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Supervisors' Perspectives: Variables Influencing the Quality of Supervision

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Supervisors' Perspectives: Variables Influencing the Quality of Supervision

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Graduate College of
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In partial fulfillment of the
requirements for
the degree of
Doctor of Psychology
In Clinical Psychology

by
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“...nothing left to do but smile, smile, smile...”

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ABSTRACT

Supervisors' Perspectives: Variables Influencing the Quality of Supervision

By Terra L. Rose

A number of studies have sought to examine clinical supervision from the perspective of the supervisee; however, fewer studies have investigated the practice of supervision from the supervisor's perspective. Using a survey approach, supervisors at all levels of expertise reported their experiences surrounding the applied and administrative aspects of supervision. Data examined training in supervision, typical supervision activities with supervisees, the value placed on supervision at work settings, and how administrative influences impact supervisory practice. Results indicated that supervisory practices were not consistent with empirically identified "best practices" of clinical supervision, with supervisors reporting not being provided the time, resources, or fiscal compensation required to provide optimal supervision. Implications surrounding the future practice of supervision with regard to ethics, training, and organizational administration are discussed.

CHAPTER ONE

Introduction

Clinical supervision is a component of virtually every clinical and counseling psychologist's training experience and is a vital component of their careers (Romans, Boswell, Carlozzi, & Ferguson, 1995). It is not merely a process that occurs during the training phase of the profession; on the contrary, it is likely to make up a significant proportion of practitioners' post-graduation responsibilities. In the case of practicing psychologists, supervision is continually listed in the top five most frequent activities; members of the American Psychological Association's (APA) Division on Psychotherapy rank supervision second in a list of most frequent activities (Borders & Leddick, 1988; Norcross, Prochaska, & Farber, 1993).

This study explores the current practices of supervision from the perspective of the supervisor. Significant research has been conducted examining supervision from the perspective of the supervisee, but fewer studies have examined the experience from the supervisor's perspective (Heckman-Stone, 2003; Nelson, 1976; Sobell, Manor, Sobell, & Dum, 2008; Tromski-Klingshirn & Davis, 2007; Wilcoxon & Magnuson, 2002; Worthen & McNeill, 1996). Additionally, studies that center their attention on supervisor based reporting tends to be outdated by research standards, and the majority of research exploring the supervisors' report was conducted a decade or more ago (Borders & Leddick, 1983; Hess & Hess, 1983; Johnson & Stewart, 2000; McCarthy, Kulakowski, & Kenfield, 1994; Tyler, Sloan, & King, 2000). These studies generally explore analogous topics to the ones inquired about in this study. Methods of supervision, administrative influence on the practice of supervision, professional responsibilities of the supervisor, and training opportunities in clinical supervision are all topics covered in these earlier articles. The time that has passed since these topics were last studied suggests a need for

investigation, given a renewed emphasis in the field on the importance of clinical supervision and on the training of clinical supervisors (Borders, 2005; Borders, Bernard, Dye, Fong, Henderson, & Nance, 2001; Magnuson, Norem, & Wilcoxon 2002). The continual development of new roles and settings for professional practice, coupled with the ever changing and challenging health care environment underscore the importance of revisiting the practice of clinical supervision from the supervisors' perspective.

CHAPTER TWO

Literature Review

Functions of Clinical Supervision

Although there is no universally accepted description of the goals associated with clinical supervision, three specific functions are often mentioned. One key function is to ensure the ethical principle of nonmaleficence on behalf of the client, which simply means “above all, do no harm” (Kitchener, 1984, p. 47). Supervisors are responsible for guarding against potentially harmful care while also contributing to the client’s well being (Bernard & Goodyear, 2004). The second vital function of supervision is teaching and mentoring supervisees. Supervision fosters an environment wherein trainees are able to practice techniques they have learned as they develop their personal repertoire. The teaching aspect complements academic and research training, develops new skills, and creates competencies in clinical practice (Falender & Shafranske, 2004). A third function of clinical supervision is evaluation of the supervisee. Evaluation involves monitoring the supervisees’ skills/competencies and then communicating those evaluations to several potential audiences, including: the supervisee, the training program, and the licensing board. This evaluative role requires the supervisor to serve as a “gatekeeper,” which ultimately protects both the profession and the public (Barnett, Cornish, Goodyear, & Lichtenberg, 2007; Falender & Shafranske, 2004).

Competency via training

The APA Ethical Principles only allow psychologists to engage in clinical roles and practices that are within their scope of competence. Competency in any applied psychology domain is achieved by receiving formal education, supervision, and consultation (American Psychological Association, 2002). Research over the previous two decades reveals that a large

number of supervisors have not received formal training in the practice of supervision (Knapp & Vandecreek, 1997; Sutter, McPherson, & Geeseman, 2002). Further, this body of research demonstrates that simply conducting supervision does not ensure supervisory competence. More recently, clinical supervision has been identified as a core competence, unique from other components of professional psychology like psychotherapy, in terms of theory and practice (Falendar et al., 2004; Schindler & Talen, 1996). Writers in the field of clinical supervision advocated for more thorough and systematic training of prospective supervisors, resulting in the development of several models for supervision training (Bradley & Whiting, 2001, Ellis & Douce, 1994). Additionally, competence in supervision is now required for graduate program accreditation by APA (Falender & Shafranske, 2007). Numerous other professional organizations endorse the necessity of formal supervision training within scholastic and professional development as well. The National Conference on Scientist-Practitioner Education and Training, the National Council of School and Programs in Professional Psychology, the APA Committee on Accreditation, and the Association of Psychology Postdoctoral and Internship Centers have all made formal announcements that supervision should not be practiced without indication of competence (Dye & Borders, 1990). Standards within the specific field of counseling psychology have been specified by the Council of Accreditation of Counseling and Related Educational Programs (CACREP, 1998), the International Association for Counseling Services (Garni et al., 1982), and the Association for Counselor Education and Supervision (Borders & Cashwell, 1992).

However, psychologists have found it easier to encourage competency than to operationally define it, and as such, training guidelines for developing competency are not yet fully in effect (Falender, et al. 2007). That is, although APA has required doctoral graduate

programs to include supervision as one of the core competencies in order to gain accreditation, they have not specified the specific tasks required to gain that competency. Thus, some training programs teach a formal courses on supervision while others do not; some offer supervision training through practica experiences and others do not; and some encourage receiving supervision training on internship.

In an effort to establish clear training guidelines, Falendar et al. (2004) proposed competency areas in supervision and encouraged APA's Committee on Accreditation and state psychology boards to agree upon specific criteria for gaining competence in supervision. At this time, there are no required courses or training activities in supervision for graduate training in clinical or counseling psychology (Lyon, Heppler, Leavitt, & Fisher, 2008). The specialties of counseling and clinical psychology have responded differently to this calling for training in supervision, with 85% of counseling programs offering the didactic course, and 79% offering supervision practicum, while those percentages for clinical programs were 34% and 43% respectively (Scott, Ingram, Vitanza, & Smith, 2000). Throughout the 1980's only 14% of supervisors received supervision training within doctoral programs and approximately 30% on internship (Borders & Leddick, 1988; Stanton, 1981; Watkins, 1992). While Johnson and Stewart present data showing supervisor training on the rise, there is no more recent data available to examine the continuity of that trend (2000). Graduate training in supervision, years of experience supervising, and continuing education all comprise the foundations of training that build competence.

Techniques and Methods of Supervision

Previous research on supervisory formats tends to emphasize the practice of the individual supervision method. All supervisors make use of individual supervision (Milne &

Oliver, 2000). Within the broad category of individual supervision, a variety of techniques exist. The most frequently reported techniques of supervision include verbal report, case note review, and review of audio recordings. Another form of individual supervision is known as “live supervision,” or direct observation, which requires the supervisor to view the trainee with the client. Direct observation can include bug-in-the-ear (BITE), co-therapy, viewing the session from behind a one way mirror, and similar formats (Bernard & Goodyear, 2004). Studies consistently show that group-style formats of supervision rank a close second to individual supervision, being implemented approximately 65% of the time (Enyedy, Arcinue, Puri, Carter, Goodyear, & Getzelman, 2003; Goodyear & Nelson, 1997). The specific formats of group-style supervision include group supervision (one supervisor working concurrently with several supervisees), vertical team supervision (with a specific structural emphasis on having clinicians from various levels of training), structured seminars, and large group supervision (several supervisors and several supervisees).

Recent emphasis on expanding clinical service provision to rural and regionally distant areas creates a challenge for providing supervision for those areas. Supervision formats have recently been adapted to bridge the gap between the urban supervisor and the rural supervisee. “Telehealth,” defined as the, “use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, and public health and health administration” was introduced to offer a partial solution to the problem (Wood, Miller, & Hargrove, 2005, p. 173). Currently implemented telehealth technologies include e-mail, teleconferencing, and videoconferencing. Examining the use the use of telehealth modalities for activities such as supervision will offer insight into one of the imminent changes that are likely beginning to affect the field.

Identified Best Practices from the Literature

Research examining the best practices of supervision generally clusters into two areas of focus: supervisory methods and supervisor characteristics. The methods of supervision that are consistently reported as most effective in training and evaluation are those methods that incorporate direct observation or demonstration (Bernard & Goodyear, 2004; Hess & Hess, 1983; Johnson & Stewart, 2000). Supervisor and trainee review of videotape or DVD recording is continually listed as one of the best practices for training supervisees (Falender & Shafranske, 2004; Gonsalvez, Oades, & Freestone, 2002; Goodyear & Nelson, 1997; Romans, Boswell, Carlozzi, & Ferguson, 1995). Other live supervision techniques such as co-therapy, bug-in-the-ear, and supervision between a one way mirror are also rated highly effective, though typically more difficult to implement due to time constraints (Bernard & Goodyear, 2004; Goodyear & Nelson, 1997; Romans, Boswell, Carlozzi, & Ferguson, 1995). From the perspective of supervisee satisfaction, graduate students report that they prefer more emphasis on demonstration and less emphasis on discussion (Gonsalvez, Oades, & Freestone, 2002.) Other frequently employed methods of supervision include self-report and review of case notes, which are techniques that are typically rated as less effective (Falender & Shafranske, 2004; Bernard & Goodyear, 2004; Goldberg, 1985; Goodyear & Nelson, 1997).

