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Supervision Quality and its Impact on Client Outcomes:

A Review of Meta-Analytic Studies with Case Examples

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Abstract

This doctoral paper explores the impact of supervision quality on client outcomes. There is currently limited literature addressing the effect of supervision quality on the treatment outcomes of doctoral trainees' clients. This doctoral paper first reviews historical and recent literature on supervision and client outcomes. It then discusses the characteristics of high quality supervision along with a relevant case example. The paper then addresses the characteristics of poor quality supervision by both noting its potential impact on client outcomes and identifying a plan of action for when a clinical psychologist or other clinical psychology professional exhibits these characteristics in his or her provision of supervision to trainees. A case example is also provided to illuminate the impact of poor quality supervision on clients and their treatment outcomes. Supervision quality is determined using Falender et al.'s (2004) supervision competencies (as part of the essential elements) as a template and for comparison.

Keywords: supervision, client outcome, supervision competency, supervision quality

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Supervision does seem to offer opportunities for [trainees] to improve . . . which raises the likelihood that client outcome is improved as a result of supervision. However, the link [of supervision] to improved outcome for clients is tentative and . . . the longer term impact of supervision is unknown. (Wheeler & Richards, 2007, p. 54)

Research regarding the impact of clinical supervision on psychotherapy clients has only marginally advanced in the last decade, despite its long and respectable role in training future clinicians. The aim of this doctoral paper is to identify both positive and negative characteristics of supervision, using an essential-elements framework for the training of health service doctoral psychology students, which could improve client outcomes. Good and poor quality supervision is illustrated through the use of case examples (with redacted demographic data). The paper concludes with recommendations for the field.

This paper defines supervision using Bernard and Goodyear's description:

...evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to clients that she, he, or they see; and serving as a gatekeeper for those who are to enter that particular profession. (Bernard & Goodyear, 2009, p. 7)

Supervision within the clinical psychology field involves a senior member (supervisor) a junior member (trainee) and the client. A supervisor acts as teacher and mentor for trainees so that they may strengthen their clinical skills and subsequently provide more effective psychotherapy. Supervisors also have an ethical mandate to serve as gatekeepers, potentially removing from the

field trainees showing indications of either causing their client(s) harm or of significant incompetence. It is logical to assume that the better the quality of a trainee's supervision, the better the chance that the client will show a more improved outcome in treatment. Yet, there remains limited empirical evidence that supports such assumptions (Watkins 2011; 2017). Thus, this paper focuses on the impact supervision quality has on client outcomes by using supervision vignettes and an essential elements supervision framework.

Supervision and Client Outcomes

How much does supervision quality account for client variance in outcomes? Does high quality supervision correlate with better client outcomes, or does its influence plateau after reaching the baseline for minimal competence? What happens when supervision is poor in quality? To date, only a few literature meta-analyses have been published with a particular focus on supervision and its efficacy. The three that cover the most relevant studies for this paper were authored by the following researchers: Ellis and Ladany (1997), Freitas (2002), and Watkins (2011, 2017).

Twenty years ago, Ellis and Ladany (1997) examined all the supervision-related studies that had been conducted since the early 1980s. They found five studies published between 1981 and 1997 that examined supervision's impact on client treatment outcomes (Couchon & Bernard, 1984; Iberg, 1991; Kivlighan, Angelone, & Swafford 1991; Sandell, 1985; Steinhelber, Patterson, Cliffe, & LeGoullon 1984). None of the nine studies were empirically-valid at that time; yet, they determined the existing research did still offer useful information regarding the potential factors that underlie supervision and its quality. Some of the studies even measured client outcomes, despite using differing rating scales of varying reliability. In 2002, five years after Ellis and Ladany (1997) wrote their review, Freitas (2002) examined the same studies considered by

Ellis and Ladany's (1997) regarding supervision characteristics and impact on trainees and clients. He conducted a comprehensive meta-analysis and added Dodenhoff (1981) to his review. Freitas (2002) criticized all these studies regarding empirical validity, reliability, and generalizability. He believed that some of the information from these studies were useful, but each study on its own was much less informative than it was in combination with the others. In 2017, fifteen years after the Freitas (2002) review, Watkins reviewed the studies present in both the Ellis and Ladany (1997) and Freitas (2002) reviews. The difference with Watkins (2017) was that he chose to place greater focus on client impact as the result of the trainee's growth via supervision.

In 1984, Couchon and Bernard (Ellis & Ladany, 1997; Freitas, 2002; Watkins, 2017) studied the timing of supervision. They looked at the length of time in between the trainee's supervision and their next therapy session with their client and measured differences in effectiveness of the sessions and influence of the supervisor's suggestions in supervision. They analyzed the logistical component of the timing of supervision by tracking client outcome differences in relation to time span between a supervision meeting and a trainee's session with a client. Couchon and Bernard (1984) hypothesized that a greater time lapse between a client's therapy session and the respective trainee's supervision would correspond with a lower level of reported client satisfaction. They measured client satisfaction with an outcome rating scale, which clients completed at the end of each weekly session. Couchon and Bernard (1984) believed that a shorter time lapse between trainee supervision and client therapy would lead to an improved treatment outcome upon therapy completion. The client's report of wellbeing indicated such an outcome through self- and other (i.e. supervisor, trainee) outcome rating scales and outcome measures as well as improvement in functioning in activities of daily living (ADLs). If there was evidence of client improvement and a steady rise in changes, progress, or both over cumulative

and regularly attended sessions, then the treatment outcome consisted of the overall change that the client indicated in his or her own rating scale reports each session as well as the outcome measures that the trainee and his or her supervisor used each session. Both the trainees and their supervisors monitored assessment of client change each therapy session, typically on a weekly or bi-weekly basis. For Couchon and Bernard (1984), data collection was an ongoing process throughout clients' psychotherapy.

