honored to know as colleagues). We are indebted to them for their efforts to establish the theoretical and empirical bases for competency-based clinical supervision.

We invite you, when reading this book, to ask yourself a number of questions:

- How does this principle or research finding apply to my practice of supervision?
- How do the conclusions of experts reflect what I have experienced (or missed) as a supervisor or supervisee?

¹This analysis was based on a comparison of publications listed in PsycInfo using the keywords “clinical supervision” or “supervision.”

- Through what lens are my supervisees viewing my clinical supervision in light of their training?
- How can I apply the ideas and recommendations presented to improve the supervision I provide?

Although this book contributes to integration of the professional and theoretical literature in a competency frame, the primary aim is to advance the *practice* of clinical supervision. This book provides a specific approach to clinical supervision that one can use in multiple settings and with all clinical specializations and services. We contend that a *systematic* and *intentional* application of our competency-based approach will foster the development of competencies in clinical supervision that anchor and structure effective supervision. Beyond the technical features and practice recommendations, we suggest that clinical supervision is first and foremost a relational experience that is established and sustained by respect, an appreciation for individual diversity and culture, and a commitment to bettering the human community. Our values should never be obscured by theories or techniques; rather, they should inform our work throughout supervision. Similarly, clinical supervision is not simply about teaching skills; it is about inspiring, and, from its root, it is about bringing to life for the supervisee the values and commitments that animate and guide our professional lives.

We take this opportunity to express our deepest appreciation to Susan Reynolds, who has provided unquestioned support of our work over many years and many books. She is a consummate professional and much more: gracious, firm, understanding, and encouraging. Her contributions to APA Books and therefore to the profession of psychology are many. We have been honored to work with Susan. We also wish to thank Gary VandenBos, founding publisher, and Jasper Simons, chief publishing officer, for their leadership and support; APA Books consultant Ted Baroody; and all of the staff at APA Books. We wish to acknowledge those who have permitted the publication of their resources in the book; Laurel Vincenty, who assisted with the final editing; and Matthew Kloeris, a doctoral candidate who served as our lead research assistant. And once again, we acknowledge the contributions of supervisors, educators, and researchers who are advancing competency-based clinical supervision.

1

The Practice of Clinical Supervision

Clinical supervision is a distinct professional activity that serves as the cornerstone of professional training in psychology (Falender & Shafranske, 2004, 2014a). It is considered a “signature pedagogy” (Shulman, 2005) and, as such, provides the means by which supervisees are prepared for three critical dimensions of clinical work: “to *think*, to *perform*, and to *act with integrity*” (p. 53, italics in original). Through the provision of a supportive relationship, supervisors orient and socialize graduate students, interns, and postdoctoral fellows into psychology as a profession (Falender & Shafranske, 2012b; Grus & Kaslow, 2014). This preparation for practice is accomplished, in part, by establishing expectations and standards, building clinical competence, encouraging the development of professional identity, and, equally important, “shaping the character of future practice and in symbolizing the values and hopes” (Shulman, 2005, p. 53) of the profession. This responsibility is a tall order by anyone’s standards.

Intrinsic to this responsibility is supervisor commitment to adherence to the highest ethical principles of beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people’s rights and dignity. Within the hierarchical nature of the supervisory relationship, the collaborative function is an essential component. It provides compassionate understanding of the valence of power and safety as a function of multicultural identities, historical experience, and trauma. Clinical supervision, as integral to the professional development of health service psychologists, is not at all

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removed from the society it serves. It reflects society and amplifies the values, attitudes, and ethical principles of psychology as a profession. We now turn to the practice of clinical supervision.

Clinical supervision occupies a central place in the training trajectory (Barnett, 2014; Falender & Shafranske, 2014a; W. B. Johnson & Kaslow, 2014), and it appears to be instrumental in developing clinical competence and in promoting clinical outcomes (Gonsalvez & Milne, 2010), although the evidence of the latter is controvertible (Callahan & Watkins, 2018; Watkins, 2011a). For more than a decade, supervision has been acknowledged consensually to be a distinct professional practice (Falender et al., 2004; Falender & Shafranske, 2014b; Kaslow, 2004); however, only recently has it been recognized as a profession-wide competency (American Psychological Association [APA], 2018a; Falender, 2018; Hess, 2011) and have formal guidelines been adopted (APA, 2014a, 2015b; Association of State and Provincial Psychology Boards, 2015). It is a complex process involving multiple roles, functions, and obligations, and it bears responsibilities not only to the supervisee but also to the clients who are receiving psychological services under supervision, to the public, to the profession, and to the associated training institutions (Falender & Shafranske, 2004, 2017a). These multiple responsibilities point to its significance as a professional practice and highlight the challenges and role conflicts that supervisors face.

CLINICAL SUPERVISION: RESPONSIBILITIES AND FUNCTIONS

As just mentioned, clinical supervision involves responsibilities to a number of individuals, constituencies, and institutions. At first glance, one might expect that commitments to client welfare and clinical training, for example, would fit smoothly, like a hand in a glove, but there are situations in which conflicts may ensue. Supervisors need to be aware of their multiple responsibilities to ensure ethical practice.

Many supervisees (and some supervisors) assume that the primary responsibility of the supervisor is to the supervisee; however, the first and foremost ethical obligation is to the client. The clinical services provided to clients must be delivered professionally, taking into consideration evidence-based practice as well as the clinical competencies of the supervisor and the supervisee. Supervisors must carefully assess their clinical competence as a preparation to provide oversight in addition to an evaluation of the supervisee's competence to perform the clinical services under their supervision.

