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Pepperdine University
Graduate School of Education and Psychology

DEVELOPMENT OF A PRELIMINARY SCALE OF COUNTERPRODUCTIVE
EXPERIENCES IN SUPERVISION: ATTITUDES OF CLINICAL PSYCHOLOGY
INTERNSHIP DIRECTORS OF TRAINING

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Chelsea Taylor Lucas, M.A.

November, 2013

Edward Shafranske, Ph.D., ABPP- Dissertation Chairperson

This clinical dissertation, written by

Chelsea Taylor Lucas

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Edward Shafranske, Ph.D., ABPP, Chairperson

Carol Falender, Ph.D.

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ACKNOWLEDGEMENTS

First and foremost, I would like to thank my Mom. Her unwavering love, support, and encouragement enabled me to persevere through the more challenging times throughout the last few years... and life in general. Love you, Mom. Next, I would like to thank my Dissertation Committee, Dr. Shafranske, Dr. Falender and Dr. Aviera; this dissertation would in no way be possible without their personal investment, guidance, and passion for advancing the quality of clinical training and supervisory practices. Lastly, I want to thank my amazing classmates and colleagues. They are among the most caring, supportive, and resourceful bunch I know; they're also a lot of fun, and have undoubtedly made this journey a memorable one.

VITA

EDUCATION

Doctor of Psychology, Clinical Psychology

Pepperdine University, West Los Angeles, CA (APA Accredited)

In Progress, Anticipated Date of Graduation - Summer 2014

Dissertation Title: *Development of a preliminary scale of counterproductive experiences in supervision: Attitudes of clinical psychology internship directors of training*

Chairperson: Edward Shafranske, Ph.D., ABPP

Final Oral Defense Passed: September 2013

Clinical Competence Examination: Passed October 2011

Master of Arts in Clinical Psychology, Emphasis in Marriage & Family Therapy

Pepperdine University, Malibu, CA

May 2009

Bachelor of Science in Psychology

University of California, San Diego, La Jolla, CA

June 2007

CLINICAL EXPERIENCE

Pre-Doctoral Internship

Twin Towers Correctional Facility, Los Angeles, CA

Los Angeles Department of Mental Health: Correctional and Community Reintegration Track

APPIC Accredited, Supervised Hours: 1800

Rotation: Forensic Inpatient Program

Clinical Supervisor: Janice Jones, Ph.D.

March 2013-August 2013

- Setting is the inpatient mental health unit of the Los Angeles County jail system. LPS designated facility that supports approximately 36 patients; treats the most psychiatrically vulnerable of the over 180,000 inmates who are booked annually.
- Carried a caseload of patients and conducted daily assessments of LPS criteria (grave disability, danger to others, danger to self).
- Initiated 14- and 30-day psychiatric holds; represented the hospital during Probable Cause hearings.
- Actively participated in crisis stabilization as part of a multi-disciplinary team.
- Engaged in weekly treatment planning for patients.
- Co-facilitated therapy groups on a weekly basis (e.g., Interpersonal Skills, Coping)
- Provided daily brief individual therapy for patients on this unit.
- Worked with patients who had been deemed Incompetent to Stand Trial and assisted them in the process of regaining competency.
- Regularly consulted and collaborated with staff (e.g., psychiatrists, medical, custody).
- Initiated aftercare planning (e.g., family contact, Outpatient Mental Health referrals).

- Wrote LPS Conservatorship applications.
- Conducted weekly intake assessments as well as provided ongoing individual therapy for Assembly Bill 109 patients (inmates transferred from state prison who were serving time in the county jail) in the medical unit of the jail.
- Attended hearings at Mental Health Court to uphold or contest rulings of Competency to Stand Trial.

Rotation: High Observation Housing

Primary Supervisor: Cheryl van der Zaag, Ph.D.

Delegated Supervisor: Joseph Simpson, M.D., Ph.D.

September 2012-March 2013

- Ethnically and culturally diverse male inmate population drawn from throughout the entire Los Angeles County region. Inmates presented with a wide range of major mental illnesses and/or personality disorders; most were dually diagnosed with substance abuse disorders. The Twin Towers Correctional Facility houses over 2000 inmates with mental illness at any given time.
- Primarily worked on the High Observation Housing (HOH) unit, which is comprised of an Outpatient population that is acutely suicidal, gravely disabled, or a serious threat to others; many patients are awaiting hospitalization in the jail's psychiatric inpatient unit.
- Conducted weekly/daily intake assessments in order to determine five axis diagnoses, level of care/housing within the jail, need for medication, and treatment options. Conducted risk assessment, looking at one's dangerousness to self or others; assessed for malingering and mental status; and provided crisis intervention.
- Worked with Assembly Bill 109 inmates to address issues surrounding recidivism (utilizing principles of Motivational Interviewing and Cognitive Behavioral Therapy), aftercare planning, and resource management; included both short- and long-term treatment. Treated inmates housed on the Inpatient Correctional Treatment Center- Mental Health Unit (CTC-MHU), gaining exposure and training on the intersection between psychology, medical, and law fields. Assessed for appropriate level of aftercare (e.g., conservatorship, Board and Care).
- Conducted rapid assessment of danger to self, danger to others, or grave disability on the Supplemental Assessment Team (SAT) for inmates urgently pending movement, evaluation, or re-evaluation.
- Led and co-facilitated mental health groups of 8-12 inmates; groups included ACT-based Anger Management group, Healthy Relationship Group, and Substance Abuse/Relapse prevention group.
- Regularly consulted with other treating physicians and worked closely within a multidisciplinary team (e.g., social workers, psychiatrists, psychologists, custody, nursing).
- Attended weekly individual and group supervision, as well as weekly didactics; presented formal case presentations to colleagues and supervisors. Attended trainings pertinent to this population (e.g., Seeking Safety, Moral Reconition Therapy, Borderline/Antisocial Personality Disorder).