Additional best practices reported in the literature typically focus on the supervisor's characteristics. The supervisor characteristics that are routinely identified as associated with effective supervision are the same traits that have historically described the "ideal therapist" (Carifo & Hess, 1987). For example, the "working alliance" consistently determines the supervisee's perception of quality supervision (Henderson, Cawyer, & Watkins, 1999; Lomax, Andrews, Burrell, & Moorey, 2005; Worthen & McNeill, 1996). Characteristics that provide

potential for developing a positive working alliance include empathy (Carifo & Hess, 1987; Worthen & McNeil, 1996), warmth and understanding (Hutt, Scott, and King, 1983; Martin, Goodyear, & Newton, 1987), attentiveness, approachability (Henderson et al., 1999) and encouragement (Worthen & McNeill, 1996). Supervisors who possess high levels of theoretical, technical, and conceptual knowledge, specifically those with a similar theoretical orientation, also aid in strengthening the supervisory relationship (Watkins, 1995). Finally, Nelson (1978) reported that mere interest in supervision is the most essential component of effective supervision, beating out all levels of experience and expertise, and thus serves as an important element of effective supervision.

Evaluation of supervisee performance is one of the landmarks of effective supervision (Bernard & Goodyear, 1998; Norcross & Halgin, 1997; Watkins, 1997). Evaluation is the tool by which supervisees learn their strengths and weaknesses, and monitor overall progress in their professional development. Freeman (1985) found that students rank receiving feedback as the most effective factor contributing to their skill development. Evaluation can be formative and summative; evaluation can be qualitative or quantitative and cover topics such as interpersonal skills, case conceptualizations, diagnosis, affective components, treatment planning, and cultural diversity competence, among others (Falender, 2004). Currently, there are few step-by-step plans for providing quality feedback. Although a small number of researchers have offered suggestions for providing evaluative feedback, it remains in the earliest stages of implementation (Munson, 2002; Heckman-Stone, 2003). Based on previous studies, it seems that future supervision research should examine the methods, specialized instruments, and frequency of the evaluation of the supervisee.

Administrative Influences on Supervision

Depending on the setting of supervision, agency and departmental policies often play a leading role in the nature of supervision that is being implemented. Academic settings and service settings typically differ in aspects of support for supervisors. Some of the reasons for this could be qualitative aspects of nonsupervision job demands, the nature of supervision activities, and the perceived importance of supervision in each setting (Johnson & Stewart, 2000; Tyler, Sloan, & King, 2000; Hess & Hess, 1983). These institutional styles can be evidenced through a variety of factors including expected supervisor workload, resources for implementing supervision, and compensation for supervisors. Supervisors in rural community settings often encounter a variety of institutional barriers to providing consistent, weekly supervision (Wood, Hargrove & Miller, 2005). On the other hand, graduate training programs appear to have long emphasized the implementation of reliable and thorough supervision by clinical supervisors (Pierce & Schauble, 1970.)

Purpose and Hypotheses

The purpose of this study is to survey current supervisors about the applied and administrative features of clinical supervision that have been deemed important in the literature. This study will be novel in the fact that it will obtain an up-to-date appraisal of the formal training of current supervisors along with the practices supervisors report using. This study will also examine supervisors' perception of the formats used in supervision and compare those to the field's "best practices." Additionally, the study will aim to build upon the current literature on administrative influences on supervision, and further examine the extent to which institutions influence the practice of supervision. Finally, the study will examine the frequency with which supervisors make use of telecommunication in implementing clinical supervision. Data will be collected to examine five central hypotheses. These include:

1) More recently trained supervisors will report more formal training experiences than those supervisors who were trained in earlier years. I suspect that the cause for this trend will likely stem from the APA's recent push to require formal training in supervision prior to graduation from a doctoral program (Falender & Shafranske, 2007).

2) Counseling psychologists will report having more formal training in the practice of supervision than clinical psychologists with equivalent degrees.

3) "Best practices" of supervision, including co-therapy, direct observation, video review, etc., will be reported less frequently than other practices such as review of case notes and general discussion of cases.

4) Supervisory practices will be mediated by theoretical orientation, APA accreditation, and the organization where supervision is being implemented. Although I hypothesize that the majority of supervisors will report that their institutions "value" supervision, I hypothesize that they will also report fewer resources than necessary for implementing that "value."

5a) There will be an increase in the use of technology to implement supervision in comparison to the previous studies reported. 5b) Psychologists practicing in rural areas will be more likely to conduct supervision with the help of technology.

CHAPTER THREE

Method

Participants

Research participants included 69 doctoral level clinical and counseling psychologists who currently provide clinical supervision. Each of the supervisors was associated with a doctoral level academic training program in psychology and/ or a psychology predoctoral internship site. Participants were drawn from across the continental United States and Hawaii, with no specific interest given to any region. The recruitment process is described in more details in the procedure section below. It is important to note that the procedure utilized for recruiting participants made it impossible to determine how many clinical supervisors were contacted with our request to participate. This limitation is acknowledged and discussed briefly in the discussion section below.

Of the 69 clinical supervisors who responded to the survey, roughly half (51%, n=35) had a Doctorate of Philosophy (Ph.D.) in clinical psychology. The second largest degree represented was Doctorate of Psychology (Psy.D.), which made up 38% (n=26) followed by Doctorate of Philosophy in counseling psychology with 10% (n=8).

With respect to the type of institution of employment, an equal number of supervisors (21%, n=13) was located at university counseling centers and VA medical centers, 17% were located at Psy.D. academic training programs for clinical psychology (n=11), 11% were located at Ph.D. academic training programs for clinical psychology (n=7), 10% were located at community mental health centers (n=6), 5% were located in private practices (n=3), 5% were located in publically supported psychiatric hospitals (n=3), 5% were located in private psychiatric hospitals (n=3), 3% were located in corrections centers (n=2), and 1% was located in

a general medical hospital (n=1). When questioned about the employment relationship with the institution endorsed, 90% reported being full time employees (n=54), 7% reported being part time employees, and 2% (n=2) reported being independently contracted with the institution specifically to provide supervision.

When asked to report the length of time serving as a clinical supervisor, the largest group of respondents had served between 0-5 years (35%, n=21), followed by 6-10 years (23%, n=14), 11-15 years (15%, n=9), 16-20 years (13%, n=8), 21-25 years, (7%, n=4), and finally 26+ years (7%, n=7). Although 8% (n=6) of respondents reported that clinical supervision was the only professional service they provide, 92% (n=63) reported providing other clinical services besides clinical supervision (e.g. therapy, consultation, etc.) as part of their daily work.

Over 90% of respondents were full time employees of their current institution. The remaining 8% (n=6) were either part time employees or privately contracted to provide supervision.

Instrumentation

The survey questionnaire (See Appendix A) was based on a review of the supervision literature, and inquires about a variety of variables that influence the quality of clinical supervision. Specifically, questions about basic demographic information, training experiences in supervision, administrative influences on supervision, typical supervisory activities, and perceived ethical responsibility as a supervisor were presented. The survey also included an opportunity to provide personalized responses to open-ended questions about the current state of clinical supervision. During data collection, the survey was available through the website of SurveyMonkey, an online survey and software company.

Procedure

Directors of training from clinical psychology, counseling psychology, and combined professional-scientific psychology graduate programs were accessed from the APA website listing of doctoral programs in professional psychology www.apa.org/ed/accreditation/doctoral.html. Directors of training at the psychology predoctoral internships were accessed from the Association of Psychology Postdoctoral and Internship Centers (APPIC) website's list of internships www.appic.org/directory/search_dol_internships.asp. Those programs contacted for participation were chosen through a quasi-random selection process, in which a random number generated by the Statistical Package for Social Sciences Software (SPSS), was used to identify programs that corresponded to that number.

After formulating the list of programs to be contacted, clinical training directors' contact information was acquired for each of the selected programs. The training directors were then sent individualized emails that included the rationale for the study, IRB approval information, expected completion time, and the link to the survey. See Appendix B for an example of the email sent to the directors. Directors were then asked to forward the email on to any psychologists, within their institution, who currently serve as clinical supervisor. If, after providing informed consent, the supervisor chose to participate in the survey, they were able to access the link at www.surveymonkey.com

The clinical training directors were asked to please send a brief reply, indicating whether or not they received the message and the approximate number of supervisors they were able to forward the request to. No direct communication was made with the clinical supervisors asked to partake in the study, unless initiated by them. A second round of follow-up emails was sent to the directors of training two weeks after the initial request to remind and possibly thank the

participants. Approximately two weeks after that, a third request was sent to those directors of training who had not yet responded.

Data Analysis

Descriptive statistics were imported in aggregate form from the SurveyMonkey website. Statistical analyses described below were conducted using SPSS. Two separate Chi-Square analyses were conducted to determine whether the type of doctorate degree earned is related to formal training in supervision, and whether training in clinical supervision has changed over the years. A stepwise multiple linear regression examined the relationship between supervisors' perceived value of supervision at their current institution based on a variety of factors which related to best supervisory practices. A MANOVA, was used to see if there were significant differences in choice of supervisory techniques associated with supervisors' theoretical orientation. Another MANOVA was used to see if there were significant differences in choice of supervisory techniques associated with supervisors who earned different types of doctorate degrees. MANOVA was also used to see if there were significant differences in choice of supervisory techniques associated with supervisors who had and did not have a formal graduate course in supervision, supervisors who had completed graduate training at different times, supervisors who belong to accredited vs. non-accredited programs, and supervisors who currently practice in a variety of settings.

CHAPTER FOUR

Results

Graduate Training in Supervision

The literature recommends that taking a course on supervision provides a foundation of training in the best practice of clinical supervision. As such, it was important to examine the current practices of that training. Of the 65 clinical supervisors who responded to the training portion of the survey, 34% (n = 22) had completed a graduate course in clinical supervision. Over 70% (n=16) of the respondents who did have a course in supervision reported that it was required for the completion of their degree. Similar to graduate training in supervision, 30% (n=19) of respondents completed an internship where at least some portion of training targeted supervision. The table below depicts the specific facets of the training experiences reported.

Table 1.

Amount of Training

| | | | |
|------------------------------------|------------------------|-----|------|
| Course on Supervision | Had course | 34% | n=22 |
| | Did not have course | 66% | n=43 |
| Of those who had course | Required | 73% | n=16 |
| | Elective | 27% | n=6 |
| Type of Instruction | Didactic instruction | 89% | n=21 |
| | Assigned readings | 79% | n=19 |
| | Group discussion | 75% | n=18 |
| | Supervision of trainee | 50% | n=12 |
| Evaluation of competence | Formal presentation | 71% | n=15 |
| | Evidence of reading | 62% | n=13 |
| | Exams/papers | 57% | n=12 |
| Internship training in supervision | Yes | 30% | n=19 |
| | No | 70% | n=34 |

Influential Factors on Graduate Supervision Training

In exploring the data related to supervisors' training experiences, it became necessary to explore what differentiated whether someone received training in supervision or not. Chi-Square analysis was used to determine whether the type of awarded doctorate degree (Clinical Ph.D., Counseling Ph.D., Clinical Psy.D.) was related to formal training in supervision. The first analysis demonstrated a significant relationship between the type of degree and the likelihood of having a formal course on supervision during doctoral level training, $X^2 (N = 69) = 16.44, p < .05$. The second Chi-Square analysis displayed a significant relationship between the type of degree and the likelihood of having supervision training within predoctoral internship, $X^2 (N=69) = 32.44, p < .05$. Results indicated that those supervisors with a Ph.D. degree in Counseling Psychology were found to be more likely to have taken a formal course in clinical supervision during graduate training and to have had supervision training within predoctoral internship than those supervisors who have doctoral degrees in clinical psychology.