Freitas (2002) and Watkins (2017) have examined Couchon and Bernard's (1984) study and neither found any differences in client outcomes. Couchon and Bernard (1984) have noted several limitations to their study: same clients under different treatment conditions, direct versus indirect supervision feedback not measured (i.e., in vivo or live feedback versus discussing sessions afterwards), measurement descriptions lacked sufficient details for replication, and there existed no psychometric data in the publication.

Another concern regarded the group whose sessions most closely followed supervision, as the participants in that group tended to use supervisor-suggested interventions and input more often than the other groups (Freitas, 2002; Watkins, 2017). Freitas (2002) and Watkins (2017) have noted that this issue could potentially hinder a trainee's growth as an incumbent professional in the field. Couchon and Bernard (1984) have expressed a similar sentiment in that an increased tendency to accept supervisory-related suggestions came at the expense of the trainee's case conceptualization in supervision. Despite several psychometric errors and ambiguous dependent variables in this study, it was the first to assess timing as a moderator of client outcome in supervision.

Although the most recent studies on this topic still lack sufficient validity, many have discovered aspects that define high and low quality supervision. Both Freitas (2002) and Watkins

(2017) have proposed creating more psychometrically valid measures for measuring supervision quality and its impact on trainee competency and client treatment outcomes. These researchers concluded that, in general, studies need to be conducted in a more meticulous manner to obtain and explicitly address psychometric data. Moreover, Freitas (2002) has noted the need for specific, psychometrically sound instruments to track client outcome data, students from similar training backgrounds and levels, randomly assigned clients, and multiple sources (e.g. trainee/trainee, supervisor, client) reporting on client outcomes. Much like Freitas (2002), Watkins (2011) has found that supervision-client outcome studies have apparently been limited in terms of validity or their ability to be generalized to other client populations. Despite this disappointment, both Freitas (2002) and Watkins (2011; 2017) have deemed the research to have value, as each of these studies highlights several factors that could provide insight into which key components of supervision could influence client outcomes. The present paper contributes to the analyses of Freitas (2002) and Watkins (2011, 2017) while providing relevant case studies to further illuminate the link between supervision quality and client outcomes.

Common Supervision Characteristics

The most basic and important aspects that comprise supervision are its format and structure. These include elements like supervision length, scheduling, and each supervision session's typical agenda. Steinhelber et al. (1984) were among the first researchers to examine how one basic aspect, timing, could have an influence on clients and their treatment outcomes.

First and foremost, Steinhelber and colleagues (1984) realized that factors as simple as the amount of supervision the trainee received (i.e., duration) and their theoretical congruence with their supervisor factor into supervision's quality and its impact on client outcomes. This

study specifically highlighted potential supervision-related factors with the ability to effect change in a client and his or her psychotherapy. Further, Watkins' (2017) published a comprehensive analysis wherein he discovered over 50 generalizable commonalities that go into the provision of high quality, competent supervision.¹ Watkins (2017) has organized these commonalities into nine categories, which makes his works easier to use perhaps as a guide for supervisors; this information could enable the provision of more competent, higher quality supervision within the clinical psychology community. These studies are discussed in further detail in this section.

Supervision Qualities

Steinhelber et al. (1984) have examined both the supervisory relationship and the measurable quality of supervision duration in terms of how they impact client outcomes, with the aim of determining whether the amount of weekly and total supervision that trainees received would impact clients and client outcomes. Additionally, these researchers sought to test supervisor-trainee theoretical congruence to analyze how that congruence—or its absence—could effect change in a client's treatment progress. They hypothesized that the amount of supervision that was received, the level of supervisor-trainee theoretical congruence, or both together would positively correlate with client outcome (Steinhelber et al., 1984).

The Steinhelber et al. (1984) study had some considerable limitations that must be taken into account when reviewing the findings. The participants receiving the services (i.e., clients) had a big rang in terms of their identified psychological disorders or other more situational diagnoses such as work stress and phase of life adjustment-related concerns (Freitas, 2002; Watkins, 2017). This study is not only restricted in terms of its client demographics, but the demographics

¹ Watkins (2017) has accounted for notable differences between supervisors, trainees, and supervision groups in his comprehensive examination of the literature. Some variances in supervision include theoretical and training-related preferences, cultural backgrounds, and interpersonal traits and skills.

of the trainees giving the psychological services. Steinhelber's (1984) participating trainees came from a diverse range of clinical backgrounds. These backgrounds varied from being a psychiatric resident to a student social worker, also including those receiving graduate training in either the counseling or clinical psychology fields (Freitas, 2002, Watkins, 2017). Furthermore, there were several limitations in Steinhelber's (1984) methodology and infrastructure. Mainly, the client outcome rating measure lacked psychometrically sound validity, as it had not been tested for efficacy prior to use and was created by a trainee participating in the study itself (Watkins, 2017). This unfortunately precluded any cause-and-effect conclusions to link supervision factors to client outcomes. Regardless, the study ultimately revealed some new factors that could guide future research using psychometrically valid measures for client outcome ratings.