Supervisors also have responsibilities to protect the public and to uphold the standards of the profession. Health service psychology¹ enjoys certain privileges of rank and standing as a profession (Shulman, 2005), including

¹The term *health service psychology* reflects the newly adopted nomenclature and refers to applied practice in the areas of clinical psychology, counseling psychology, and school psychology. It is reflected in accreditation standards (APA, 2018b). We use *health service psychology* interchangeably with the commonly used term *professional psychology*.

self-definition and, to a great extent, autonomy in self-regulation. Similar to medicine, this societal contract demands accountability, among other obligations (Cruess & Cruess, 2004), including “the commitment to serve responsibly, selflessly, and wisely” (Gardner & Shulman, 2005, p. 14). It also establishes the profession’s responsibilities for education and training, and requires oversight and gatekeeping to assure the qualifications of psychologists. These responsibilities are closely aligned and inform the process of supervision and its obligations.

Following the commitments to society and the profession, we come to the responsibilities of the supervisor to the supervisee. Supervision facilitates the development of clinical and professional competence, which eventually enables supervisees to obtain their credentials to practice as psychologists and to establish their professional identity and membership in the profession (Falender & Shafranske, 2012b; Milne & Watkins, 2014). In the course of training, supervisees often grow as individuals (e.g., gaining insight, deepening self-awareness); however, the primary aim of supervision is the promotion of clinical competence. Although personal growth intertwines with professional development, the responsibilities to the client require the supervision to focus on the client and development of clinical competence, which is in service to the client’s care. Supervision requires competence, commitment, and use of best practices of the supervisor (which are set out in guidelines [APA, 2014a, 2015b] and described in this text). The training objective is not in conflict with the aforementioned responsibilities to clients, the public, the profession, and its institutions; however, it is essential to remember that these obligations should be the priorities that inform supervisory decision making and practice. All of the supervisor’s efforts (which include support, understanding, engagement, challenge, and guidance within an empathic relationship) assist the supervisee in enhancing competence and contribute to meeting these multiple obligations.

In our view (Shafranske & Falender, 2016), clinical supervision fulfills its responsibilities through the following interrelated functions:

1. ensuring the quality of care and welfare of clients through safe and effective assessment and treatment, in keeping with evidence-based practice;
2. facilitating supervisees’ clinical competence, professionalism, and professional identity; and
3. safeguarding the public and the profession through oversight of all professional services provided by supervisees, including application of law and ethics, conducting performance evaluations, providing feedback, directing learning, monitoring improvement and establishing remediation plans (as needed), and serving as a gatekeeper. (pp. 175–176)

CLINICAL SUPERVISION: AN OVERVIEW

Definitions serve as a useful starting point to introduce the relationships, functions, and processes that make up supervision as well as to identify significant periods in the development of supervision as a distinct professional

practice. Among the many definitions from which to choose, we have selected three for discussion:

- J. M. Bernard and Goodyear's (1992) definition, which has been widely adopted within the field;
- Falender and Shafranske's (2004) definition, which was presented in the first edition of this book and reflected a turning toward an explicit competency-based approach to supervision; and
- the definition that was developed by the Board of Educational Affairs Task Force on Supervision Guidelines (BEA Task Force) and was adopted by APA (2014a) in 2014.

These definitions, similar to other definitions, present areas of overlap as well as illustrate points of difference and emphasis (see Milne, 2009, for a comprehensive review of definitions and a proposed evidence-based definition). Each definition informs supervision practice and marks important developments in the theory and practice of supervision.

J. M. Bernard and Goodyear proposed the following definition of *supervision* in 1992 with only slight changes contained in the present version (J. M. Bernard & Goodyear, 2019):

Supervision is an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship

- is evaluative and hierarchical,
- extends over time, and
- has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (p. 9)

In 2004, Falender and Shafranske defined *supervision* to be

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

Whereas J. M. Bernard and Goodyear (2019) framed supervision to be an intervention, Falender and Shafranske (2004) saw it as a distinct professional activity and emphasized the collaborative and interpersonal aspects of the supervisory relationship, a perspective later reflected in APA's (2014a) definition.

The BEA Task Force APA (2014a) included the following definition in its report:

Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. (p. 2)

This definition, drawn from scholarship in the field, provides the foundation for the practice of clinical supervision. Consistent with other definitions, evaluation is a prominent component and demarcates supervision from other learning and development activities, such as consultation and mentoring. Moreover, responsibilities to clients and the public are described in terms of monitoring and gatekeeping. Recognition of the responsibilities to the public and profession are relatively new in the history of supervision theory and practice, and reflect more recent emphasis on accountability within the professions. Attention to the aims of supervision, as articulated in the definition, as well as implementation of the associated guidelines to achieve these objectives requires a values-based commitment to the highest standards of the profession as well as developing knowledge and skill in the conduct of supervision.

Before we turn to the *Guidelines for Clinical Supervision in Health Service Psychology* (hereinafter, *Supervision Guidelines*; APA, 2014a, 2015b) and approaches to the conduct of supervision, we wish to clarify the differences between supervision and other professional activities, which often play a role in the supervisee's professional development, such as consultation, peer consultation, mentoring, or psychotherapy.

Consultation plays an important role in health service psychology, particularly, for example, in medical settings in which interprofessional practice is essential to patient care (Cubic, 2020). During clinical training, supervisees receive as well as provide consultation (under supervision). Consultation is a distinct professional activity involving a *consultant*, who is an expert or possesses particular competence in the area to be discussed, and a *consultee*, who has a particular work issue, question, or problem (Falender & Shafranske, 2020). For our purposes, the important points to consider are the supervisee's understanding of the relationship of the consultant to the client and the supervisee's use of the information and recommendations that are provided. The consultant does not serve as the consultee's supervisor, and although they provide expert opinion regarding a specific case, consultants have limited knowledge of the case and, therefore, are not in a position to provide clinical oversight. They also do not have the legal responsibility for the case; that obligation is held by the supervisor of record. Information or recommendations provided to the consultee/supervisee by the consultant (no matter how authoritative) should not be acted on without the supervisor's prior approval. This can be confusing to supervisees, particularly if they were directed to

obtain the consultation by their supervisor. Therefore, it is advised that the supervisor (and the consultant) remind the consultee/supervisee that the supervisor has the responsibility for the case and that any clinical decisions require the involvement of the supervisor.