Separate Chi-Square analyses determined whether the amount of graduate training in supervision has changed over time. The first Chi-Square in this sequence demonstrated a significant relationship between the time of graduate training and likelihood of having a formal course on supervision, $X^2 (N=69) = 33.13, p < .05$. The second analysis revealed a significant relationship between the time since graduate training and the likelihood of having received training in supervision during the internship year, $X^2 (N=69) = 32.44, p < .05$. This observed relationship seems to suggest that formal training in supervision appears to have steadily increased over time.

Ongoing Supervision Training for Supervisors

In addition to formal training in academic coursework and within internship programs, another source of training in supervision is through post-degree continuing education of various types. Table 2 presents data on the frequency and type of ongoing supervision reported by participants. Workshops proved to be the most frequently utilized source of post-degree training in this domain.

Table 2.

Ongoing Supervision Training

| | | | |
|----------------------------------|--|-----|------|
| Post-degree supervision training | Training | 59% | n=38 |
| | No Training | 41% | n=27 |
| Of those who had training | Workshops | 66% | n=25 |
| | Seminar Presentations | 24% | n=9 |
| | Graduate course not required for degree completion | 5% | n=2 |
| | | | |

Supervisory Techniques Implemented

As training in supervision would likely teach the techniques that comprise supervision, the following section explores the techniques reportedly being used by current supervisors in the field. Case discussion was reported as the leading technique being used among supervisors. Overall, objective techniques that allow for direct observation of supervisees work were reported as being used much less frequently than the more indirect, subjective methods. In fact, when the categories “None of the time” and “Infrequently” are combined, they accounted for approximately 70% of direct observation occurrences. The frequencies of all supervisory techniques are reported in Table 3.

Table 3.

Report of Supervisory Techniques Used

| Technique | Most or almost all of the time (81-100%) | Frequently (61-80%) | Regularly (41-60%) | Occasionally (21-40%) | Infrequently (1-20%) | None of the time |
|-------------------------------|--|------------------------|-----------------------|--------------------------|-------------------------|---------------------|
| Discussion of Cases | 46% (n=26) | 29% (n=16) | 21% (n=12) | 1% (n=1) | 0% (n=0) | 1% (n=1) |
| Review of written material | 7% (n=4) | 5% (n=3) | 23% (n=13) | 19% (n=11) | 43% (n=25) | 3% (n=2) |
| Audio/DVD Review | 0% (n=0) | 1% (n=1) | 13% (n=7) | 19% (n=10) | 37% (n=20) | 30% (n=16) |
| Live Observation | 0% (n=0) | 1% (n=1) | 1% (n=1) | 10% (n=6) | 38% (n=22) | 49% (n=28) |
| Role-play | 0% (n=0) | 1% (n=1) | 3% (n=2) | 20% (n=11) | 41% (n=23) | 35% (n=19) |
| Co-therapy | 1% (n=1) | 1% (n=1) | 1% (n=1) | 15% (n=8) | 31% (n=16) | 50% (n=27) |

One interest of this study was to explore whether there were any supervisor characteristics that might differentiate the use of specific supervisory techniques. An independent measures multivariate analysis of variance (MANOVA) examined the effect between theoretical orientation and the frequency of the supervisory techniques; discussion of cases, review of written material, audio/DVD review, live observation, role-play, and co-therapy. The overall MANOVA was significant, $F(6, 52) = 1.57$, Wilks' Lambda = 0.35, $p < .05$. An analysis of variance (ANOVA) demonstrated a significant relationship between the supervisory technique of role play and theoretical orientation $F(6, 52) = 3.93$, $p < .05$. A Bonferroni post-hoc analysis indicated that role play was significantly more prevalent in the Cognitive Behavioral and Generalist/Integrative/Eclectic orientations, demonstrating that theoretical orientation did have an influence on choice of supervisory techniques, and in particular the use of role-play activities during supervision. Theoretical orientation, however, did not influence the frequency of the review of written material, the review of DVD/Audio recordings, discussion of cases, live observation, or co-therapy.

Because type of doctorate degree was found to affect whether or not respondents received supervision training in graduate school and internship, a follow up question explored whether type of doctorate degree would also predict differences between the techniques that are used. A MANOVA was performed to examine the effect between type of doctorate degree earned the

frequency of the supervisory techniques; discussion of cases, review of written material, audio/DVD review, live observation, role-play, and co-therapy. The overall MANOVA revealed no statistical difference, $F(6, 52) = 0.67$, Wilks' Lambda = 0.77, $p > .05$. Since the overall multivariate F was not significant, univariate F statistics were not examined. The type of doctorate degree was not related to the type of supervisory techniques that occur during supervision.

Receiving graduate training in supervision would be expected to result in an increase in frequency of best practices from those supervisors who received training. A MANOVA examined the relationship between having had a graduate course in supervision and the frequency of utilizing the various supervisory techniques; discussion of cases, review of written material, audio/DVD review, live observation, role-play, and co-therapy. The overall MANOVA was not significant, $F(6, 52) = 0.89$, (Wilks' Lambda = 0.92, $p > .05$). Since the overall multivariate F was not significant, univariate F statistics were not examined. Having a graduate course in supervision did not affect supervisory techniques used.

Because the time frame of graduate training influenced whether or not a respondent had a course on supervision or internship training in supervision, a follow up question explored whether time since graduation would influence the use of supervisory techniques. A MANOVA examined the effect between years one has served as a supervisor and the frequency of using supervisory techniques; discussion of cases, review of written material, audio/DVD review, live observation, role-play, and co-therapy. The overall MANOVA was not significant, $F(6, 52) = 0.72$, (Wilks' Lambda = 0.66, $p > .05$). As the overall multivariate F was not significant, univariate F statistics were not examined. The number of years one had served as a clinical

supervisor did not appear to influence the type of supervisory techniques that are used during supervision sessions.

It was reported earlier that the respondents were derived from a variety of institutions (i.e. university counseling center, VA Medical Center, academic training program, etc.). Independent measures multivariate analysis of variance (MANOVA) examined the effect between type of institution of employment and the reported use of supervisory techniques. The overall MANOVA revealed no statistical difference, $F(6, 53) = 0.90$, Wilks' Lambda = 0.40, $p > .05$. As the overall multivariate F was not significant, univariate F statistics were not examined. The type of institution of employment was not related to the type of supervisory techniques that were employed during supervision. Institution type alone did not appear to influence the type of supervisory techniques that occurred during regularly scheduled supervision.

The final MANOVA examined the effect between APA accreditation and frequency of the supervisory techniques: discussion of cases, review of written material, audio/DVD review, live observation, role-play, and co-therapy. The overall MANOVA was not significant, $F(6, 52) = 0.72$, Wilks' Lambda = 0.66, $p > .05$. As the overall multivariate F was not significant, univariate F statistics were not examined. Whether or not a training program had received APA accreditation did not appear to influence the type of supervisory techniques that were used during supervision sessions.

Administrative Influences Affecting Supervision

The administration under which a supervisor practices could potentially have had an effect on the degree to which high quality supervision was valued and the resources needed to implement supervision were made available. Respondents were questioned about the

administrative expectations and support they encounter as supervisors. The distribution of supervisor case loads is listed in Table 4.

Table 4.

Number of supervisees per supervisor

| Number of Supervisees on Case Load | | |
|------------------------------------|-----|------|
| 0 | 1% | n=1 |
| 1 | 32% | n=19 |
| 2 | 28% | n=17 |
| 3 | 8% | n=5 |
| 4 | 10% | n=4 |
| 5 | 5% | n=3 |
| 6+ | 15% | n=9 |

The modal response of supervisor caseload is one. However, when one and two are combined, over 50% of the supervisors were accounted for. Therefore, a significant number of supervisors were responsible for one or two supervisees. The typical supervisee caseload proved to be more diverse, dispersing fairly equally among the first three categories of options. These findings can be seen in Table 5.

Table 5.

Typical Supervisee Caseload

| Number of Supervisees | | |
|-----------------------|-----|------|
| Per Supervisor | | |
| 0 to 3 | 24% | n=14 |
| 4 to 6 | 25% | n=15 |
| 7 to 10 | 34% | n=20 |
| 11 to 15 | 10% | n=6 |
| 16+ | 7% | n=5 |

When asked, "Over the previous two weeks how much time was scheduled for *regularly* scheduled supervision...informal supervision...and supervisory related tasks (e.g. DVD review, case note review, preparation for session)", respondents reported a variety of different time segments. The most frequent time segment reported was 46-60 minutes. The results from this inquiry can be seen in Table 6.

Table 6.

Time Requirements for Supervision

| Time | Regularly scheduled supervision | Informal supervision | Supervisory related tasks |
|----------------|---------------------------------|----------------------|---------------------------|
| 1-15 minutes | 0% (n=0) | 17% (n=19) | 9% (n=5) |
| 16-30 minutes | 5% (n=3) | 24% (n=14) | 12% (n=7) |
| 31-45 minutes | 3% (n=2) | 22% (n=13) | 10% (n=9) |
| 46-60 minutes | 73% (n=43) | 20% (n=12) | 32% (n=19) |
| 61-75 minutes | 10% (n=6) | 8% (n=5) | 3% (n=2) |
| 76-90 minutes | 0% (n=0) | 5% (n=3) | 10% (n=6) |
| 91-120 minutes | 9% (n=5) | 1% (n=1) | 12% (n=7) |
| 120+ minutes | 0% (n=0) | 3% (n=2) | 12% (n=7) |

Administrative Influences on Supervision

Given the aforementioned responses concerning the administrative influences on supervision practice, a stepwise multiple linear regression was conducted to examine the relationship between financial compensation awarded to supervisors, resources available to supervisors, the degree to which supervision is considered in promotion decisions, temporal compensation for supervisory tasks, and the supervisors' perceived value of supervision at the current institution. The analysis rendered two models. The resulting one predictor model, including equipment available for supervisory tasks, was significant $F(1, 67) = 33.56, p < .05$. The two predictor model had an R^2 change of 0.05 and was kept. The resulting two predictor model, which included equipment available to supervisors and adequate space provided for

supervisory tasks, was significant $F = (2, 66) = 20.01, p < .05, R^2 = .39$. Equipment available to supervisors ($\beta = 0.32, t = 3.80, p < .05$) and space available for supervision ($\beta = 0.20, t = 2.42, p < .05$) were both significant predictor variables. Financial compensation ($\beta = -.03, t = -.27, p > .05$), degree to which supervisors are considered in promotion decisions ($\beta = 0.13, t = 1.27, p > .05$), and temporal compensation for supervisory tasks ($\beta = 0.21, t = 0.17, p > .05$) were not significant predictor variables, and were, therefore, dropped from the model. According to supervisors, having satisfactory supervisory equipment and adequate space for supervisory related tasks was a key factor in influencing supervisor perceptions of whether or not a facility values high-quality supervision.