Furthermore, Watkins (2017) has emphasized the influence of structure in supervision, particularly in its consistency from week to week throughout the duration of a particular supervision. Watkins (2017) has noted that supervision occurs primarily in educational or education-minded settings in which supervisors set up a routine format for supervision sessions and maintain this format during most if not all, of their sessions with their respective trainees. Structural implementations are the implicit and explicit guidelines set forth within each supervision group that set precedence for the supervision sessions. These should demonstrate the supervisor's ability to balance the sessions' integrity or consistency with his or her ability to customize and adapt the structure of sessions when necessary. Items and exercises a supervisor could choose to implement into their sessions' agenda: a check-in, case presentations, and didactic trainings. Structural implementations should be used to further assist their trainees with providing competent therapy to their clients.

Trainee Qualities

Another factor to consider is the qualities of the trainee--that is, both the personal and professional characteristics of the trainee that may influence the supervision and any related supervisory relationships (e.g., peers in group supervision or one's supervisor). This area includes several factors commonly found to be influential across all supervision models, modalities, and settings. These factors include many trainee(s) characteristics: (1) psychologically mindedness, (2) engagement in the supervisory process, (3) investment in the supervisory relationship, (4) open-mindedness, (5) positive expectations of one's work in supervision and with clients, and (6) self-reflection and awareness of one's growth areas, both professionally and personally (Watkins, 2017). Many professionals within the clinical psychology field have maintained that supervision without these seven factors present may be ineffective and thereby may make it more difficult or impossible for the trainee to develop as a professional in the field.

Supervisor Qualities

Supervisor qualities and characteristics are another area that Watkins (2017) has deemed important to quality supervision. This area includes the common factors of (1) having a level of engagement or investment in the supervision process and in the trainees, (2) showing trainees a level of warmth and support in supervision, (3) being concrete in supervision when helpful or necessary, (4) showing trainees a level of acceptance, (5) cultivating positive expectations and hope amongst the supervision trainees, (6) having positive regard, (7) showing empathy for trainees and their clients, (8) being genuine individuals, and (9) endorsing and practicing their own reflectivity as supervisors. These factors coincide with the generally accepted concept that regards supervision to be a largely relational training experience.

Watkins (2017) has stated that the supervisor-trainee relationship is considered one of the most vital mediators—if not the most vital—for making supervision interventions progressively

helpful. Together, these factors build and maintain a strong working alliance within the supervisor-trainee dyad. The supervisor is a role model for the trainee with regard to characteristics that are inherent to a good psychotherapist. The supervision relationship is probably the most important relationship that trainees have during their training years, as the majority of their clinical expertise is guided by supervisors who oversee their psychotherapy and foster their clinical capacity and competence.

Supervision Change Processes

Watkins (2017) has examined the impact of trainee change processes on the effectiveness of supervision and found several factors that impact the supervisory experience and clinical outcomes. These trainee change processes may include (1) opportunities to share training-related developmental concerns, (2) anxiety and tension reduction, (3) self-observation (i.e. looking at one's own processes, biases, and/or countertransference), (4) exposure to learning difficulties, (5) acquisition of new skills and information, and (6) mastering clinical knowledge and skills in a developmentally appropriate manner (Watkins, 2017). Watkins' (2017) factors are helpful in identifying the catalysts for change and growth commonly found in the natural course of trainee development. These catalysts for change contribute to trainees' professional identities and their "conviction about the meaningfulness of psychotherapy" (Watkins, 2017, pp. 144).

The aforementioned traits must be present in supervision to enable the supervisor to provide feedback, constructively challenge the trainee, and assist the trainee in developing his or her sense of professional identity as a psychotherapist (Watkins, 2017). In the trainee's learning process in a doctoral training program, skills and knowledge build upon one another, and problem-

atic behaviors and mindsets are challenged early in the trainee's development of his or her identity as a clinician. Without these processes present in trainee change behaviors, growth as a clinician may entirely come to a halt.

Supervisory Relationships

Watkins (2017) has described the supervisor-trainee relationship and noted its importance in competent clinical supervision. The supervisor-trainee relationship is comprised of the supervisory alliance (i.e. the professional relationship), the real (i.e. personal) supervisory relationship, transference, and countertransference. The nonworking or personal relationship between a supervisor and trainee is decisive in forming a bond that can sufficiently withstand the challenging work that is expected of both supervisors and trainees in supervision. Most current supervision models and perspectives also allow for the processing of transference, whereby trainees may process their own personal experiences, which may occasionally have a substantial impact on how they experience their respective supervisors. There is also consideration of countertransference, which is similar to transference but extends to the trainee's experience of his or her client and the supervisor's experience of the trainee and the trainee's client (Watkins, 2017).

The Supervisory Working Alliance. The working alliance cultivation involves utilization of one's interpersonal and professional skill-set and intuition to create a trustworthy, supportive atmosphere amongst colleagues within the same system or organization (Barnett, 2007). The supervisor must not only model professional and personal self-assessment and reflection but also actively teach and support or encourage these as a piece of the supervision experience for the trainee (Barnett, 2007; Kaslow et al., 2007). Although overall interpersonal competency is difficult to quantify, it is clear that use of both self- and peer- assessment in supervision im-

proves trainees' overall professional development, interpersonal skills, and meta-knowledge capabilities. This collective feedback² has evidenced remarkable improvement in trainees' self-awareness and the supervisors' abilities to teach this to their trainees with an expanded awareness of their trainees' professional strengths and developmental needs or growth areas (Barnett, 2007).

Supervision Practice Principles

Common supervision practice principles are also significant. These include "creating an enabling space and tailoring to fit" (Watkins, 2017, p. 210) supervision so that it meets the learning, clinical, and developmental needs of each student or supervisory group. These two components of supervision are considered to be foundational to all supervision groups and supervisory practices. The goal of supervision is to provide an optimal learning environment for student trainees to develop and grow exponentially while customizing their experiences of supervision to their individual developmental level and learning needs (Watkins, 2017).