Peer consultation, which is sometimes mislabeled “peer supervision,” is an educational activity in which nonlicensed peers, usually more advanced doctoral students, provide consultation to more junior peers. Although it may appear that the primary objective is to assist the peer consultees (or students) in their clinical work and development, often the benefit is to the peer consultant, who is given the opportunity to practice quasisupervisory skills under supervision. Advice or direction given by a peer consultant should first be brought to the supervisor for decisions regarding implementation. Peer consultants may not serve as supervisors nor make clinical decisions; these activities are the supervisor’s responsibility. Supervisors should provide supervision and oversight to peer consultants as well as clarify the nature of the peer consultant’s role and authority with the peer consultants and their peer consultees to avoid confusion and role conflicts.

Mentoring has been defined as

a personal relationship in which a more experienced faculty member [or supervisor] acts as a guide, role model, teacher, and sponsor of a less experienced graduate student [supervisee, intern, or postdoctoral fellow]. A mentor provides the protégé with knowledge, advice, challenge, counsel, and support of the protégé’s pursuit of becoming a full member of a particular profession. (adapted from W. B. Johnson & Huwe, 2003, p. 6)

A supervisor cannot relegate their role of supervisor; however, supervisors may provide mentoring functions (as just described). Giving direction and providing evaluative feedback as a mentor are inherently different from those tasks when performed as a supervisor (in which directions must be followed, and evaluations have consequences). A supervisor who provides career advice can be helpful; however, providing this form of guidance does involve a blurring of roles, and a conflict may ensue. Both parties need to be mindful of the distinct roles and obligations when the supervisor engages in mentoring as distinct from clinical supervision (e.g., the supervisee is not required to follow the supervisor’s career advice); open discussion is useful to avoid any misunderstanding.

Although it is hard to imagine that a supervisor would provide psychological treatment to a supervisee, it does happen. *To be clear: to provide psychotherapy or any other form of psychological treatment to a supervisee is, in our opinion, an ethical violation.* For example, a supervisee becomes overwhelmed in supervision when discussing a client’s recent sexual assault. Although it is appropriate to intervene with empathy and to assist in down-regulation to proceed with supervision, it would be unacceptable for the supervisor to engage the supervisee to construct a personal trauma narrative or to implement a therapeutic procedure, such as trauma-focused cognitive behavior therapy (CBT). What is likely more common are instances in which a supervisor engages in the

inappropriate exploration of a supervisee's personal life (i.e., when such inquiry is not directly related to the treatment of the client). For example, asking questions about a supervisee's family, personal relationships, or trauma history to obtain general background information (when starting supervision with a new supervisee) would be a violation of the professional ethics (see Standard 7.04, Student Disclosure of Personal Information, in APA's, 2017a, *Ethical Principles of Psychologists and Code of Conduct*; see also Chapters 6 and 7, this volume). Exploration of supervisee reactivity is a legitimate supervisory activity because poor management of countertransference affects the therapeutic process and may compromise the alliance with the client (see Chapter 6). However, engaging in a therapeutic process with a supervisee for the sole purpose of the supervisee's health is unacceptable, no matter the desire or impact on the supervisee. We turn now to guidelines that inform the practice of clinical supervision.

GUIDELINES FOR THE PRACTICE OF CLINICAL SUPERVISION

In addition to providing a definition of supervision, the BEA Task Force developed guidelines to ensure implementation of best practices in the conduct of clinical supervision. The *Supervision Guidelines* (APA, 2014a, 2015b) were predicated on the following assumptions, which are embedded throughout this text, that clinical supervision

- is a distinct professional competency that requires formal education and training;
- prioritizes the care of the client/patient and the protection of the public;
- focuses on the acquisition of competence by and the professional development of the supervisee;
- requires supervisor competence in the foundational and functional competency domains being supervised;
- is anchored in the current evidence base related to supervision and the competencies being supervised;
- occurs within a respectful and collaborative supervisory relationship, that includes facilitative and evaluative components and which is established, maintained, and repaired as necessary;
- entails responsibilities on the part of the supervisor and supervisee;
- intentionally infuses and integrates the dimensions of diversity in all aspects of professional practice;
- is influenced by both professional and personal factors including values, attitudes, beliefs, and interpersonal biases;
- is conducted in adherence to ethical and legal standards;
- uses a developmental and strength-based approach;
- requires reflective practice and self-assessment by the supervisor and supervisee;
- incorporates bi-directional feedback between the supervisor and supervisee;

- includes evaluation of the acquisition of expected competencies by the supervisee;
- serves a gatekeeping function for the profession; and
- is distinct from consultation, personal psychotherapy, and mentoring. (p. 35)

The *Supervision Guidelines* (APA, 2014a, 2015b) set the stage for effective supervisory practice. Exhibit 1.1 presents the *Supervision Guidelines* by domain. We do not repeat the background discussion presented in the report (APA, 2014a) and publication (APA, 2015b). However, we recommend studying these documents and offer a brief discussion as we continue our introduction to supervision.

EXHIBIT 1.1

Guidelines for Supervision in Health Service Psychology

Domain A: Supervisor Competence

Guideline 1: Supervisors strive to be competent in the psychological services provided to clients/patients by supervisees under their supervision and when supervising in areas in which they are less familiar they take reasonable steps to ensure the competence of their work and to protect others from harm.

Guideline 2: Supervisors seek to attain and maintain competence in the practice of supervision through formal education and training.

Guideline 3: Supervisors endeavor to coordinate with other professionals responsible for the supervisee's education and training to ensure communication and coordination of goals and expectations.

Guideline 4: Supervisors strive for diversity competence across populations and settings (as defined in APA [American Psychological Association], 2003).

Guideline 5: Supervisors using technology in supervision (including distance supervision), or when supervising care that incorporates technology, strive to be competent regarding its use.

Domain B: Diversity

Guideline 1: Supervisors strive to develop and maintain self-awareness regarding their diversity competence, which includes attitudes, knowledge, and skills.