Of the variables excluded from the model, the perceived value of supervision at the organization of employment was significantly related to financial compensation awarded for supervision ($r = 0.24, p < .05$). Being more highly esteemed for providing clinical supervision was related to the quantity of financial compensation rewarded for supervision ($r = 0.26, p < .05$), the degree to which supervision is considered in promotion decisions ($r = 0.40, p < .05$), and temporal compensation for supervisory tasks ($r = 0.22, p < .05$). Equipment available for supervisory tasks was strongly associated with the availability of video cameras, two-way mirrors, bug-in-the-ear, etc. ($r = 0.44, p < .05$) as well as having adequate space to complete supervisory tasks ($r = 0.53, p < .05$). Although financial compensation for supervision did not contribute to the significant model, it did have some influence on the perceived “value” of supervision at an institution or agency. Being highly esteemed for providing supervision appears to be associated with the amount of monetary reimbursement, consideration for promotion based on supervisory services, and work hours that can be compensated for supervising. As evidenced in the model, equipment available for supervision was a key predictor of the value an

organization places on supervision. Not surprisingly, equipment was related to the availability of video cameras, two-way mirrors, and other technical equipment, along with the space available for that equipment.

Accreditation

Of those programs surveyed, 74% ($n=58$) were accredited by APA, 21% ($n=13$) were not accredited by the APA, and 5% ($n=3$) reported that their institution was not eligible for accreditation. Results indicated that there was no significant correlation between APA accreditation and the requirement to provide supervision as an employee, $\chi^2 (n=55) = 2.17, p > .05$; the requirement to provide evidence of previous training in clinical supervision prior to supervising, $\chi^2 (n=55) = 0.41, p > .05$; the encouragement of continuing education in supervision, $\chi^2 (n=55) = 0.34, p > .05$; the provision of training in supervision, $\chi^2 (n=55) = 0.28, p > .05$; the allowance of “excused” leave of absence for training in supervision, $\chi^2 (n=55) = 0.28, p > .05$; or financial reimbursement for attending conferences, trainings, etc. on the topic of supervision, $\chi^2 (n=55) = 0.48, p > .05$. Overall, having or not having APA accreditation did not appear to significantly influence the quality of supervision that training sites attempted.

Technology Usage

Roughly forty percent ($n=34$) of respondents reported that they and their supervisees make use of technology (i.e. telephone, email, webcam) as part of supervision. Of those people who do make use of technology to supplement supervision, the only two devices reported as being used were email and telephone. Live or Real Time internet, chats, webcams, polycom or similar devices were reported as never used. A χ^2 analysis examined the relationship between rurality and the use of technology to bridge distances during supervision, $\chi^2 (n = 69) = 11.57, p >$

.05. The statistic showed that there is no difference between sites that identify as rural and those that do not identify as rural with regard to the use of technological equipment for supervision.

Evaluation

All respondents reported providing summative evaluation to supervisees. The provision of summative evaluative feedback occurred at a variety of occasions. For example, 32% ($n=19$) of supervisors provided feedback once per semester, 26% ($n=15$) provided evaluation twice per semester, 12% ($n=7$) provided evaluation twice per academic year, 11% ($n=8$) provided evaluation once per quarter, 9% ($n=5$) provided evaluation three times per academic year, 4% ($n=3$) do so once per quarter, and 1% ($n=1$) only gave evaluation once per year.

Overall, of four trainee feedback methods investigated, two predominant methods were used by supervisors to assess and inform the supervisee about performance. These frequently endorsed methods included numerical or Likert-type scales developed by the training program (92%, $n=53$) and qualitative statements (81%, $n=47$). Less frequently used were personally created rating scales (7%, $n=4$), and empirically validated rating scales (1%, $n=1$).

With regard to weekly, informal, formative evaluation, oral reflection of strengths and weaknesses was most frequently used (92%, $n=53$). General observation of skills was used almost as frequently (76%, $n=44$), followed by written observations on case notes (47%, $n=27$), with utilization of written instruments (9%, $n=5$) being far less frequently employed. One participant reported using no formative evaluation.

Summative evaluation is used by all supervisors represented in this sample, and formative evaluation was used by all but one supervisor. Typically, summative evaluation is scheduled within the academic calendar, occurring at specific times within the semester, quarter, or rotation. The method of summative evaluation most frequently used was Likert-type scales

developed by training programs and/or general, qualitative statements about the supervisees' performance. Formative evaluation is most often seen in the form of oral reflection or as a general observation of skill development.

Qualitative Data Analyses

A simple inductive content analysis was conducted on three open-ended questions that requested supervisors' personal experiences and opinions regarding the current practice of clinical supervision. Each question was analyzed to identify patterns and themes that emerged in the responses.

The first open-ended item asked, "If you were to provide the most optimal supervision, what would it look like?" In total, 36 participants responded to this particular question. One primary, one secondary, and one tertiary theme emerged from the replies to this question. The primary theme, which was reported by 24 of the respondents, referred to the use of incorporating more objective supervisory techniques into training. The most frequent technique that was mentioned was videotaping, followed by direct observation, and co-therapy. Some examples of actual responses to this question include; "with respect to individual therapy, optimal supervision would include reviewing videotapes of sessions or observing through a one-way mirror," "a mix of co-therapy, role play, case discussion, and video review," "more viewing of video recordings," and "more real time observation of therapy."

A secondary theme that emerged from this question, appearing 11 times in the comments, was the notion of incorporating a variety of supervision styles into the typical one-on-one format. There were multiple mentions of the use of group supervision as an additional format. In general, respondents reported that a mixture of supervisory formats would offer a broader perspective of the supervisees work and conceptualization. Examples of these responses

included; “weekly individual supervision and group supervision,” “multimodality in terms of a variety of ways in which we review cases (group and individual),” and “weekly individual, weekly group, didactics, and observation of clinical activities.”

A tertiary theme that emerged from the responses was the use of a developmental model of supervision tailored to the supervisees’ needs. This theme appeared seven times within the responses. A number of supervisors appeared to be interested in the “assessment of supervisee current skill level.” They suggested that such assessment would allow for an informed choice of which supervisory techniques to employ. Other responses provided by supervisors that addressed the importance they attribute to the developmental model in optimal supervision include the importance the “using a standardized measure, subsequent modality of supervision dictated by the assessed level of appropriate clinical autonomy” and supervision “which facilitates both the development of the person as a professional and [his/her] clinical skills.”

The second open-ended question asked, “What, if anything, prevents you from providing optimal supervision?” Of the 35 respondents, 27 made specific references to time, which serves as the main theme of this response set. Seven respondents answered this question by typing only the word “time” in the text box. Other respondents combined time with other specific issues such as having a full caseload of their own, having seemingly too many supervisees, and working on research and publications.

The secondary theme from this response was the lack of accessibility to technology, and was mentioned by 11. Multiple supervisors indicated that their place of employment does not have the equipment needed to conduct optimal, objective supervision. Some examples of the responses in this theme include; “I’d need access to better technology, two way mirrors, etc...we have applied for grants to purchase appropriate technology, but have not received any at this

time,” “lack of electronic equipment...,” and “very limited recording methods or means.” Thus, as time appeared to be the largest deterrent to optimal supervision among these supervisors, lack of appropriate equipment also presented challenges.

The third open-ended question that aimed to gain supervisors’ perspectives regarding clinical supervision was, “What do you perceive as the current and emerging challenges of providing clinical supervision?” Of the 21 participants who offered opinions about this topic, limitations on time again emerged as a major theme. Supervisors appear to be concerned that supervision time will not be “protected,” in reference to the vitality of its purpose compared to the “administrative mission.” Respondents reported that “there is more of a demand to see clients and engage in activities that are considered billable versus other aspects of clinical work,” such as supervision. “Bean counting” and “increasing pressures to produce billable hours” were reported as challenges which play a leading role in the goal of many organizations.

The secondary theme, being mentioned seven times by respondents, was the suggestion that supervisors expect to encounter more serious ethical and legal challenges in the future. One respondent believed that there will be an increased “emphasis on careful documentation of all aspects of the supervision relationship,” including contracting, documentation of supervision sessions, and increased “liability.” Other respondents noted beliefs that “attending to the ethical and legal responsibilities” will be emphasized more strongly in the future.

CHAPTER FIVE

Discussion

The purpose of this study was to investigate clinical supervisors' reports about the applied and administrative aspects of supervision. Generally, the study attempted to supplement the current literature on the topics of supervision training, actual supervisory practices, comparisons between reported practices and best practices, and the potential administrative influences on the practice of clinical supervision. The purpose of this section is to discuss the limitations of the study, evaluations and interpretations of the findings, and implications for further research.

Training

Approximately one third of respondents reported having formal coursework training in supervision while completing either their graduate training program or their predoctoral internship. Of those, 75% indicated that the course was required for the completion of a degree, whereas one fourth chose the course as an elective. Approximately half of the respondents reported supervising at least one trainee during internship. Although these findings indicate that the frequency of formal training in clinical supervision is comparable to reports from other studies (e.g., Borders & Leddick, 1988; Hess & Hess, 1983; Lyon, Heppler, Leavitt, & Fisher, 2008), the findings also present a concern for professional psychology. Over the past twenty years, many professional organizations representing the helping professions have emphasized that supervision training guidelines should be implemented in the professional fields (CACREP, 1998; Dye & Borders, 1990). More specifically, in 2002, APA's Committee on Accreditation identified clinical supervision as one of the primary competency areas of training for those clinical and counseling programs seeking accreditation. In the current study, over 55% of

respondents reported serving as a clinical supervisor for a time period of zero to ten year(s).

Taking this demographic into consideration, it was expected that the frequency of formal training would have been significantly higher from this sample group within the larger sample. However, this was not the case. The current finding that only one in three supervisors had formal training, matching those findings from the 1980s and 1990s, suggests that simply making supervision a formal training objective is not increasing the incidence of formal course training in supervision. In the future, APA's Committee on Accreditation and similar organizations will likely need to explicate specific criteria to denote competency in supervision. Delineating course work requirements, seminar topics, practica experiences, and/or a variety of other learning methods will ideally result in some type of uniformity of the training graduate students receive in this area.