Tasks, Roles, and Practices. The tasks, roles, and practices of the supervisor and trainee in the course of supervision are fundamental to competent supervision. They form the supervisory foundation, which allows for its continuous improvement. Tasks include establishment of the supervisor-trainee relationship, trainee education, trainee needs, and progress assessment and evaluation. The final task, monitoring and evaluation, enables a supervisor to practice a gatekeeper role in an appropriate, methodical manner. Gatekeeping is a potentially unpleasant but necessary role within clinical supervision. It may entail deciding whether a trainee is suitable for clinical psychology. The supervisor may also need to assume the responsibility of determining if

² Collective feedback includes the trainee's self-assessment, the supervisor's assessment of the trainee, and the peer assessments. The peer assessments may include just the other peers in that particular supervision group, or your entire class within your training program if they have adequate knowledge of your professional development and current clinical/interpersonal skills

a trainee is capable of eventually providing competent psychological services and if the potential for harm exceeds the potential benefits of the individual's treatment (Watkins, 2017). Practices include the regular and consistent implementation of tasks and appropriate use of supervisor roles in the clinical supervision framework. The 50 common factors that Watkins (2017) analyzed were categorized into one of the following groups— both trainee and supervisor qualities and/or characteristics; trainee change or clinical development processes (i.e., catalysts for change in improving trainee competency); supervision structure (e.g., session agenda norms); supervision relationship traits; and lastly, common supervision principles, tasks, roles, and practices. Within these categorized groups, several commonalities were found across competent supervision groups that account for the majority of supervisions in a variety of supervision settings. Watkins and other researchers have provided a satisfactory template regarding relevant characteristics and skills that are necessary for competent clinical supervision. Though not all-encompassing or exhaustive, this comprehensive view of the typical composition of supervision can offer insight to more effectively identify high and low quality supervision.

Supervision Framework

To examine the elemental framework of supervision quality, this doctoral paper uses the competencies that Falender et al. (2004) have described. Although supervision quality occurs on a continuum, this paper focuses specifically on the roles of high and low quality supervision in client treatment outcomes. The supervision competencies provide a list of six categories for competent supervision: knowledge, skills, values, social context of overarching issues, training of supervision competencies, and assessment of supervision competencies (Falender et al., 2004). These competencies are based upon the framework elements of knowledge, skills, values, and

meta-knowledge (i.e. understanding the limitations of one's knowledge as supervisor) (Falender et al., 2004).

Knowledge. This first element, knowledge, pertains to a supervisor's lifelong commitment to continually learn relevant skills and information related to clinical supervision. The word "lifelong" must be emphasized, for it is crucial that any individual who assumes the responsibility of providing clinical supervision to trainees remains aware of and receives education and training in state-of-the-art interventions, research, and theoretical modalities of both clinical psychology and clinical supervision. Failure to do this may prevent a supervisor from providing effective, relevant supervision to trainees. Knowledge of the most recent literature, skills, and interventions allows supervisors to impart valuable information to trainees that can improve the long-term wellbeing of their clients.

Skills. Certain skills can be taught, while others must be learned through observation, tact, and subjective yet professional clinical judgment. For example, a supervisor who partakes in self-disclosure should do so only if relevant to and appropriate for the trainee's growth and development as a clinician. Such skills may include:

“relationship skills...sensitivity to multiple roles with supervisee and ability to... balance multiple roles, ability to provide effective... feedback, ability to promote (trainee) growth and self-assessment... ability to assess the (trainee's) learning needs and development level... didactic skills, ability to set appropriate boundaries and seek consultation when... outside (one's) domain... flexibility... and the translation of scientific findings to practice...” (Falender et al., 2004).

These clinical skills are vital to supervision, as they enable the trainee to benefit from what the supervisor has to offer in terms of training and modeling competency as a professional in the

psychology field. If a trainee or supervisor lacks several of these qualities that are catalysts for growth and development, it could be disastrous and potentially harmful to all involved, including the trainee and the client for whom the trainee is providing clinical therapeutic services.

Values. The value element of supervision quality includes diversity-related, ethical, legal, and personal values. It refers to a supervisor's attention to diversity as it relates to supervision and the supervisory relationship. Although diversity is relevant to all elements of clinical supervision, it is important to maintain a separate awareness of it in view of its all-encompassing impact on people's professional and personal backgrounds and relationships in supervision, therapy, and the outside world.

Meta-Knowledge. Meta-knowledge refers to an individual's awareness and insight into his or her developing professional competence (Epstein & Hundert, 2002). It is also seen as the awareness one holds of his or her current knowledge and abilities in addition to the awareness of what one lacks in both these capacities. Falender and Shafranske (2004) refer to this similarly using the terminology collaborative self-assessment, stating that supervision is a collaborative process which entails the ability of the supervisor to provide feedback so that the trainee can acquire better understanding of how to discern his or her current knowledge as well as one's limitations to knowledge. However, several researchers found inherent biases² within a supervisory relationship. These biases, including transference and countertransference, may affect the supervisor's ability to provide effective feedback and the trainee's own self-assessment, or meta-knowledge, capacities. Student meta-knowledge can be developed through this blend of supervisor-based feedback and trainee self-assessment, with the hopes of leading a trainee towards professional competence (Falender & Shafranske, 2004). Since self-awareness is such a large

part of supervision, it is thereby valuable in shaping the quality of a student's supervision. Studies including those by Couchon and Bernard (1984), Dodenhoff (1981), Harkness and Hensley (1991), Iberg (1991), and Steinhelber et al. (1984) have illuminated current characteristics that improve client outcomes when embedded within the supervisory experience.