Guideline 2: Supervisors planfully strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of their supervisees.

Guideline 3: Supervisors recognize the value of and pursue ongoing training in diversity competence as part of their professional development and lifelong learning.

Guideline 4: Supervisors aim to be knowledgeable about the effects of bias, prejudice, and stereotyping. When possible, supervisors model client/patient advocacy and model promoting change in organizations and communities in the best interest of their clients/patients.

Guideline 5: Supervisors aspire to be familiar with the scholarly literature concerning diversity competence in supervision and training. Supervisors strive to be familiar with promising practices for navigating conflicts among personal and professional values in the interest of protecting the public.

EXHIBIT 1.1**Guidelines for Supervision in Health Service Psychology (Continued)****Domain C: Supervisory Relationship**

Guideline 1: Supervisors value and seek to create and maintain a collaborative relationship that promotes the supervisees' competence.

Guideline 2: Supervisors seek to specify the responsibilities and expectations of both parties in the supervisory relationship. Supervisors identify expected program competencies and performance standards, and assist the supervisee to formulate individual learning goals.

Guideline 3: Supervisors aspire to review regularly the progress of the supervisee and the effectiveness of the supervisory relationship and address issues that arise.

Domain D: Professionalism

Guideline 1: Supervisors strive to model professionalism in their own comportment and interactions with others, and teach knowledge, skills, and attitudes associated with professionalism.

Guideline 2: Supervisors are encouraged to provide ongoing formative and summative evaluation of supervisees' progress toward meeting expectations for professionalism appropriate for each level of education and training.

Domain E: Assessment/Evaluation/Feedback

Guideline 1: Ideally, assessment, evaluation, and feedback occur within a collaborative supervisory relationship. Supervisors promote openness and transparency in feedback and assessment, by anchoring such in the competency development of the supervisee.

Guideline 2: A major supervisory responsibility is monitoring and providing feedback on supervisee performance. Live observation or review of recorded sessions is the preferred procedure.

Guideline 3: Supervisors aspire to provide feedback that is direct, clear, and timely, behaviorally anchored, responsive to supervisees' reactions, and mindful of the impact on the supervisory relationship.

Guideline 4: Supervisors recognize the value of and support supervisee skill in self-assessment of competence and incorporate supervisee self-assessment into the evaluation process.

Guideline 5: Supervisors seek feedback from their supervisees and others about the quality of the supervision they offer, and incorporate that feedback to improve their supervisory competence.

Domain F: Professional Competence Problems

Guideline 1: Supervisors understand and adhere both to the supervisory contract and to program, institutional, and legal policies and procedures related to performance evaluations. Supervisors strive to address performance problems directly.

Guideline 2: Supervisors strive to identify potential performance problems promptly, communicate these to the supervisee, and take steps to address these in a timely manner allowing for opportunities to effect change.

Guideline 3: Supervisors are competent in developing and implementing plans to remediate performance problems.

Guideline 4: Supervisors are mindful of their role as gatekeeper and take appropriate and ethical action in response to supervisee performance problems.

(continues)

EXHIBIT 1.1**Guidelines for Supervision in Health Service Psychology (Continued)****Domain G: Ethics, Legal, and Regulatory Considerations**

Guideline 1: Supervisors model ethical practice and decision making and conduct themselves in accord with the APA ethical guidelines, guidelines of any other applicable professional organizations, and relevant federal, state, provincial, and other jurisdictional laws and regulations.

Guideline 2: Supervisors uphold their primary ethical and legal obligation to protect the welfare of the client/patient.

Guideline 3: Supervisors serve as gatekeepers to the profession. Gatekeeping entails assessing supervisees' suitability to enter and remain in the field.

Guideline 4: Supervisors provide clear information about the expectations for and parameters of supervision to supervisees preferably in the form of a written supervisory contract.

Guideline 5: Supervisors maintain accurate and timely documentation of supervisee performance related to expectations for competency and professional development.

Note. Adapted from "Guidelines for Clinical Supervision in Health Service Psychology," by American Psychological Association, 2015, *American Psychologist*, 70(1), pp. 35–41 (<https://doi.org/10.1037/a0038112>). Copyright 2015 by the American Psychological Association.

Domain A: Supervisor Competence

As set forth in the *Supervision Guidelines* (APA, 2014a, 2015b), supervisors must attain a number of competencies to be prepared to offer supervision. The recommendations for supervisor competence are not new in the literature (see, e.g., the 2004 consensus statement of supervision competencies, Falender et al., 2004); however, the specifications established in the *Supervision Guidelines* demark an important step because such expectations were not assumed or required before. Although supervisors are expected to be competent in the practice areas in which they supervise and to have knowledge of clinical supervision (APA, 2018b), clinical supervision as a functional area of competency has not been universally achieved. It is critical to not only attain knowledge but also to develop skills in the practice clinical supervision (Rodolfa & Schaffer, 2019).

Watkins (2011b) reminded that, for too long, the predominant view was, in part, that when a clinician finished training as a psychologist, they were assumed to be ready to begin supervising. Furthermore, it was assumed "that supervisors learn by doing and can simply use their therapy skills and supervisee experience to provide this service" (S. M. Whitman et al., 2001, p. 160, cited in Watkins, 2011b, p. 64). Although the recognition of the requirement of supervisors to attain competence in supervision is an advance, we agree with Watkins (2011b) that "still the actual training of supervisors across mental health disciplines is an ideal not yet achieved" (p. 64). Many supervisors have only cursory familiarity with the supervision literature,

and even fewer have received specific supervised training in supervision. Even though the recently adopted APA accreditation standards requiring demonstration of competence in supervision as a profession-wide competence (APA, 2018b, p. 9) give some structural or institutional support, much more is necessary to ensure that supervisors are adequately prepared to provide supervision. Without required training (which parallels the degree of training required in other professional competencies), competence in supervision will remain an aspiration.