New to the study of supervision training, teaching and evaluative methods from supervision courses were also examined in an attempt to more thoroughly describe the training process of those supervisors who have had formal training in supervision. Previous research has clearly stated that there is a dearth of current literature on the topic of supervisory teaching methods (Scott, Ingram, Vitanza, & Smith, 2000). In examining these methods, this study found that there appears to be an equal quantity of didactic instruction, assigned reading, and group discussion occurring within the courses on supervision, with each of these occurring around 70% of the time. Only supervision of a less experienced supervisee proves to be used less frequently than others. This is interesting since supervision of a less experienced supervisee is the single training method that gives the developing clinician the opportunity to participate in the actual art of supervision. As professionals in the field of psychology, most clinicians are familiar with the reality that typical classroom activities (i.e. reading, writing, discussion), no matter how well

implemented, are rarely considered full preparation for the actual implementation of a clinical role. Given the importance placed by graduate training curricula for preparing people for clinical skill implementation, it is reasonable to wonder why the competency area of supervision is not addressed with equivalent pre-professional training. In the practice of psychotherapy, training programs would never allow trainees to begin therapy based entirely on didactic training and without carefully supervised experiential practice, so why would training in clinical supervision be any different?

Similar to the types of teaching methods employed, methods for evaluating proficiency in supervision were also explored. Formal presentations, evidence of reading, and exams/papers were all reported as being used by approximately 60% of the respondents. Only one respondent indicated that there was no evaluative component to the course, which is unlike Scott et. al.'s study that reported 28% of their respondents did not encounter formal or informal evaluation (2000). It is possible that APA's initiative to label supervision as a major competency requirement for accredited programs has influenced those programs who do offer a course in supervision to enforce more rigorous evaluative techniques.

Similar to previous studies, analyses indicated significant differences between counseling psychology and clinical psychology programs in reference to the training of supervisors (Romans et. al., 1995; Scott et al., 2000). Counseling psychologists receive more formal training in clinical supervision than their clinical counterparts. Likewise, counseling psychologists were also found to be more likely to have formal supervision training during internship than those interns coming from clinical training programs. One possible explanation for this is that counseling psychology emphasized the importance of high quality supervision, produced literature on the practice of supervision, and labeled supervision as a core competency for over

fifteen years before clinical psychology took notice (Davis, Alcorn, Brooks, & Meara, 1992; Borders & Cashwell, 1992). At the doctoral level, instruction in supervision theory, demonstrable skill development, and the supervised practice of supervision are required for counseling psychology programs to receive CACREP accreditation. Also, supervision has been accepted as a defining sector of professional identity for counseling psychologists since the 1980s and counseling psychologists are urged to participate in ongoing supervision across their professional career (Meara, Schmidt, Carrington, Davis, Dixon, Fretz, Myers, & Suinn, 1988). Finally, supervision has traditionally been a key component of selection criterion for intern applicants at university counseling centers, sites that are much more frequently associated with the profession of counseling psychology than clinical psychology (Borders, 2005). Moreover, university counseling centers provide more thorough supervision than other practica and internship sites (Romans et al., 1995). Thus, from each direction, the counseling psychologist receives additional supervision experiences within a professional specialty that explicitly values and prioritizes the supervision competency. The identification of training requirements in both graduate training programs and predoctoral internships could better develop the preparation of all professional psychologists, particularly those in clinical psychology programs that may not be receiving as many opportunities for training. The implementation of supervision training standards in clinical psychology training programs and in internships that historically select clinical psychologists has shown to better the practice of counseling oriented supervision and would likely improve clinically oriented supervision.

Supervisory Techniques

Bernard and Goodyear (2009) report that optimal supervision occurs when the supervisor receives data about the supervisee's performance from a range of sources, thereby developing a

fully informed picture of the supervisees' skill set. Specifically, the importance of objective supervision has gained attention throughout the literature as the hallmark of optimal practice (Bernard & Goodyear, 2004; Goodyear & Nelson, 1997; Hess & Hess, 1983; Johnson & Stewart, 2000; Romans, Boswell, Carlozzi, & Ferguson, 1995). The results of this study indicate that direct observation measures of any kind are rarely used. Over three fourths of supervisors indicated that the objective techniques of live observation, role-play, and co-therapy are implemented either infrequently or not at all. Audio/DVD review was reported as occurring slightly more frequently, but none of the objective measures came close to matching the frequency of the subjective supervisory practices of case discussion or review of written materials. In sum, the data suggest that supervisors do very little to directly observe the clinical work for which they are responsible in their supervisory role.

This abovementioned observation is both expected and disheartening. Objective supervision is vital because it allows for first-hand observation, which is key especially when working with early trainees. Findings suggest that supervisees are not good reporters of their own clinical histories. Leaving supervision open to supervisee report can result in a supervisory ethical predicament due to the supervisee's potential to avoid anxiety inducing topics and negative evaluation (Ladany, Hill, Corbett, & Nutt, 1996). Supervisors can only serve as the "gatekeeper," protecting both the profession and the public, when they have accurate knowledge of the supervisees' clinical skills and the clients' level of functioning (Barnett, Cornish, Goodyear, & Lichtenberg, 2007). Supervisors who do not have comprehensive knowledge of the trainees work are unable to provide specific intervention training, cannot legitimately critique a supervisee's work, fail to see the improvement or worse, the decline of the client, and ultimately make themselves vulnerable to ethical and legal violations (Knapp & Vandecreek, 2006).

After gaining a general understanding about the frequency of both direct and indirect supervision methods, it was desirable to see whether any of the variables that classify supervisors increase or decrease the frequency of usage of techniques. The following categories were analyzed to examine potential differences between sub-groups of clinical supervisors: type of doctorate degree, having vs. not having formal graduate training in supervision, time served as a supervisor, institution of current employment, and theoretical orientation. Of all the categories analyzed, only theoretical orientation demonstrated a significant effect on the techniques used within supervision. Supervisors who endorsed the theoretical orientations of Cognitive Behavioral and Generalist/Integrative/Eclectic orientations use role-play in supervision significantly more frequently than those supervisors who subscribe to other orientations.

This finding could be related to Cognitive Behavioral Therapy's (CBT) emphasis on objectivity. Just as CBT is a systematic, goal-oriented approach to therapy, CBT supervision follows the same direction. As described by Padesky (1996), the main goal of CBT supervision is to help teach the theory; the second goal is to teach the supervisee the specific techniques for therapy. There is notably a significant push in CBT supervision for practicing new skills through role-plays, behavioral rehearsals, and imagery exercises, which logically increases the frequency of those activities in session (Rosenbaum & Ronen, 1998). Theoretical orientations other than CBT have historically followed theories that emphasize the clinical development, sequential learning process, and professional maturity of the trainee but focused less on specific supervisory activities. This detail is likely to affect the frequency of the behavioral interaction differences that occur with CBT and be the reason for the significant difference.

Administrative Influences

One of the unique features of this study is the focus and attention put on the administrative influences of supervision. Participants chosen were targeted based on the fact that they were connected to either training programs or internships; therefore their training/supervisory roles are overseen by administrative practices within a larger organization. Supervisors are frequently responsible for upholding the guidelines for training. However, they are providing supervision within the context of those agencies' management practices. Supervisors report that time is the single variable that prevents the provision of "optimal supervision." Specific references were made to the stress of providing supervision in addition to teaching requirements, publishing requirements, and sometimes a full caseload.

To further understand the quantity of supervisors' responsibilities, consider the following circumstances. The modal response for supervisors' caseload was one to two supervisees. The majority of respondents also reported 46-60 minute weekly supervision sessions with each trainee, who carries an average of seven clients. From the supervisors' perspective, this means that two work hours each week must be dedicated to the supervision of roughly 14 individual clients, in addition to any clients the supervisor may have of his/her own. With 92% of supervisors reporting that they provide clinical services aside from supervision and reports of their caseloads growing constantly, it is likely that their own caseloads reach numbers that are hard to manage responsibly. The final component to this pie chart of time division is the one hour each work week that is devoted to informal supervision requested by supervisees, and the range of 15 minutes to two hours that is used for supervisory tasks such as: reading and signing off on case notes, the occasional tape review, offering evaluation, etc. Ideally, supervisors should be able to dedicate five hours each week to their supervisory requirements. Yet, in this current climate of limited resources, greater demands for billable hours, and overall anxiety

about business-related issues, it is likely that supervisors are gaining more and more pressure from management concerning the "billable hours," and being forced to neglect obligations, supervision included, that do not generate income.

However, another concern naturally follows the discussion on time allotment. Even with unlimited time for supervision, should there be an ethical limit for the caseload responsibilities of a supervisor? In working with modes and averages in the example above, any given supervisor would be carrying 14 supervised clients in addition to their own full caseload. As Knapp and Vandecreek explained, supervising psychologists are responsible for the services provided by the supervised psychologist to the extent that they maintain full ethical and legal responsibility for those clients as though they were their own (2006). One possible approach, which seems tied to the heavy reliance on supervisee initiated case discussion, is that the more "difficult" or "challenging" cases are discussed more frequently in sessions, and those cases deemed as less challenging are either briefly discussed or completely ignored. Equally as troubling, supervisors are relying entirely on the supervisee's judgment and description for information. This type of supervision has multiple implications, and the literature on the developmental model suggests that supervision needs vary depending on clinical skills and professional maturity (Barnett, Goodyear, Cornish, & Lichtenbert, 2007; Bernard & Goodyear, 2009). It may be more acceptable for an intern or supervised psychologist preparing for state licensure to be supervised mostly on the cases they perceive as necessary compared to an early practica student. Unfortunately, previous studies illustrate that the level of supervisee experience does not affect the frequency, methods, or techniques of supervision (Amerikaner & Rose, 2007). Further, any differentiation should be based on a careful evaluation of the supervisee's skills, and this is quite difficult, if not impossible, without appropriate amounts of direct observation

Accreditation

APA is the only organization authorized by the U.S. Department of Education to accredit doctoral-level professional psychology programs. Almost three fourths of the supervisors included in this study supervised at a training site accredited by APA. When analyzed, those sites which were accredited by APA showed no significant difference in supervisory training, methods, or techniques used, in comparison to the practices at sites who were not accredited. That is, supervisors at accredited sites were not more likely to use direct observation measures, devote extra time to informal supervision, participate in role-play or co-therapy, or “value” supervision any more than supervisors from unaccredited program. Furthermore, there was no significant difference in the requirement to demonstrate previous training and experience in supervision, the provision of additional training for supervisors, the financial reimbursements for being a supervisor, or the allowance of “excused” absence to attend conferences, training seminars, or similar proceedings. Overall, APA accreditation of a training site does not appear to significantly influence the quality of supervision practice.

In reflecting upon the lack of difference between APA accredited sites and non-APA accredited sites, there is the potential that a “ceiling effect” is the cause of differences. That is, perhaps supervisors at all institutions, whether accredited or not, believe that their organization values supervision, offers resources to provide optimal supervision, provides training on supervision, etc. Yet, the data confirms that this is not the case. The majority of supervisors did not receive training in supervision, did not receive financial compensation for their supervisory responsibilities, were not asked to provide evidence of previous training in supervision prior to providing supervision, nor did they have the equipment necessary to provide optimal supervision. Thus, the lack of difference between accredited and unaccredited programs was not

the result of the ceiling effect; rather, it appears that APA accreditation had no significant influence on the practice of supervision occurring at training sites.