Supervisory meta-knowledge includes the supervisor's ability to integrate his or her self-assessment with the assessments given to this supervisor by his or her peers. This concept of integrating self-assessment with supervisor-peer assessments is a fairly robust method for increasing a supervisors' meta-knowledge abilities so they may continue to grow as a mentor and provide supervision with more awareness of his or her biases, values, and competencies. For the trainees receiving supervision, it is up to the supervisor to integrate adequate meta-knowledge training into the supervision sessions. A good way to increase trainees' meta-knowledge competency skills is to provide direct feedback to them on their sessions with clients. Although this may seem difficult to do, direct supervision is definitely possible. Direct supervision is actually one of the most effective supervisors can assist trainees in improving their self-awareness of their biases, competency levels, and interpersonal influences—otherwise known as improving meta-knowledge.

Supervision Quality

As the review of the current literature has mentioned, even the most recent supervision-client outcome studies appear to be limited by a lack of validity or applicability to the general client population that is served in therapy. However, there is evidence that the elements of competent supervision can be met and can lead to higher quality supervision that potentially improves treatment outcomes for clients. Falender et al. (2004) have listed several supervision qual-

ities that comprise supervision competence, including the supervisory dyad (i.e. relationship between supervisor and trainee), the supervisor's competence, the working alliance, and the trainee's openness and ability to disclose crucial information about his or her therapy sessions (Falender et al., 2004).

High Quality Supervision

Supervision competency is a newer guideline in the field of psychology, and it has been gradually integrated into the training model for doctoral trainees; however, there is no set requirement for supervisors to undergo regular, continuous supervision competence training throughout their professional careers (Falender et al., 2004). Falender and colleagues (2004) have provided a comprehensive list³ of the components that comprise the supra-ordinate five factors within supervisory competency, which encompasses knowledge, skills, values, and meta-knowledge. A supervisor who provides high quality supervision must at least abide by those five supra-ordinate factors. Competency-based supervision is considered a meta-theoretical model or,

...An approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develop learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence based practices and the requirements of the local clinical setting. (Falender & Shafranske, 2007, pp. 233)

Falender and Shafranske (2007) have explained that supervision maintains the integrity of the psychology field (i.e. via gatekeeping) and additionally prioritizes client protection while they undergo therapy with a trainee. This was noted in Falender et al.'s (2014) supervision competen-

³The supervisors' (1) commitment to lifelong learning; (2) awareness and understanding of all diversity's forms; (3) awareness of ethical and legal issues and commitment to ethical practice; (4) understanding of personal and professional factors in supervision and therapy; and their (5) ability to use self-assessment and peer-assessment for professional growth (Falender et al., 2004)

cies, which are comprised of several key parts for ease of measurement in the clinical supervision training process. Assuming that competent supervision is the minimal adequate standard, high quality supervision is defined as not only meeting the competency standards but ultimately exceeding them.

Barnett (2007) found that a supervisor can provide higher quality supervision through a number of intuitive, evidence-based interventions and competencies, several of which have been mentioned above (Falender et al., 2004). Some of the ideas that Barnett (2007) has identified as vital for a supervisor and his or her provision of better quality supervision include the following: ongoing professional development and education, cultivation of a strong working alliance, engagement in ongoing self-assessment and reflection, knowledge of one's own limits in both professional and personal practice, provision of individualized supervision, balance of support with challenge, and maintenance of an ethical and legal practice and provision of supervision. Ongoing learning and professional development can be as simple as completing a basic supervision course, either during or following graduate school training, and regularly engaging in continuing education training opportunities as a professional in the clinical psychology field (Barnett, 2007).

Supervisor's Competency Awareness. A supervisor may use his or her meta-knowledge to become aware of blind spots and inherent biases that could affect the supervision, including the trainee and client's wellbeing. A competent, high quality supervisor understands when they must seek consultation for their supervision (Falender et al., 2014; Kaslow et al., 2007). These high quality supervisors understand, both professionally and personally, where they may lack competence, for example—a client comes to the intake session with the trainee and requests to receive Dialectical Behavior Therapy (DBT) only during their treatment. If neither the trainee nor their supervisor have sufficient knowledge and training in DBT, then the supervisor must

consult with a colleague (trained in DBT) on how to handle this case in a professional and competent manner⁴. Also, meta-knowledge skills help supervisors understand when their professional or personal issues are beginning to interfere with their supervision. A supervisor must recognize when personal psychotherapy or other forms of self-care are needed in order to provide ethical supervision (Kaslow et al., 2007).

The Provision of Customized Supervision. A good supervisor must uniquely consider each trainee and provide customized supervision based upon his or her individuality (Barnett, 2007). A supervisor should offer a balance of support and challenges to each individual trainee depending on his or her developmental level in training. This entails empathy and support for each trainee in addition to adequate, developmentally appropriate, and constructive feedback and challenges. A supervisor must also maintain ethical and legal practices at all times. If supervisors follow the competency supervision standards and employ the list as a guideline, supervision throughout the clinical psychology field could advance in terms of competence and overall quality and thereby benefit not only doctoral trainees but also trainees' psychotherapy and assessment clients and their treatment outcomes. Unfortunately, this is not currently the case, as there are no set competency standards that supervisors must follow. In fact, in most states within the U.S., psychologists can currently provide supervision without any formal training or experience. This has resulted in the unfortunate statistic of more than half of all doctoral trainees reporting incompetent supervision experiences at some point during their training careers (Falender et al., 2004). The next subsection provides an example of high quality supervision.