Domain B: Diversity

Consistent with APA's (2017a) ethical principles (Principle E: Respect for People's Rights and Dignity) and guidelines with respect to multicultural competence (APA, 2017b), supervisors must strive to enhance self-awareness and diversity competence, including knowledge of the means to enhance diversity competence in supervision. This domain is critically important. We (Falender, Shafranske, & Falicov, 2014) wrote the following with Celia Falicov:

As psychologists, we are called to become aware of individual differences and to engage in a process of discovering and entering into the "cultural labyrinth in which clients present their lived experience" (Tsoi Hoshmand, 2001, p. 106). We do so because at its heart, psychology respects the dignity and worth of all people (APA, 2010) and values the multiverse of individual and cultural factors that shape a person's worldview. Developing multicultural competence ensures that all clients will be respected and their unique cultural identities will find a fitting place in clinical understanding. (p. 3)

Clinical supervision provides the "lived-world" environment to learn how to integrate an appreciation of multicultural identities into the therapeutic process (see Chapter 4). We cannot overstate the importance of infusing a multicultural lens throughout the process of supervision. Individual diversity and contextual factors affect the supervisee and supervisor as well as the client. The appreciation of the role of culture includes both individual and systemic expressions (e.g., racism) as well as the development of an understanding of the impact of personal bias on working with diverse populations. These factors shape attitudes and behaviors concerning clinical understanding, therapeutic and supervisory relationships, responsibility and professionalism, and commitments to justice and inclusion—in sum, each dimension and function of clinical supervision.

Domain C: Supervisory Relationship

The research literature consistently points to the importance of the supervisory relationship and alliance in the effectiveness of supervision (see Chapter 5). Without the development of a working alliance, which rests to some degree on the quality of the supervisory relationship, the responsibilities and the

possibilities of supervision cannot be fulfilled or attained. As conveyed in the *Supervision Guidelines* (APA, 2014a, 2015b), attention to the relationship goes beyond positive, friendly, interpersonal engagement; rather, collaboration builds on clearly established responsibilities and expectations, identification of competencies and learning goals, and attention to the supervision process and relationship. Consistent with alliance theory (Bordin, 1983; Hatcher & Barends, 2006), the identification of supervision goals and the means to achieve the goals (i.e., responsibilities and expectations) promotes collaborative purposeful work and leads to the emotional bond, which is a marker of an effective working alliance.

Domain D: Professionalism and Domain G: Ethics, Legal, and Regulatory Considerations

We began this book by emphasizing psychology as a profession and the role of supervision to train supervisees to “act with integrity.” These were not intended to be just words; rather, they are a call—a call to professionalism and to ethical practice that abides by legal and regulatory obligations. Beyond the development of technical competence, clinical supervision provides the context for learning how to be a professional, which requires knowledge and application of law and ethics (see Chapter 7). The *Supervision Guidelines* (APA, 2014a, 2015b) operationalize the requirements to fulfill this mandate. We join with the BEA Task Force in emphasizing the importance of modeling. We suggest that the supervisee’s observation of their supervisor’s behavior, including compliance with legal statutes and regulations, and, that of the clinic staff powerfully transmits professionalism and what it means to “act with integrity.” This “hidden curriculum” (Hafferty, 1998), which includes implicit norms, values, belief systems, attitudes, skills, desires, and behavioral and social expectations (Andarvazh, Afshar, & Yazdani, 2017; Yazdani, Andarvazh, & Afshar, 2020), influences and inculcates professionalism and legal and ethical standards.

Domain E: Assessment/Evaluation/Feedback and Domain F: Professional Competence Problems

The *Supervision Guidelines* (APA, 2014a, 2015b) presented recommendations directed to the interrelated processes of assessment, evaluation, and feedback as well as to the commitment to address professional competence problems. The recommendations are consistent and, to a great extent, draw on the competency-based approach to clinical supervision presented in this book (see the Competency-Based Clinical Supervision section later in this chapter; see also Chapters 2, 3, and 8). Supervisors are responsible for providing feedback, evaluation, and gatekeeping (as needed); it is critical to view these functions as integral to training and to the supervisee’s professional development (in addition to our obligations discussed previously).

SUPERVISION APPROACHES

Definitions and guidelines articulate general purposes, responsibilities, and processes, but they do not specify the means by which desired outcomes will be obtained. Different approaches or models of supervision have been developed that are based on principles believed to be salient to the process and effectiveness of supervision and the development of clinical competence. Each approach provides a specific theoretical orientation to supervision and orients supervisory practices to the explicit approach to learning. Our intent is not to provide a comprehensive survey (J. M. Bernard & Goodyear, 2019); rather, we present four general categories of supervision approach to provide a context for and contrast to our competency-based approach to clinical supervision.

Clinical supervision can be clustered into four major approaches (Gonsalvez & Calvert, 2014; Shafranske & Falender, 2016): (a) *developmental approaches* that propose a specific and common trajectory in professional development and tailor supervision expectations and practices accordingly; (b) *process-based approaches*, such as the systems approach to supervision (Holloway, 1995, 2014) and the discrimination model (J. M. Bernard, 1997; J. M. Bernard & Goodyear, 2019) that elucidate the unique roles within the dyad that inform supervisory processes; (c) *psychotherapy-based approaches* that are aligned with specific forms of psychotherapy, such as CBT and psychodynamic psychotherapy; and (d) the *competency-based approach*, which incorporates principles of competency- or outcome-based education and training and focuses on the systematic development of clinical competence. Additional models of supervision exist that are grounded in a specific approach, such as feminist supervision or alliance-focused supervision, are not clearly aligned within one of the major clusters.

Developmental Supervision Approaches

Developmental approaches, such as the conceptual model of Loganbill et al. (1982), have a long history and are intuitively appealing because it is assumed that competencies develop over time from novice to expert (compared with “one-shot” learning or knowledge and skill acquisition; see Stoltenberg, 2008, for further discussion). Additionally, the developmental status of both supervisor and supervisee, and their interactions based on their developmental levels are considered. The integrative developmental model (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 2010) explicitly presents stages and characteristics of supervisees, and highlights the need for supervisors to better understand and finely tune their interventions on the basis of developmental level. In our view, developmental models are useful to attuning supervisors to the differing stage-dependent needs of the supervisee (Gonsalvez & Calvert, 2014); however, assumptions of competence (based on level of experience or training) do not supplant careful assessment of competencies. Deane et al. (2018) demonstrated that developmental trajectories can be systematically studied using time-anchored assessments of competencies.