Accreditation by APA requires demonstration of an organized program with a sequential plan of study, an adequate number of qualified faculty members or training staff, and sufficient resources, such as access to databases, libraries, and offices. It also generally provides graduates with an advantage over non-accredited graduates, due to the demonstration by accredited sites of the high quality of training and a commitment to meet the requirements of most state licensing boards (APA, 2002). Although one member of APA's Office of Program Consultation and Accreditation and its Committee on Accreditation (CoA) stated, "in general, there's a reasonable expectation that you're going to have a better level of developed skills having gone through an accredited program," this may not be true when looking specifically at supervision experiences (Bailey, 2004). APA may claim to only accredit sites that provide optimal training, but it seems that they give little notice the supervisory practices that are being implemented.

Evaluation

Evaluation has long been included in the literature on both best and worst supervision. The general finding is that supervisees believe the more evaluation and feedback received, the more effective the process (Freeman, 1985; Hutt, Scott, & King, 1983). Effectively implemented evaluation has been found to supplement the working alliance, supervisor and supervisee self-efficacy, and goal setting (Lehrman-Waterman & Ladany, 2001). Summative evaluation was used by all respondents represented in this study, and was typically scheduled around the academic calendar followed by the respondent's institution. This finding is consistent with previous studies on summative evaluation (Lehrman-Waterman & Ladany, 2001). Formative evaluation was used frequently by all but one respondent. Locally created Likert scales were the

most common type of summative feedback given to supervisees, typically also combined with qualitative statements. Generally, Likert scales have been used to inform supervisees about progress, strengths, weaknesses, and concerns; however, they have limited validity in terms of ensuring a training standard. Basically, the evaluation of any given supervisee at any given institution is based on subjective judgment of the supervisor. The standard for “above average” at one university, may only meet the standard of “average” at another, and even more specifically, standards from professors within individual departments can also vary. There needs to be a level of internal consistency occurring within the practice of supervision evaluation in order to assure that all trainees are being held to the same, or at least similar, standards. While nonstandardized measures may have some value for personal goal setting within supervision, some balancing with standardized, behaviorally anchored scales could be an important focus for future work.

Earlier, it was reported that APA claims to ensure a “standard” of training from each of the institutions it accredits, but standardization of evaluation is a flaw from the supervisory perspective. Empirically validated rating scales are available, however these are not easily accessible, and their validation is still being monitored (Munson, 2002; Heckman-Stone, 2003). In the future, it will be important to develop standardized evaluation tools, create studies to validate their effectiveness, and begin to implement a more organized and efficient method to evaluate and provide feedback to supervisees.

Technology

In keeping with the “on-the-horizon” trends of the profession, the use of technology was examined in relation to supervision practices. The Marshall University School of Medicine was one of the first programs to provide medical supervision through e-mail in order to allow medical

students to expand their services to clinics and hospitals in West Virginia (Stamm, 1998; Stamm 1999), and the Psy.D. Training program at Marshall University currently provides clinical services to the rural populations of West Virginia through the use of technology both for the provision of services and for supervision. Other disciplines including nursing and psychiatry have also integrated telehealth into practice (Blackmon, Kaak, & Ranseen, 1997; Marrow, Hollyoake, Hamer, & Kenrick, 2002). The literature suggests that telehealth and telesupervision is a growing trend that may soon emerge as a method that is more widely utilized by supervisors at a variety of settings.

Contrary to this assumption, fewer than half of respondents reported that they and their supervisees made use of some type of technology as part of supervision. The only two devices reported being used were email and telephone; synchronous equipment, such as polycom devices and Real Time Internet chat systems were never used. Surprisingly, there were no differences between rural sites and non-rural sites in regard to the use of technology or the types of technology being used. This finding may be due to the nature of the training experience. If services are provided on-site by supervisees and supervisors, there is little need for the use of technical equipment. This sample population was largely non-rural, with only ten respondents indicating they served rural areas. In the future, a more representative sample may show greater usage of technology, specifically a sample that targets under resourced training programs that operate in multiple sites.

Discussion of Qualitative Responses

Respondents were aware that current practices do not meet the “gold standard” of supervision implementation. The consensus was that direct observation methods need to be implemented in order for the supervisor to form a legitimate understanding of supervisees’ work

and monitor clients' progress. This finding corresponds directly with previous literature on the best practice of supervision (Bernard & Goodyear, 2004; Hess & Hess, 1983; Johnson & Stewart, 2000). Particular emphasis was put on the incorporation of videotaping, even more so than observation or co-therapy. This finding may result from the fact that supervisors are hard pressed for time in general, which generalizes to the task of supervision. Live observation and co-therapy require the supervisor to be available during billable working hours, while videotape can be reviewed whenever a moment of free time presents itself to the supervisor.

There was a theme that increasing the frequency of multimodal supervision would enhance the state of the discipline. Flexible formats of supervision are valued because they are time efficient and open learning opportunities to a large number of supervisees. Increasing the frequency of group supervision was of particular interest in this population. This coincides with previous findings that report group supervision is highly valued among both trainees and supervisors (Milne & Oliver, 2000). It is possible that other formats of supervision (i.e., individual supervision in a group, peer supervision, peer group supervision) were not mentioned because they are less familiar than traditional group supervision (Carroll, 1996).

Both the use of objective measures and the incorporation of multiple modes of supervision are limited by time and availability, the chief deterrent to providing optimal supervision. Supervisors indicate that there is rarely enough time to provide the quality of supervision they would like to provide. There is persistent pressure to provide billable services, and from a strictly financial perspective, supervision is not beneficial to the advancement of the organization. However, if organizations would take the time to recognize the value of good supervision, specifically the supervisors' knowledge in relation to the professional and skill development of the supervisees, the system could begin emphasizing the "training" component

rather than the “requirement” component. Then, a system of well trained professionals would all be in-house with the organization that had provided training gaining the potential to hire well trained professionals, while the organization could have more confidence in the quality of services being provided by the trainees at their site.

Many supervisors felt overwhelmed with professional responsibilities including full caseloads, research and publication requirements. Furthermore, some supervisors believed that they are given too many supervisees in addition to their fundamental responsibilities. This finding is not new in the study of supervision and suggests an even larger dilemma, which is the ethical responsibility of the supervisor (Falendar & Shafranske, 2007). For better or worse, the responsibility for a client’s degree of functioning rests on the shoulders of the supervisors. It is unrealistic to expect that a supervisor is fully knowledgeable about as many as thirty individual cases in addition to his/her own caseload. Furthermore, time allotted for supervision is rarely in abundance and is vulnerable to be cut when needs for billable services arise. Productivity, too, often rests on the shoulders of financial success instead of success in learning and training. Only the most naïve believe that an overextended supervisor is capable of bestowing the amount of time, effort, and mental resources needed to keep up with such a number of supervisees and cases. Overall, supervisors need to be given more resources to ensure the quality of supervision. Time, adjustments to workload tied to supervisory responsibilities, fiscal compensation for the duties of “supervisor”, and respect for the service being provided will all support the supervisor and increase the initiative that supervision is a valuable, indispensable process. Administrations need to be persuaded that it is in the agency’s long term best interest to provide high quality supervision.

Previous research indicates that the best supervision tends to come from university training programs and “in-house training clinics.” As trainees move on to external training institutions, the focus on supervision and supervision quality tends to diminish (Romans et al., 1995). A dilemma arises when supervisees need the experiences offered in community settings in order to make them well-rounded, competent psychologists, but the institution providing the experience does not have the resources to provide high quality training. Respondents believe that there will soon be a push to emphasize the ethical and legal responsibilities of the supervisor. Gone will be the days of traditional supervision sessions consumed by case discussion; instead, the supervisory practice may well change, with requirements to document objective supervisory activities becoming the new norm. The data from this study suggests that measure such as these may be needed to prevent the occurrence of the sub-standard practice of supervision.

Limitations of the study

Data from a sample of 69 respondents was reported. Given that this is a relatively small number of respondents and as was noted earlier, it was impossible to identify with any accuracy what this number represented in terms of an overall response rate, the results discussed here should be interpreted with caution. The difficulty with calculating a response rate was a consequence of the process used to solicit participants. Training Directors were asked to both forward the participation request to current supervisors and also to respond with an indication of how many supervisors were contacted. Unfortunately, very few Training Directors responded with that number; therefore it was not possible to calculate a meaningful response rate. On the other hand, the sample did represent both clinical and counseling psychologists, Ph.D. degrees, Psy.D. degrees, various theoretical orientations, and a number of employment organizations.

Thus, there was diversity within the participant group, although additional research will be needed to assess how well these results represent the overall field of supervisory practice.

The self-report nature of this study may also present concerns, since social desirability has been shown to influence self-report (Ladany et al., 1996). What's more, it is possible that those training directors interested in supervision and supervision research were more likely to pass along the recruitment emails than supervisors with no particular interest in supervision. However, since the responses of the survey tended to indicate less than optimal individual and organizational practices in relation to clinical supervision, this does not appear to be an obvious concern for this particular study. Another limitation of this study is missing data. On some items, as many as 13 respondents failed to provide responses, which is concerning for such a small sample size. If the sample size was larger, statistical analyses may have evidenced other relationships and effects that were not present in this sample. Finally, having only one rater for the qualitative analysis may be seen as a limitation. However, due to the straightforward and specific responses from the participants, this is not expected to have invalidated the results.

Conclusion

Clinical supervision is the underpinning of the advancement of professional psychology. It has been recognized as a “profession in its own right” and includes skills and knowledge unique from any other aspect of psychology (Bernard & Goodyear, 1998; Carroll, 1996; McMaon & Simons, 2004). Unfortunately, the emphasis given to supervision in the “real world” does not do justice to the pivotal role attributed to it in the profession.

Previous studies demonstrate that trained supervisors are more highly rated by trainees (McMahon & Simons, 2004). The findings here suggest that training programs are providing more formal training in supervision than they have in the past. APA recently incorporated

supervision training into all accredited programs, which is the likely cause of this change (APA, 2002). Although this study failed to demonstrate a significant difference between the practices of those supervisors who had and had not received formal training, the nonsignificant findings may be due to the small sample size and decreased power of the analysis. In the future, it will be important to continue monitoring the degree of training in supervision and examine the effects training has on clinical practice, supervisee learning, and client outcomes. In addition, further exploration of the role CACREP plays in supervision training in counseling psychology, and the specifics surrounding the enhanced training of supervisors in counseling psychology are needed. Counseling psychology could serve as a supervision training template for clinical and school psychology programs.