High quality case example

⁴For example, the supervisor and trainee could decide on having the trainee discuss his or her limitations in providing DBT and suggest either a different yet equally effective form of treatment (one that the supervision group is competent in) or perhaps a transfer of the client to a DBT-trained peer at that same agency or clinic.

This case example (all identifiable demographic data redacted) occurred in a hospital setting serving an adolescent population. The 40-year-old white supervisor held a PhD in clinical psychology. The trainee identified with the same race as the supervisor but was younger. The trainee was in her 3rd year externship⁵ and had chosen this site to gain more experience working with teens and children in a hospital setting.

This supervisor provided trainees with individual and group supervision. Both forms of supervision occurred on time and on a consistent weekly basis. The supervisor allowed for the full hour of individual supervision but punctually concluded the session in order to set an appropriate and professional boundary with the trainee. In individual supervision, the supervisor had the trainee provide a brief case conceptualization of clients and an overview of progress for existing clients. After the trainee provided her cases, the supervisor demonstrated empathy, support, and feedback on par with the trainee's developmental level. The results of this high quality supervision are evident in the trainee's clients, as the majority reported a decrease in symptoms and an increase in functioning in important settings, such as school and home life.

During group supervision, the trainee would meet with their supervisor as well as two colleagues or peers, both whom also worked at the same externship site that year. Each trainee took turns formally presenting cases to the clinical team and providing questions for a group discussion regarding the case and its conceptualization. Thereby, this trainee provided formal case conceptualizations about once a month, since there were three trainees in rotation for these presentations. The supervisor instructed trainees to read and review empirically valid, peer-reviewed journal articles. All the trainees reported their findings on the highlighted case⁶ with

⁵ Externship—similar to internships in that students in training will work, for free or with a small stipend, to gain clinical skills and experience in the real world through these agencies that are outside of their direct training program.

questions for group discussion, thus enhancing the knowledge and skills of all those engaged in the group supervision.

The trainee reported an enhancement of her clinical competencies, received developmentally appropriate challenges and constructive feedback, and witnessed and documented significant improvements in the majority of her inpatient and outpatient adolescent clients. This supervisor established a strong working alliance with the trainee and was empathic toward the trainee when she was experiencing professional difficulties. Moreover, the supervisor imparted appropriate feedback to allow the trainee to continue her growth. Potentially, the trainee could more effectively treat her clients as a result of her possible increase in competency and confidence as well as the support received from the agency as a whole in addition to the individual supervisor. In this case, the supervisor showed adequate competence in knowledge, skills, values, and meta-knowledge that appear to benefit the trainee and furthermore, the client and treatment outcome. The supervisor provided feedback to the trainee using professional competence and maintained a growing awareness of what they did or did not know (i.e., meta-knowledge). They engaged the trainee in didactic trainings to teach them how to retain and pass knowledge and skills forward to peers and, some day, their own trainees, in a clinical setting. This particular supervisor also upheld the highest level of professional legal and ethical standards; furthermore, they maintained personal and professional boundaries that were appropriate in this setting and served as a form of modeling for this particular trainee.

Outcomes. The majority of clients who started treatment continued to attend until termination, arrived (mostly) on time, completed homework, and maintained a good rapport and strong therapeutic alliances. The trainee attributed these outcomes to the supervisor, her working

alliance with both the trainee and clients, and the consistency and professionalism of supervision sessions.

Successful supervision such as this appears to be greater than the required competency standards for general supervision (Falender et al., 2004). The establishment of a strong working alliance between the supervisor and trainee is another factor that can contribute to client outcomes. The supervisor maintained professional and empathic support during supervision, specifically when the trainee reported feeling “stuck” in her therapy or experiencing challenges with a client and his or her treatment progress. The supervisor also delivered helpful and direct feedback. This supervisor exemplified high quality, but it is also important to consider how supervision can negatively impact clients when it is poor in quality.

Poor Quality Supervision

It is crucial to discern between competent and incompetent supervision. Psychology agencies should determine if a supervisor is providing competent, poor, or even harmful supervision. Supervision and the supervisor have an impact on not only the trainee and supervisory dyad but also its organizational system and the outside community (Kaslow et al., 2007). Kaslow et al. (2007) has conceptualized some of the various factors that may lead a supervisor to provide poor quality supervision:

The most expert and experienced psychologists will not be able to effectively use their knowledge and skills if they are overwhelmed with stress or experiencing burnout, if they are suffering from depression or other mental health difficulties, if they are abusing substances, or if other significant emotional or physical challenges are present. (Kaslow et al., 2007, pp. 512)

Poor quality can occur when a supervisor demonstrates an inability to meet the minimal level of competence. A poor quality supervisor may not possess the necessary skills to develop the working alliance and establish a strong professional relationship with the trainee. Furthermore, an incompetent supervisor may lack cultural awareness, particularly as it relates to the supervisor-trainee and trainee-client relationships. Power dynamics may also play a role in whether or not the supervision is effective.

The supervisor also has power over his or her trainees and can positively or negatively influence the trainee's evaluations, references, and standing within their doctoral program. Since many trainees are seemingly reluctant to share negative experiences during or after their supervision year, power dynamics could potentially be the cause (Leung, 2012). This reluctance could be due to fear of being reprimanded or of losing a future reference or good standing at one's training program. The poor quality supervision case example in the following section reflects several issues that arise in real-life supervision and can potentially have a negative impact on client outcome.