Social Role or Process-Based Supervision Approaches

Models, such as Holloway's (2016) systems approach, focus on the roles, tasks, relationships, and interactions that contribute to the supervisory process. These atheoretical approaches focus attention on specific activities and the interactions between the members of the supervisory triad (i.e., client, supervisee, and supervisor). The discrimination model (J. M. Bernard, 1997) similarly provides a map to identify changeable roles in supervision and to analyze the interpersonal activities and processes. Supervisors are better able, then, to direct inquiry and focus evaluation and feedback with a degree of specificity and direct awareness to the impact of their supervisory interventions. In addition, attention can be directed to the roles and power being engaged in the supervisory process.

Psychotherapy-Based Approaches

Clinical supervision approaches derived from explicit clinical theories (e.g., psychodynamic theory, Frawley-O'Dea & Sarnat, 2001; Sarnat, 2016; CBT, C. F. Newman & Kaplan, 2016) incorporate the assumptions, theoretical principles, technical practices, and relational roles of client and therapist, and provide close alignment between the theory and structure of change in psychotherapy and learning in supervision. For example, CBT supervision usually applies the structure used to organize a therapy session to supervision. In psychodynamic supervision, theoretical models involving transference, countertransference, and parallel process are used; free association and dreams are examined; and focus is often placed on the supervisee's countertransference. Given the emphasis that is placed on the supervisee's personal reactions, psychodynamic supervisors need to be particularly careful to maintain a clear boundary between supervision and psychotherapy (referred to as the *teach–treat controversy*; Sarnat, 1992), including inquiries or interventions that are therapeutic in intent or effect (Watkins, 2013a).

Psychotherapy-based approaches to supervision likely enhance the supervisee's understanding of the theoretical and technical features of the therapy model and foster internal consistency. However, "a caveat must be issued—the learning paradigms embodied in clinical theory, while offering a consistent heuristic, are limited and are not sufficient to address the complexity of supervisory processes" (Shafranske & Falender, 2016, p. 177). They are inherently limited because the goals, processes, and responsibilities in supervision are quite different than those in psychotherapy (Falender & Shafranske, 2010).

Competency-Based Supervision Models

Gonsalvez and Calvert (2014) aptly noted:

Competency-based models of supervision constitute a fourth and new category, and owe their roots to pedagogical advances in education and training. In a

somewhat overly simplistic sense, competency models centre around the careful and systematic formulation of competencies (or learning outcomes) for specific situations, supervision contexts, and, on a larger scale, for scope of practice and discipline. (p. 202)

Competency-based clinical supervision, which is the subject of this book, is closely aligned with efforts to establish evidence-based supervision practices (Milne, 2009, 2014) and directs attention specifically to the competencies of the supervisor as clinician and supervisor, and infuses the competencies model throughout the process of supervision.

A COMPETENCY-BASED APPROACH TO CLINICAL TRAINING AND SUPERVISION

All approaches to supervision are intended to support the supervisee's professional development. A competency-based approach (Falender & Shafranske, 2004, 2007, 2017a, 2017b), however, provides an explicit framework and method to orient, develop, evaluate, and enhance the clinical competencies that are required for professional practice as a psychologist (Fouad & Grus, 2014). Rather than focusing on the *input*—that is, what was provided in the course of education, training, or supervision (e.g., number of staff or trainings)—emphasis is placed on *output*, which, from the perspective of competence, refers to the demonstration of competence based on a site-specific criterion-referenced standard. Gonsalvez and Calvert (2014) commented:

A key feature of the competency models is that competence is judged on output-determined indicators rather than by measures of input. For many decades, training and supervision in psychology have focused primarily on input criteria. . . . If competence is the desired outcome and standard, trainees should be required to demonstrate a range of competencies to an acceptable standard. (p. 203)

We would argue that competence is certainly (or should be) the desired outcome and standard. Reorientation to the demonstration of competence is the logical outcome on which clinical training and supervision should be based. Among other benefits, anchoring professional development to competencies enhances learning throughout the system (i.e., education, training, and supervision) by aligning learning goals, curriculum, training, evaluation, and outcomes, and it improves accountability at each point of contact (Falender & Shafranske, 2007; Kaslow, 2004).

Such an approach, consistent with the decades-long implementation of competency-based education (W. B. Johnson & Kaslow, 2014; Rubin et al., 2007), places emphasis on the ability to apply knowledge and skills, conjoined with professional attitudes, in the real world and uses performance outcomes as criteria for evaluating both learners and training programs (U.S. Department of Education, National Center for Education Statistics, 2002; A. B. Voorhees, 2001; R. A. Voorhees, 2001). Competence is the centerpiece of this approach. But what do we mean by “competence”?

DEFINITION OF COMPETENCE

Competence may be understood—drawing on its 14th-century French roots—“to fall together, to coincide” (Oxford University Press, 2006)—as being in a state of sufficiency in a given context or with respect to a particular requirement (Falender & Shafranske, 2007). Within the professions, *competence* refers to both capability and demonstrated ability to understand and to perform certain tasks in an appropriate and effective manner consistently akin to Shulman’s (2005) earlier noted dimensions of work: “to *think*, to *perform*, and to *act with integrity*” (p. 53). The demonstration of those capacities represents a standard, and the assessment of competence at that point in time might be considered an end point (Kaslow, 2004). However, competence can never truly be an end point because the unique clinical needs of clients and the ongoing expansion of knowledge continuously challenge the static view of competence conveyed by the term “end point.”