Exploration of the administrative effects provided insight into the current trends of supervision. On average, supervisors are responsible for more supervisees, and therefore more clients, than ever before (Hess & Hess, 1983; Tyler, Sloan, & King, 2000). The growing need for supervisors in the field is resulting in a disproportionate number of supervisees to supervisors, and is causing ethical and legal concerns for the profession. To compound this, as financial demands increase, billable services are emphasized and valued supervisory time is minimized, which results in significantly less time to implement those supervisory methods that account for optimal supervision. Examination of legal liabilities and national and state regulating agencies in comparison to current practices may offer insight into whether the limits of supervisor responsibilities have truly been crossed or if we are overly concerned. Better guidelines surrounding the ethical practice of supervision may be needed, and may urge agencies to give more merit and increased resources to supervision/supervisory work entirely.

In the future, it will be important to develop standards for the practice of supervision. The process of supervisee evaluation would benefit from more consistency in the way it is practiced. Further development and validation of supervision inventories will be helpful to the extent that they clarify training goals, measure supervisee skill development and competence, and offer reliable feedback to supervisees and external groups such as training programs and licensing boards. A push toward awareness surrounding the methods by which supervisors are gaining information from their supervisees is also warranted. Supervisors cannot continue to gain the majority of their knowledge of cases from the self-report of the supervisee (Ladany et al., 1996). Preparations must be made to incorporate technology into the field to expand and prepare for the developing ethical, legal, and training responsibilities of supervisors.

The practice of supervision needs to be re-organized so that the training component is more strongly emphasized. It is important to explore more fully how educators and training programs can encourage and support the most advantageous ways to incorporate trainees into off site training facilities. If organizations and administrations begin to recognize the usefulness of high quality supervision and its impact on the professional community, they would likely begin to provide better resources to supervisors, and thereby require higher quality supervisory practices. Clinical supervision plays a pivotal role in advancing the practice of professional psychology and cannot continue to function as it has been, when such an approach so clearly raises important ethical and professional responsibility questions. A need for clearer expectations and higher standards for clinical supervision is clearly supported by the data presented and discussed in this study.

APPENDIX A

Supervisors' Perspectives

amerikan@marshall.edu. If you have any questions regarding this study or what is expected of your voluntary participation, please feel free to contact me at rose73@marshall.edu . For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Stephen Cooper or ORI at (304) 696-4303.

PLEASE CHOOSE A NUMBER:

- (1) I have read this page, and I would like to take the web based survey. (Please click NEXT to access the survey)
(2) I have read this page, and I would NOT like to take the web based survey. (Please close your window)

Demographics

1. Are you currently a student?

Yes

No

* 2. What is your highest earned degree and in which field?

M.A. - Counseling Psychology

Ph.D. - Clinical

M.A. - Clinical

Ph.D. - Counseling Psychology

M.S. - Counseling Psychology

Psy.D. - Clinical

M.S. - Clinical

Psy.D. - Counseling Psychology

MSW

Ed.D.

3. Are you licensed?

Yes

No

Training

1. During your formal training (i.e. required for completion of your degree), did you take a formal class on clinical supervision?

Yes

No

Training (5)

Supervisors' Perspectives

1. Was the training experience required or offered as an elective?

- Required
- Elective
- Not Applicable
- Other (please specify)

2. Which of the following teaching methods were employed: (check all that apply)

- Lecture/Didactic Instruction
- audio/Video Learning
- Group Discussion
- Individual Supervision of Supervisee
- Assigned Readings
- N/A

Other (please specify)

3. What were the primary learning activities you were asked to engage in?

***Check all that apply**

- Exams/Papers
- Journal Readings
- Textbook Readings
- Presentations
- Supervision of a less experienced trainee

Other (please specify)

4. Were you ever required to provide supervision to another student as part of your own training?

- Yes
- No

Supervisors' Perspectives

1. Do you currently serve as a clinical supervisor?

Yes

No

2. Do you currently provide clinical services, other than supervision, as part of your line of work?

Yes

No

3. Which of the following best describes the length of time you have served as a clinical supervisor?

0-5 years

6-10 years

11-15 years

16-20 years

21-25 years

26+ years

Supervisors' Perspectives

7. Generally speaking, how many supervisees are you primarily responsible for at one time?

- 0
- 1
- 2
- 3
- 4
- 5
- 6+

8. At any given time, what is the typical case load for each of your supervisees?

- 0-3
- 4-6
- 7-10
- 11-15
- 16+

9. Which of the following best describes your theoretical orientation?

- Behavioral
- Cognitive Behavioral
- Psychodynamic
- Interpersonal
- Feminist
- Existential
- Client Centered
- Adlerian
- Eclectic, Generalist, Integrative
- Other (please specify)

Supervisors' Perspectives

13. In one week, approximately how much time do you spend conducting informal supervision (i.e. supervisee(s) stopping by to ask a question).

- 1-15 minutes
- 16-30 minutes
- 31-45 minutes
- 46-59 minutes
- 60-90 minutes
- 91-120 minutes
- Over 120 minutes

14. Outside of regularly scheduled supervision sessions, approximately how much time each week is devoted to supervisory related tasks (i.e. co-therapy, review of case notes, review of videos, etc.)

- 0-15 minutes
- 16-30 minutes
- 31-45 minutes
- 46-60 minutes
- 61 -75 minutes
- 76-90 minutes
- 91-120 minutes
- 120+ minutes

15. Typically, who selects the cases that will be reviewed during individual supervision?

- Supervisee selects cases
- Supervisor selects cases
- Supervisee & Supervisor equally share responsibility
- All cases are discussed each session

16. Are you responsible for implementing group supervision?

- Yes
- No

Supervisors' Perspectives

1. Which of the following best describe the frequency with which you provide **SUMMATIVE** evaluation?

- Once per semester
- Twice per semester
- 3X per semester
- Once per quarter
- Twice per quarter
- 3X per quarter
- Once per year
- Twice per year
- 3X per year
- No Summative Evaluative Feedback is Provided
- Other (please specify)

2. Which method(s) do you employ for summative evaluation? (check all that apply)

- Qualitative Statements
- Empirically Validated Rating Scales
- Numerical or Likert-type Scales Developed by Training Program
- Personally Created Rating Scales
- Not Applicable
- Other (please specify)

Supervisors' Perspectives

Logic (6)

1. Which of the following technologies have you used for the purpose of supervisory communication because you and your supervisee were not in the same location?

(check all that apply)

- Email
- Telephone
- Live or Real Time Internet "Chat"
- Interaction via webcams or television (e.g. polycom or similar technology)
- None
- Other (please specify)

Administration Questions

The following questions will focus on the administrative influences on supervision.

1. Is the program you are currently associated with APA accredited?

- Yes
- No
- Not Applicable

2. Is supervision required as a part of your job description?

- Yes
- No

3. Did your institution require evidence of previous training in supervision prior to including supervision as part of your work requirement?

- Yes
- No

Supervisors' Perspectives

3. If you answered "Yes" to the above question, which of the following method(s) are used?

Administrative Training

Collegial Consultation

Seminar

Not Applicable

Other (please specify)

4. Does your institution offer excused leave of absence to attend continuing education in supervision?

Yes

No

5. Does your institution offer financial reimbursement to attend continuing education in supervision?

Yes

No

Likert Portion

Please answer the following questions using the likert scale provided.

Supervisors' Perspectives

3. To what extent do you consider yourself legally responsible for your supervisees' cases?

| | Fully Responsible | | Moderately Responsible | | Not at all Responsible | N/A | |
|--|-----------------------|-----------------------|------------------------|-----------------------|------------------------|-----------------------|-----------------------|
| To what extent do you consider yourself legally responsible for your supervisees' cases? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Qualitative Portion

1. If you were to provide the most optimal supervision, what would it look like?

2. What, if anything, prevents you from providing optimal supervision?

3. What do you perceive as the current and emerging challenges of providing clinical supervision?

APPENDIX B

Email Requesting Participation

Dear Director(s) of Training,

I am a doctoral student at Marshall University in West Virginia, and I am conducting research for my dissertation about supervisors' perspectives of current trends in clinical supervision. I am asking if you will please forward this email to all clinical or counseling psychologists on staff at your training program who are currently supervising trainees at either the practicum or internship level. Your assistance is greatly appreciated.

Thank you,

Terra Rose, M.A.

Doctoral Candidate, Clinical Psychology

Marshall University

Dear Psychologist,

Through this email, I am asking you to participate in a research project regarding clinical supervision in professional psychology. Specifically, I am interested in supervisors' perspectives of current trends in supervision. The study includes questions related to training experiences in supervision, recent practices of supervision, and institutional factors that may affect supervisory practices. In addition, participation includes responding to items on the questionnaire pertaining to demographic information.

The entire survey is online and will take approximately ten to fifteen minutes to complete. You are welcome to complete part of the survey, and then return to complete it at a different time. Your participation in this study is completely anonymous and voluntary.

I sincerely hope that you will agree to participate in the study! If you have further questions or would like more information regarding this research, including information about the results of this study, you may contact the principal investigator via email at: rose73@marshall.edu or my dissertation advisor, Dr. Marty Amerikaner at: amerikan@marshall.edu.

To participate in the study, please go to the following website:

Thank you sincerely,

Terra Rose, M.A.

Doctoral Candidate

Marshall University

Huntington, WV 25755

- This study [#112451-1] has been approved by the Marshall University Institutional Review Board

APPENDIX C

INFORMED CONSENT

Purpose and Duration of Research:

I greatly appreciate your time and willingness to consider participating in this study. With your participation, I hope to learn more about the practice of clinical supervision in professional psychology. It is estimated that your participation in this survey will take approximately fifteen to twenty minutes.

Procedures:

You are invited to take part in this survey if you are currently a psychologist serving as a clinical supervisor. The survey is composed of questions related to various professional issues including, graduate training, recent practices of supervision, and institutional factors that may affect supervisory practices. Additionally, basic demographic information will be requested.

Voluntary Participation/ Anonymity:

Participation in this study is completely voluntary and anonymous. You may withdraw your participation from this study at any time without consequence. You will not be asked to reveal any identifying information and there will be no way of identifying who submitted any particular piece of data or survey protocol. Any publication of the data from this survey will in no way identify you or your institution. Results will be reported in aggregate form only.

You will receive no payment or other compensation for taking part in this study.

Anonymity/ Confidentiality Maintenance:

No data collected on this survey program can be traced to your name, email address, or institution. The content of the survey information will be reported from the website in aggregate form and will be collected in the strictest confidence. The online survey will be contained within a password protected program. In addition, data files created for statistical analysis will involve no identifying information. Survey data will be accessible only to the researchers named at the closing of this form and members of my dissertation committee.

