

PRE-CONVENTION

Clinical Supervision: A New Era

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Since identification of supervision as a distinct professional practice, supervision training, distinct from clinical practice, has become a priority (Falender & Shafranske, 2004). Supervisors are aided by specific tools and procedures that structure and assist—monitoring and feedback. In addition, attention to ethical standards is a critical component of supervision practice.

Consider the following vignette to understand the shift in the practice of supervision:

Dr. Stone had been looking forward to beginning supervision with Amanda, a new Psychological Assistant. In their preliminary meeting she was animated, articulate, and seemed very sophisticated for her level of training. In the first formal supervision session, faced with completing the Supervision Agreement for the Board of Psychology (<http://www.psychboard.ca.gov/applicants/sup-agreement.pdf>), Dr. Stone was surprised to find Amanda quiet, almost withdrawn, and reticent. She did not volunteer much information to assist with developing a sequential structured plan, or developing goals and objectives for Supervised Professional Experience (SPE) including how socialization into the profession would be achieved. In retrospect, Dr. Stone felt he was doing all the work. He chalked it up to inexperience, and proceeded along but found the next session was not much different.

What issues does this vignette raise for you? How would you proceed to supervise?

How should Dr. Stone proceed with Integrity (Principle C) and with Respect for People's Rights and Dignity (Principle E)?

To understand how to proceed, we must consider aspects of supervisor competence: knowledge, skills, and attitudes, as well as ethical and legal practice.

To begin, Dr. Stone will try to assess Amanda's competence as a clinician and as a supervisee. He will encourage her to discuss her previous experience, interests, and goals for supervision in this setting. Ideally Dr. Stone will have Amanda complete a self-assessment using Competencies Benchmarks (<http://www.apa.org/education/grad/competency-benchmarks.pdf>), a state of the art assessment of her competence. He will collaboratively assist her in identifying her level of training, whether it be Readiness for Practicum, Readiness for Internship, or Readiness for Entry to Practice. She will identify her strengths and areas in development in Foundational (e.g., Professionalism; Reflective Practice-Self-Assessment, Self-Care; Relationships; Individual and Cultural Diversity; Ethical and Legal Standards and Policies) and Functional (e.g. Interventions, Assessment, Consultation, Supervision) competencies all

of which are described in Benchmarks. She will describe and rate areas that are in development and areas of strength. Dr. Stone will assist Amanda in critical reflection, stepping back and thoughtfully analyzing experience and clinical development, freeing her from prejudgments of what she *should* know to focus on the realities of her present level of competence. (Falender & Shafranske, 2012).

Collaboratively Dr. Stone and Amanda would draw upon Benchmarks to construct the Supervision Agreement, the Board of Psychology required document. Specific goals and objectives based on her self-assessment (and supported by Dr. Stone's knowledge and observations regarding her training and experience) are integrated with the plan for socialization into the profession and focused on enhancing her professionalism. Providing Amanda with the opportunity to thoughtfully self-assess and formulate her goals for the setting and clients in Dr. Stone's practice will provide structure for her, making the task easier and supporting the development of a supervisory alliance with Dr. Stone. He could take this opportunity to highlight the complexity of his multiple roles with Amanda. As a supervisor he is tasked with forming a supervisory alliance, supporting her clinical development, and serving as both her evaluator and as a gatekeeper for the profession.

Next, Dr. Stone should identify expectations for Amanda. Ideally he and Amanda will formalize these into a *supervision contract*, distinct from the Supervision Agreement required by the California Board of Psychology. He will describe specifics of what the supervision hour entails. For example, he might discuss how she would prepare for the supervision session, e.g., chart review, identifying appropriate interventions, diagnostic questions, diversity and multiple identities (ethnicity, gender, religion, socio-economic status, sexual orientation) and associated belief structures and worldviews. If he plans to use video/audio review or live observation, he should describe the requirements and the focus of the review. He might discuss his theoretical orientation(s) for clinical work and for supervision, how feedback will be given (linked to her self-assessment on Benchmarks), and his expectation that Amanda give him feedback as well. Dr. Stone should inform Amanda of the expectation that she refer frequently to the Ethical Principles for Psychologists and Code of Conduct (2010) in its entirety and attend to Ethical Standards 7 (Education and Training), as well as legal regulations and standards. Additional topics he will define include limits to supervisee confidentiality, since he will be reporting to her school, the Board of Psychology, and possibly discussing her development with others in his practice. He will identify what constitutes an emergency, what steps Amanda will take to assess the emergency, and how to contact him immediately. He will discuss Ethical Standard 7.04 (Student Disclo-

PRE-CONVENTION

sure of Personal Information), the importance and value placed on personal exploration in supervision, and he will remind her that when she observes herself having an unusual emotional reaction to her client (i.e., anger, irritation) it is important to disclose and process that in the supervision session.

Dr. Stone may find that Amanda is less experienced (or more so) than he anticipated. It is also possible that Amanda has less confidence in her clinical skills than he had assumed. If so, Dr. Stone will need to provide more structure for her during supervision.

Dr. Stone could comment on the difference in behavior he noted from when he first met her, demonstrating that he is monitoring and tracking and providing on-line feedback on her behavior as it relates to her clinical work and her supervision. This also provides an opportunity for her to respond to him, perhaps letting him know of her concerns or desire for a more highly structured or different approach to supervision.

Increasingly, psychology is adopting competency-based clinical supervision, "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 require-

ments of the local clinical setting" (Falender & Shafranske, 2007, p. 233). In short, competency-based clinical supervision is a means for tracking the component parts of supervisee competencies, comparing each supervisee's development with competencies consensually agreed upon by the psychology profession and providing feedback. For supervisors, competency-based supervision increases accountability and monitoring as well as the clarity of expectations and outcomes. The artful execution of supervision is preserved. ▲

Carol Falender, Ph.D., is Chair of the LACPA Ethics Committee. She is co-author of Clinical Supervision: A Competency-based Approach, co-editor of Casebook for Clinical Supervision, and co-author of Getting the Most Out of Clinical Training and Supervision, all published by APA.

References in this article are available upon request from the LACPA office: lacpsych@aol.com.

Dr. Falender will present "Clinical Supervision: A New Era" during Session I, 8:30 a.m. - 10:30 a.m., of the October 13 LACPA Convention.

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