Drawing from medicine, competence has also been defined as the “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (R. M. Epstein & Hundert, 2002, p. 226). This definition has been widely adopted, and its appeal may stem from its inclusion of human qualities and values. It also features an approach that locates competence in the individual rather than tethers competence to a specific technical capability. Or, perhaps, the definition is effective in conveying the subjective experience of the practitioner. We also appreciate this definition. However, when assessing competence, we find it important to focus on the specific, discrete competencies that have been demonstrated and attained. We view competence in the context of a discrete criterion-referenced standard.

COMPETENCY-BASED CLINICAL SUPERVISION

Psychology has entered a competency and implementation science era in which accountability plays a major role. Similar to medicine and other health care professions, it is no longer sufficient in health service psychology to assume that competence is routinely attained through the accumulation of academic and training experiences. Professional practice and training are situated in a “culture of competence” (Roberts et al., 2005, p. 356) that requires the demonstration of specific competencies that are used in health service psychology (Falender & Shafranske, 2012b). The principle and practices on which competency-based clinical supervision is conducted are clearly aligned with the broad objectives of competency-based education and the competencies movement. The approach is not only aligned, but it provides an orientation and a method to develop, evaluate, and verify clinical competence (or, rather, discrete clinical competencies).

We turn now to our definition and provide an overview of the approach. We (Falender & Shafranske, 2007) defined *competency-based clinical supervision* to be

a metatheoretical approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and requirements of the local clinical setting. (p. 233; note: The qualifier *metatheoretical* was added in subsequent publications.)

Our definition was developed in response to what Watkins (2012a) referred to as “the press of and push toward competency-based, evidence-based, accountable supervision and training” (p. 199). The model aims to enhance the quality and effectiveness of supervision by providing a systematic and comprehensive approach to both assess and develop clinical competencies in the supervisee and to enhance supervision competencies in the supervisor. The model infuses “competence” in the performance of the interrelated functions of education and training, observation, evaluation, feedback, and gatekeeping. The model is unique in its deliberative focus on the knowledge, skills, and attitudes that are assembled to form the specific competency. The approach is metatheoretical or atheoretical and can be applied across all competencies and areas of clinical training (e.g., psychotherapy, neuropsychology, behavioral health, school). It is equally well suited for application with a variety of psychotherapy orientations (Gonsalvez & Calvert, 2014), such as CBT supervision. Competency-based clinical supervision orients the supervisor and supervisee to the task of developing professional competence by providing structures and processes designed to achieve training objectives.

Competencies and Benchmarks

The application of the competency-based model begins with identifying specific competencies and the essential knowledge, skills, and attitudes that are assembled in each of the competencies. A competency—for example, diagnostic interviewing—requires particular knowledge (i.e., knowledge of psychiatric disorders, criteria, and approaches to differential diagnosis, decision making, and so on); skills (i.e., ability to establish rapport, conduct the diagnostic interview, synthesize observations, self-reports, history, and so on); and attitudes (i.e., respect and valuing of the client as a person, and respect for science, professional responsibility, and so on). Each of these constituents (knowledge, skills, and attitudes) contributes to the performance of the competency.

The challenge of identifying all of the competencies and their constituents that are used in health service psychology has been greatly reduced by the creation of competency benchmarks. As experts in their respective fields, teams of psychologists have produced benchmarks that identify both the essential areas of competence and components that contribute. The

Competency Benchmarks for Professional Psychology (hereafter and throughout, *Competency Benchmarks*; Fouad et al., 2009) identifies the essential components and behavioral indicators for three key levels of professional development: readiness for practicum, readiness for internship, and readiness for entry to practice. The *Competency Benchmarks* is an exemplar and illustrates the immense value and utility in furnishing a document that can readily be used in clinical training and supervision. Its specification of developmental levels (based on competency-standards) is useful to the evaluation of a supervisee's competence and to provide meaningful feedback. Benchmarks are now available for a number of clinical specializations. The use of these resources can be of assistance in developing criterion-referenced tools used to establish training objectives and to perform evaluation. Such benchmark documents complement the profession-wide competencies identified in the *Standards of Accreditation* set forth by APA (2018b) and by other authoritative bodies (see also, e.g., *Accreditation Standards for Psychology Programs*; Australian Psychology Accreditation Council, 2019).

Criterion-Referenced Competencies

We strongly advocate for the use of “criterion-referenced” standards, by which we mean to competencies that have been consensually agreed on by our profession, such as the *Competency Benchmarks* (Fouad et al., 2009; Hatcher, Fouad, Campbell, et al., 2013), and are tailored to the requirements of the local setting. The identification of the constituents of a competency through disassembly of the competence into definable and potentially measurable units (i.e., specific knowledge, skills and attitudes/values) helps the supervisor and supervisee tailor methods of evaluation and training to the competency (Falender & Shafranske, 2004). Such articulation allows for greater clarity in formulating training objectives and can lead to more precise observations and targeted feedback supporting supervisee development. Furthermore, such an approach to competence informs every aspect of clinical training—from the contents of the training rotation recruitment materials, criteria that are used in trainee selection, method of evaluation, nature of feedback, competence-based learning processes, and so forth. In addition, clear articulation of the competencies under training provides coherence in training and encourages transparency in supervision and training expectations. Gonsalvez and Calvert (2014) further discussed the use of criterion-referenced benchmarks or standards:

In terms of assessment, competency approaches deliberately advocate a shift from a relative and normative standard to a criterion-based anchor of competence. In other words, it is recommended that the performance of trainees and professionals be evaluated against a predetermined standard (e.g., professional conduct and practice that will be deemed adequate, acceptable, and effective) rather than merely be ranked in comparison with other trainees (Falender & Shafranske, 2004; Gonsalvez et al., 2013). (p. 203)

Furthermore, efforts to identify criterion-referenced standards lead to the development of measurement approaches used in goal setting, evaluation, and feedback. Rather than providing very general evaluative comments, competency-based tools provide precise feedback. Feedback that specifies areas of strength or areas for improvement anchored in specific knowledge, skills, and attitudes encourages growth and development attuned to clinical competence.