We will do our best to make sure that your personal information is kept confidential. However, we cannot guarantee absolute confidentiality. Federal law says we must keep your study records private. Nevertheless, under unforeseen and rare circumstances, we may be required by law to allow certain agencies to view your records. Those agencies would include the Marshall University IRB, Office of Research Integrity (ORI) and the federal Office of Human Research Protection (OHRP). This is to make sure that we are protecting your rights and your safety. If we publish the information we learn from this study, you will not be identified by name or in any other way.

Anticipated Risks and Discomfort:

There are no known risks involved with this study. Participation is completely voluntary and there will be no penalty or loss of benefits if you choose to not participate in this research study or to withdraw. If you do experience psychological discomfort, please exit the study. Additionally, if psychological discomfort persists, please contact your university counseling center or locate a mental health professional.

Research Contact:

We would like to thank you in advance for your time and consideration. If you wish to receive a copy of the study's results, you may contact us at the email addresses below. For questions about the study or in the event of a research-related problem, contact the principal investigator, Dr. Marty Amerikaner at (304) 696- 2783 or amerikan@marshall.edu. If you have any questions regarding this study or what is expected of your voluntary participation, please feel free to contact me at rose73@marshall.edu . For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Stephen Cooper or ORI at (304) 696-4303.

By clicking on the "Next" button below, you confirm that you have read and understand the foregoing information, that you have received answers to any questions, and you consent to participate in the study.

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- Watkins, C.E., Jr. (1992). Reflections on the preparation of psychotherapy supervisors. *Journal of Clinical Psychology, 48*, 145-177.
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TERRA L. ROSE

Curriculum Vitae

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300 Veazey Road
Butner, NC 27509
Phone: (919) 764-2238

Email: rose73@marshall.edu

EDUCATION

September 2009- Present

Psychology Predoctoral Intern
Central Regional Hospital/Dorothea Dix Hospital
Raleigh, NC
University of North Carolina School of Medicine
Chapel Hill, NC
American Psychological Association-approved program
September 2010 (Anticipated Completion)

August 2005 – Present

Psy.D. Candidate, Clinical Psychology
Marshall University, Huntington, West Virginia
American Psychological Association-approved program
2010 (Anticipated Graduation)

August 2005- August 2007

M.A., Clinical Psychology
Marshall University, Huntington, West Virginia

August 2001 – May 2005

B.A., Psychology, May 2001
Summa Cum Laude
University of Tennessee, Knoxville, Tennessee

HONORS AND AWARDS

Feil Memorial Scholarship for Excellence in Clinical Psychology, May 2010

Excellence in Campus Leadership Award – APAGS Division of APA, June 2008

Marshall University Graduate Research Travel Award – 2007, 2010

Psi Chi National Honor Society, August 2003-present

National Dean's List, December 2001-2005

University of Tennessee Dean's List, Eight Semesters

PROFESSIONAL AFFILIATIONS

American Psychological Association (2006 – present) Student Affiliate

West Virginia Psychological Association (2007-present) - Student Affiliate

Association of Behavior and Cognitive Therapies (ABCT) - Student Affiliate

OFFICES HELD WITHIN PROFESSIONAL ORGANIZATIONS

APAGS – Advocacy Coordinating Team Subcommittee – Campus Representative (August 2007 – August 2009)

Represented APAGS on campus to psychology graduate students; served as mediator to relay student concerns, questions, and issues to the APAGS Board for consideration; kept students abreast of professional and legislative issues as directed by APAGS.

University of Tennessee Psi Chi – Vice President (August 2004 – May 2005)

University of Tennessee Psi Chi – Secretary (August 2003-May 2004)

ADVISORY BOARDS/COMMITTEES

Marshall University Student Operated Advisory Panel (SOAP)

Class Representative to SOAP

August 2006 – May 2009

APAGS Representative to SOAP

August 2007 – May 2009

Let's Get Moving!

February – April 2007

Served as the mental health consultant to this state program that provides behavioral health interventions to children in West Virginia

Marshall University Gay/Straight Alliance

August 2006 – May 2009

Graduate Mentor

CONTACT Rape Crisis Center

January 2006 – July 2009

Committee on Intervention Development

SUPERVISED DOCTORAL TRAINING

- Central Regional Hospital/Dorothea Dix Hospital** September 2009 – present
Butner, NC and Raleigh, NC, Pre-Doctoral Intern
Supervisors: Thomas Guthrie, PhD; Madeleine Crockett, PhD; Trinda Lee, PhD;
John Helminski, PhD, ABPP
Provide clinical services to an inpatient population; serve as the resident
psychologist to multidisciplinary treatment teams, provide individual and group
therapy, provide behavioral assessment and intervention, provide full diagnostic
assessment (personality, neuropsychological screening, cognitive functioning).
- University of North Carolina School of Medicine** March 2009 – present
Chapel Hill, NC, Pre-Doctoral Intern via Central Regional Hospital
Supervisor: Eileen Burker, PhD
Provide lung and heart pre-transplantation evaluations; provide consultation
to lung transplantation and heart transplantation multidisciplinary teams, provide
individual psychotherapy to individuals on pulmonary and cardiology units.
- Prestra Community Mental Health Center** August 2008 – June 2009
Wayne, West Virginia
Supervisor: Paul Mulder, PhD
Provided individual and family therapy primarily to low-income clients in an underserved, rural
area in West Virginia; conducted psychological evaluations (e.g. psychoeducational, adult court
ordered, and general cognitive functioning); provided consultation to a multidisciplinary mental
health treatment team; participated in live, individual, and team supervision weekly.
- Veterans Affairs Medical Center** May 2008 – September 2008
Huntington, West Virginia
Supervisors: Clifton Hudson, PhD
Roslyn Feierstein, PhD, ABPP
Provided psychological evaluations (e.g. neuropsychological screenings, pre-operative
assessments, psychoeducational batteries); provided individual therapy
- Presley Ridge Residential Treatment Center** February 2008 – April 2008
Supervisor: Keith Beard, PsyD
Developed and conducted a psychoeducational and social skills group for youth ages 13-17 who
had mental health and/or delinquency issues.
- Mildred Mitchell Bateman Hospital - Psychiatric** August 2007 – June 2008
Supervisor: R. Vernon Kirk, PsyD
Emphasis on SPMI population; completed intake evaluations; participated in multidisciplinary
treatment team planning; completed psychological evaluations (e.g. neuropsychological
screenings, personality assessment, Title IX evaluations); provided individual and group therapy
to general population; planned, organized, and implemented group therapy for forensic patients;
participated in live, individual, and team supervision weekly.
- Psychological Services Center, Marshall University** August 2006 - August 2008
Supervisor: Tom Ellis, PsyD, ABPP
Provided individual, couples, and family psychotherapy to college students and community
members with a variety of Axis I and Axis II diagnosis; completed psychological evaluations (e.g.
psychoeducational, ADHD, personality assessment); conducted long-term individual and couples
psychotherapy as a member of the clinic's advanced team; participated in live, individual, and
team supervision weekly.

West Virginia Head Start Association

August 2006 – July 2007

Supervisor: Marianna Footo-Linz, PhD

Served as mental health consultant to local agency; provided individual and family therapy to diverse clients from multicultural backgrounds; provided consultation to instructors and parents regarding appropriate childhood development; developed behavior support plans for home and classroom

OTHER CLINICAL EXPERIENCE

Emily Wilson Psychological Associates

March 2009 – present

Conduct psychological testing in a variety of locations for the purposes of disability evaluations, TBI impairment, cognitive functioning, and ADHD diagnosis.

CONTACT Rape Crisis Center and 24-Hour Hotline June 2007 – August 2009

Counseled distressed callers concerning sexual victimization, depression, feelings of loneliness, alienation and abandonment; provided counseling/consultation during hospital visits for women who have recently been sexually assaulted.

Princeton Community Hospital Behavioral Medicine Unit May 2004 – August 2004

Administered structured intake interviews, provided psychoeducational group presentations; observed the administration of a variety of neuropsychological and health psychology assessment instruments.

RESEARCH EXPERIENCE

Dissertation (Defended August 2009)

Chairperson: Marty Amerikaner, PhD

Research examined supervisors' report of variables influencing quality of supervision (e.g. levels of training, monetary reimbursement, methods of supervision).

Efficacy of Group Therapy for Rape Survivors Research Project (June 2008 – present)

Collaboration with CONTACT Rape Crisis Center in development of study examining efficacy of time-limited process group for rape survivors.

Graduate Research Assistant (August 2005 – May 2007)

Mentor/Supervisor: Dr. Marty Amerikaner, Marshall University

Contributed to literature reviews; developed survey; project management; data from the project contributed to poster presentations at national and state conferences; manuscript in review.

Undergraduate Research Assistant (August 2003 – May 2005)

Mentor/Supervisor: Dr. Robert Wahler, University of Tennessee

Contributed to literature reviews; collaborate in research for and conceptualization of a study that examined the relationship between self-reported mindfulness and psychological symptoms, autobiographical narratives, and parenting styles; ran subjects; trained other assistants to administer inventories.

PROFESSIONAL PRESENTATIONS

Rose, T., & Amerikaner, M. (2010) Supervisors' Perspectives: Variables Influencing the Quality of Supervision. Anticipated poster presentation at the annual American Psychological Association national convention, San Diego, Ca.

Rose, T. (2009). Psychological and Behavioral Health Issues in Appalachia. Lecture presented as part of a panel discussion at the annual Appalachian Studies Association, Scioto, OH.

Rose, T. (2008). Clinical supervision in professional psychology: Current practices and problems. Poster session presentation at the annual West Virginia Psychological Association (WVPA), Morgantown, WV.

Amerikaner, M., & Rose, T. (2007). Current practices in professional psychology: A "snapshot" of real world practices. Poster session presentation at the annual American Psychological Association national convention, San Francisco, CA.

Amerikaner, M., & Rose, T. (2007). Supervision in Appalachia: Current practices and problems. Lecture presented as part of a panel discussion at the annual Appalachian Studies Association, Maryville, TN.

PUBLISHED ARTICLES

Rose, T. (2006). A successful addition to abduction-prevention skills training, *Behavior Analysis Digest*, 18(3),

Amerikaner, M., & Rose, T. (Manuscript in review). Clinical supervision in professional psychology: Current practices and problems.

TEACHING EXPERIENCE

Graduate Teaching Assistant, Marshall University (August 2006 – May 2008)

Supervisor: Christopher Legrow, PhD

Instructor of General Psychology (201) class for four semesters; independently responsible for lecture preparation and presentation, test construction, grading, developing and managing class website.

Course on University Teaching, Marshall University (January – May 2006)

Completed preparation course for future teaching position at the university level.

Undergraduate Teaching Assistant, University of Tennessee (August 2004-May 2005)

Supervisor: Richard Saudargass, PhD

Teaching assistant to four individual courses; responsible for administration and scoring exams, weekly office hours, tutoring, calculating grades, and updating course website.