Poor Quality Case Example

In this case, the supervisor was an older White male in an acute inpatient setting who lacked fluency in English. The trainee was a Latina female who was considered advanced in her training development. The supervision structure was set to involve two hours a week of individual supervision in addition to two hours of weekly group supervision with a different supervisor at the same site. After receiving little to no feedback from this supervisor, the trainee requested

feedback from the supervisor directly, with her knowledge that a developing clinician needs helpful and constructive feedback to grow and cannot rely on vague compliments such as “Good work!” or “Great job!” to continue to develop clinical competence. In the meantime, when the supervisor still refused to provide any tangible feedback to the trainee, the trainee heard the supervisor speaking to another colleague of his in the lunchroom about how much he disliked her (referring to the trainee) as she was walking in for her lunch. This was when the trainee initiated a supervisor change after having an open discussion on her part regarding what she felt she needed, had asked for (e.g., feedback, modeling ethical and moral professionalism, competent knowledge and skills growth), and had not received despite numerous requests for the necessary trainee development that should be found in competent clinical supervision. Although the trainee had begun to rely heavily on group supervision for feedback from her peers in lieu of not receiving direct feedback from her supervisor, after hearing this she set up a second meeting to discuss feedback a second time. The trainee received solid feedback from her peers in group supervision, but she continued to request and be denied specific feedback from her supervisor. At this point in time, the trainee felt she needed to discuss changing supervisors within the same site so she could receive the knowledge and learn the skills from a more competent supervisor.

Since this trainee felt she was lacking the feedback she needed from her supervisor and had heard her supervisor nonchalantly discussing his dislike of her with a colleague in the common lunchroom whether her interventions were directly improving her client’s treatment, but she could not acquire her supervisor’s feedback on these concerns. The trainee finally requested additional supervision from a separate supervisor.

The supervisor’s regular inconsistencies and lack of effectiveness in supervision prevented the trainee from receiving the minimal standards of competent supervision. Reasons why

the supervisor might have been ineffective include: lack of formal supervision training, failure to attend regular continuing education courses, difficulty communicating with a slight language barrier, compassion fatigue or burnout. When one of the trainee's regular therapy clients was abruptly ejected from the treatment center due to "misconduct," the supervisor failed to inform his trainee of her client's expulsion from treatment. When the trainee discovered that her client left without notice, she asked her supervisor to explain the situation. He had been removed from treatment for being in the wrong place at the wrong time, as he was considered to be guilty by proxy during an on-site bullying incident. The trainee was informed too late to provide support and treatment planning, and the client unfortunately relapsed on heroin after over four months of sobriety. He reportedly overdosed and passed away three days after treatment. It seems that the supervisor in this case example was lacking in one of the four fundamental elements necessary to provide the trainee with the quality of supervision necessary for their client to have a greater chance of a good prognosis in their treatment outcome. Although it cannot be stated from this example alone whether this particular supervisor simply lacked the training and continuing education necessary for providing competent supervision, the lack of professional competence was shown by the supervisor's inability to model good values in their ethics and to model the use of meta-knowledge by understanding their own limitations as a supervisor in general.

Outcomes. Missing from the poor quality supervision case was that supervisor's commitment to providing the trainee with both ethical and competent supervision. It is a necessity that all supervisors meet minimal competency standards before providing supervision to trainees in order to prevent emotional or ethical harm to either the trainee and/or the client him- or herself. A system of checks and balances is helpful in creating a gold standard for supervision to reduce the incidence of poor quality, incompetent, and possibly harmful supervision practices. In

this case, poor supervision may have indirectly led to the worst possible outcome: the death of the client from an overdose.

Summary and Recommendations

Effective supervision depends on a supervisor's knowledge, skills, values, and meta-knowledge. to have a strong working alliance and an awareness on behalf of the trainee to render the supervision helpful or detrimental in affecting client change (Freitas, 2002; Watkins, 2011, 2017). Most researchers have discussed limitations of supervision that directly affect supervisors and trainees. However, present knowledge of supervision and the effects of its limitations on clients still lacks adequate data and case examples. Supervision quality has remained largely dependent on the assumption that the supervisor has sufficient knowledge, skills, values, and meta-knowledge. Supervision has been evidenced to subjectively improve clients' treatment outcomes, but research has neglected the effect of its quality on client outcomes (Watkins, 2017).

Further qualitative and quantitative research is necessary to better understand how the various qualities of the supervisor and supervision (and its dynamic/working alliance) affect client outcomes. Despite the large amount of research still necessary to make more concrete conclusions regarding supervision's impact on client outcomes, this paper was an attempt to provide greater understanding of the factors that underlie supervision quality as that quality also directly impacts the clients and their treatment. Through the integration of current research and real life case examples, we can see how hundreds of factors and characteristics and even cultures can affect the clients for whom the trainees provide treatment.

References

- Alpher, V. S. (1991). Interdependence and parallel processes: A case study of structural analysis of social behavior in supervision and short-term dynamic psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 28(2), 218-231. doi:10.1037/0033-3204.28.2.218
- American Psychological Association, Board of Educational Affairs (2014). Guidelines for clinical supervision in health service psychology. Retrieved from <http://www.apa.org/about/policy/guidelines-supervision.pdf>
- Barnett, J. E., Erickson Cornish, J. A., Goodyear, R. K., & Lichtenberg, J. W. (2007). Commentaries on the ethical and effective practice of clinical supervision. *Professional Psychology: Research and Practice*, 38(3), 268-275. doi:10.1037/0735-7028.38.3.268.
- Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Boston, MA: Pearson.
- Couchon, W. D., & Bernard, J. M. (1984). Effects of timing of supervision on supervisor and counselor performance. *The Clinical Supervisor*, 2(3), 3–20. doi:10.1300/J001v02n03_02
- Dodenhoff, J. T. (1981). Interpersonal attraction and direct-indirect supervisor influence as predictors of counselor trainee effectiveness. *Journal of Counseling Psychology*, 28(1), 47–52. doi:10.1037/0022-0167.28.1.47
- Ellis, M. V., & Ladany, N. (1997). Inferences concerning trainees and clients in clinical supervision: An integrative review. In C. E. Watkins (Red.), *Handbook of psychotherapy supervision* (pp. 447–507). New York, NY: Wiley.
- Falender, C. A. (2014). Supervision outcomes: Beginning the journey beyond the emperor's new clothes. *Training and Education in Professional Psychology*, 8(3), 143-148. doi:10.1037/tep0000066