End-Point Competencies

Gonsalvez and Calvert (2014) also proposed an important innovation when designing competency-based training, supervision, and evaluation. They suggested that we “start with the end in mind”—that is, the focus should be on the end-point competencies. They wrote:

In contrast to the conventional axiom that “the beginning is a good place to start,” a hallmark of competency models is the critical emphasis that, for purposes of planning effective programmes—be they curriculum design, or programme planning for internship or supervision—one must begin with the end in mind. In this regard, competency approaches are akin to objectives-based approaches to course or subject design (Newble & Canon, 1995), but applied more systematically and on a grander scale across courses and across the developmental trajectory of the professional’s career. The framework of end-point competencies outlined for a profession becomes central to and guides all aspects at every stage of training. In a similar but more circumscribed manner, the set of discrete competencies carefully formulated for a placement is expected to determine supervision content, tasks and activities, methods, nature of assessment tasks, process and evaluation. (p. 202)

Competency-based clinical supervision also assists supervisors and supervisees in the development of *metacompetence*, which is “the ability to assess what one knows and what one doesn’t know—[it] holds a pivotal position in the development of competence and is required to address the complex responsibilities involved in maintaining competence throughout one’s career” (Falender & Shafranske, 2007, p. 232). Competency benchmarks or criterion-referenced standards alert the supervisor and supervisee to areas of competence or knowledge, skills, and attitudes of which they are unaware.

VALUES AND COMMITMENTS IN COMPETENCY-BASED CLINICAL SUPERVISION

The implementation of competency-based clinical supervision is not only based on knowledge or skills but, consistent with the model, also requires attitudes and values. The principles that are enumerated in the American Psychological Association’s (2017a) *Ethical Principles of Psychologists and Code of Conduct* provide a foundation for psychology practice (see Chapter 7), and considerations of diversity, inclusion, equality, and commitment to

antidiscriminatory and antiracist relationships inform competency-based clinical supervision. We turn briefly to the attitudes and values implicit in the application of the model.

First, we suggest that competency-based clinical supervision is not “supervision as usual” (akin to “treatment as usual”). The approach requires both commitment and effort to implement, but we suggest it offers benefits that supervision as usual may not. Its focus on competence as well as the strategies to attain competence as a supervisor and to facilitate the competence of supervisees ensure client welfare and the protection of the public, profession, and educational and training institutions. Values such as professionalism, commitment to client welfare, respect for supervisees, responsibility, and dedication to quality training and supervision for the benefit of future generations of psychologists inform the implementation of the approach.

CLINICAL SUPERVISION: CONTEXT

The practice of clinical supervision is in the midst of a transformation—a transformation that is a long time coming. The practice of supervision is transitioning from an era in which supervision was conducted in a highly individualistic, if not idiosyncratic, manner, that was based on the erroneous assumption that competence in supervision could be attained through osmosis (i.e., by simply having received supervision during clinical training; Falender & Shafranske, 2004). However, over the past 25 years, scholarship has increased, supervision models have been developed, and greater attention has been focused on the relationship and processes of supervision (J. M. Bernard, 2006); efforts to formalize practice based on competencies were initiated; and supervision was recognized as a distinct competence and required in psychology training (APA, 1996). These developments led to optimism about the future (Watkins, 2012a). However, it appears that the transformation to science-informed, competence-based professional practice in clinical supervision has not been realized. Indeed, supervision is the one competency (required by accreditation standards) in which the graduate does not have to demonstrate competence (Rodolfa & Schaffer, 2019). Put another way, “acceptance has been variable, with scholarly opinion outpacing actual practice” (Falender & Shafranske, 2017b, p. 87). Similarly, in medicine, although it appears that a paradigm shift has been achieved (particularly in medical school curricula), the promise of ensuring competent graduates has not been achieved (Touchie & ten Cate, 2016). Falender (2018) concluded:

Although 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 . . . and use of a supervision

contract. . . . 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. (p. 1240)

The intent of this book is to inspire and to provide the tools to enhance competence in clinical supervision and, in so doing, to advance the competence of supervisees and future psychologists (and other mental health practitioners) for the good of clients and the public at large.

STRUCTURE OF THE BOOK

So far, we have furnished an introduction to clinical supervision generally and aimed to provide an orientation to competency-based clinical supervision. Our intent is not to provide a broad survey of supervision approaches in this work; rather, we are providing a comprehensive and practical guide to the implementation of competency-based clinical supervision. This book aims to be comprehensive, cohesive, and practice oriented. The chapters describe clinical supervision processes from the perspective of clinical and supervisory competence, and research findings and theory are framed in terms of their salience for the development of competence and competency-based clinical supervision.

In Chapter 2, we discuss “best practices” as well as the regrettable evidence that many supervisees are receiving either inadequate or harmful supervision. Our aim is not to mount criticism but, rather, to highlight solutions and opportunities for competent and extraordinary supervision. In Chapter 3, we present a systematic approach to the implementation of competency-based clinical supervision and draw on best practices. The chapter provides step-by-step coverage of supervision practices that are designed to ensure competent, if not outstanding, supervision and to facilitate clinical competence in supervisees. In Chapters 4 through 8, we then turn to the critically important topics of diversity and multicultural competence; alliance in supervisory relationships, including the repair of ruptures; personal factors and reactivity in supervision, and how to address them; law and ethics; and evaluation, feedback, and ways to address professional competence problems. In Chapter 9, we cast an eye toward the future of clinical supervision and toward opportunities and challenges.

To close on a personal note, we hope that you derive a measure of inspiration as well as a wealth of information as you read this book. We are reminded of Plutarch’s musings about education—“The mind is not a vessel to be filled but a fire to be kindled”²—so, we hope our discussion lights a fire when you provide clinical supervision.

²The quotation is an adaptation of “For the mind does not require filling like a bottle, but rather, like wood, it only requires kindling to create in it an impulse to think independently and an ardent desire for the truth” (Plutarch, 1965).