- Falender, C. A., Cornish, J. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., & ... Grus, C. (2004). Defining Competencies in Psychology Supervision: A Consensus Statement. *Journal Of Clinical Psychology, 60*(7), 771-785. doi:10.1002/jclp.20013
- Falender, C. A., & Shafranske, E. P. (2017). Implementing competency-based clinical supervision and best practices. In , *Supervision essentials for the practice of competency-based supervision* (pp. 17-46). Washington, DC, US: American Psychological Association. doi: 10.1037/15962-002
- Freitas, G. J. (2002). The impact of psychotherapy supervision on client outcome: A critical examination of 2 decades of research. *Psychotherapy: Theory, Research, Practice, Training, 39*(4), 354-367. doi:10.1037/0033-3204.39.4.354
- Genuchi, M.C., Rings, J.A., Germek, M.D. & Erickson Cornish, J.A. (2015). Clinical supervisors' perceptions of the clarity and comprehensiveness of the Supervision Competencies Framework. *Training and Education in Professional Psychology, 9* (1), 68 – 76.
- Harkness, D. (1995). The art of helping in supervised practice: Skills, relationships, and outcomes. *The Clinical Supervisor, 13*(1), 63–76. doi:10.1300/J001v13n01_05
- Harkness, D. (1997). Testing interactional social work theory: A panel analysis of supervised practice and outcomes. *The Clinical Supervisor, 15*(1), 33-50. doi:10.1300/J001v15n01_03
- Harkness, D., & Hensley, H. (1991). Changing the focus of social work supervision: Effects on client satisfaction and generalized contentment. *Social Work, 36*(6), 506–512. doi:10.1093/sw/36.6.506
- Holloway, E., & Carroll, M. (1996). Reaction to the Special Section on supervision research: Comment on Ellis et al. (1996), Ladany et al. (1996), Neufeldt et al. (1996), and Worthen

and McNeill (1996). *Journal Of Counseling Psychology*, 43(1), 51-55. doi:10.1037/0022-0167.43.1.51-55

Iberg, J. R. (1991). Applying statistical control theory to bring together clinical supervision and psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59(4), 575–586. doi:10.1037/0022-006X.59.4.575

Kivlighan, D. M., Angelone, E. O., & Swafford, K. G. (1991). Live supervision in individual psychotherapy: Effects on therapist's intention use and client's evaluation of session effect and working alliance. *Professional Psychology: Research and Practice*, 22(6), 489–495. doi:10.1037//0735-7028.22.6.489

Leung, K. K. P. (2012). An exploration of the use of power in social work supervisory relationships in Hong Kong. *Journal of Social Work Practice*, 26(2), 151-162. doi:10.1080/02650533.2010.536201

Rieck, T., & Callahan, J. L. (2013). Emotional intelligence and psychotherapy outcomes in the training clinic. *Training and Education in Professional Psychology*, 7(1), 42-52. doi:10.1037/a0031659

Rings, J.A., Genuchi, M.C., Hall, M.D., & Erickson Cornish, J.A. (2009). Is there consensus among predoctoral internship training directors regarding clinical supervision competencies? A descriptive analysis. *Training and Education in Professional Psychology* (3)3, 140 – 147.

Sandell, R. (1985). Influence of supervision, therapist's competence, and patient's ego level on the effects of time-limited psychotherapy. *Psychotherapy and Psychosomatics*, 44(2), 103–109. doi:10.1159/000287900

- Steinheilber, J., Patterson, V., Cliffe, K., & LeGoullon, M. (1984). An investigation of some relationships between psychotherapy supervision and patient change. *Journal of Clinical Psychology, 40*(6), 1346-1353. doi:10.1002/1097-4679(198411)40:6<1346::AID-JCLP2270400612>3.0.CO;2-L
- Triantafillou, N. (1997). A solution-focused approach to mental health supervision. *Journal of Systemic Therapies, 16*(4), 305–328. doi:10.1007/978-1-4614-6052-7
- Watkins, C. E., Jr. (2011). Does psychotherapy supervision contribute to patient outcomes? considering thirty years of research. *The Clinical Supervisor, 30*(2), 235-256. doi:10.1080/07325223.2011.619417
- Watkins, C. E. Jr. (2017). Convergence in psychotherapy supervision: A common factors, common processes, common practices perspective. *Journal Of Psychotherapy Integration, 27*(2), 140-152. doi:10.1037/int0000040
- Watkins, C. E. Jr. (2017). How does psychotherapy supervision work? Contributions of connection, conception, allegiance, alignment, and action. *Journal of Psychotherapy Integration, 27*(2), 201-217. doi:10.1037/int0000058.
- Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research, 7*(1), 54-65. doi:10.1080/14733140601185274
- Wrape, E. R., Callahan, J. L., Rieck, T., & Watkins, C. J. (2017). Attachment theory within clinical supervision: Application of the conceptual to the empirical. *Psychoanalytic Psychotherapy, 31*(1), 37-54. doi:10.1080/02668734.2016.1261927