Pre-Doctoral Externship

UCLA Semel Institute for Neuroscience and Human Behavior, Los Angeles, CA

Longevity Center, Geriatric Psychiatry Division

Neuropsychology Extern

Supervisor February 2012-July 2012: Karen Miller, Ph.D.

- Provided neuropsychological assessment services for patients in a teaching hospital setting, with a special focus on adult and geriatric psychology.
- Involved in the clinical interview, administration, assessment and interpretation of scores, and report writing for research and outpatient cases.

- Participated in feedback sessions with patients and patients' families to provide focused treatment planning and appropriate follow-up care for patients diagnosed with various neurological disorders, general medical disorders, and psychiatric disorders.
- Received training in a variety of weekly didactics in areas related to neuropsychology, neuroscience, cognitive research, neurology, and clinical psychology; attended Grand Rounds lectures.
- Attended weekly individual and group supervision and provided formal case presentations to externs, supervisors, residents, and postdoctoral fellows.
- Trained new externs on test administration, battery scoring, and report writing.

UCLA Resnick Hospital and Semel Institute, Los Angeles, CA

Aging and Memory Research Center, Neurology Division

Neuropsychology Extern

Supervisor August 2010-August 2011: Kathleen Tingus, Ph.D.

Supervisor August 2011-February 2012: Po Lu, Psy.D.

- Provided weekly neuropsychological and psychological assessments to outpatient adults (ages 25-90) referred for neurological disorders including Alzheimer's disease, vascular dementia, frontotemporal dementia and stroke.
- Independently conducted clinical interviews and administered neuropsychological test batteries to participants enrolled in various research studies related to aging and cognitive decline.
- Generated comprehensive research reports integrating background information, relevant medical records, neuroimaging findings, and neuropsychological test results, including a diagnosis for research classification.
- Attended weekly neuropsychology didactics targeted for postdoctoral fellows through the UCLA Medical Center & Semel Institute.
- Attended the weekly Alzheimer's Disease Research Forum (ADRF).
- Attended brain-cutting seminars to examine post-mortem neuropathology of degenerative brain diseases, led by Dr. Harry Vinters.

Pepperdine University Community Counseling Center, West Los Angeles, CA

Psychotherapy Extern

Supervisor: Joan Rosenberg, Ph.D.

July 2010-June 2012

- Conducted intake assessments and diagnostic interviews; wrote intake reports which include five axis diagnoses and treatment plans for an outpatient population.
- Provided brief dynamic, cognitive-behavioral, and longer-term psychotherapy to a wide range of clients struggling with Axis I and Axis II disorders.
- Administered and interpreted intake and follow-up outcome measures to monitor clients' response to intervention.
- Followed emergency protocol while carrying a 24-hour pager in order to support all clinic clients during crisis situations.
- Presented clinical case presentations in weekly individual and group supervision.

Union Rescue Mission, Los Angeles, CA

Pre-Doctoral Practicum Therapist

Supervisors: Aaron Aviera, Ph.D. and Stephen Strack, Ph.D.

September 2009-August 2010

- Awarded the Conrad N. Hilton Foundation Fellowship to work with an underserved population in the East Los Angeles Skid Row area.

- Conducted intake assessments and provided individual psychotherapy with men and women enrolled in a residential, long-term, faith-based substance abuse recovery program.
 - Gang affiliated population; post-correctional population; chronic mental illness and dually diagnosed population
- Conducted psychological assessments to clarify diagnosis and to supplement treatment planning (e.g., MCMI, MMPI).
- Maintained communication with referral sources, community resources, and psychiatrists to promote continuity of care and adherence to treatment plan.
- Participated in weekly individual and group supervision; attended monthly didactic seminars.
- Participated in additional weekly peer supervision with a third-year doctoral student.

Master's Practicum

Valley Trauma Center, Northridge, CA

In-Home Outreach Counselor/ Rape Crisis Advocate

Supervisor: Wendy Massey, L.M.F.T

January 2008-April 2009

- Conducted in-home counseling for high-conflict families in the San Fernando Valley, as part of the Family Preservation Program required by the Department of Children and Family Services (DCFS).
- Actively worked with families on issues related to substance abuse; violence; and family separation and eventual reunification.
- Conducted individual therapy for children and adults who were directly or indirectly affected by various forms of abuse and trauma.
- Worked within a multidisciplinary team to provide coordinated and comprehensive services (e.g., social workers, lawyers, employers, schools).
- Advocated for victims of rape and sexual abuse through C.A.T.S (Child Abuse Trauma Services); provided emotional support for survivors in addition to references for counseling and other necessary resources.
- Worked a crisis hotline and provided rapid intervention on a weekly basis.
- Certified by the Los Angeles County Department of Children and Family Services for completion of the Sexual Assault and Family Systems Services Training Programs.

Undergraduate Clinical Experience

UCSD Autism Laboratory, La Jolla, CA

Research Assistant

Supervisor: Laura Schreibman, Ph.D.

January 2006-June 2006

- Directly coached children by utilizing PECS (Picture Exchange Communication System) and PRT (Pivotal Response Training) to help increase adaptive functioning and decrease maladaptive behaviors, reduce interfering behaviors, and develop new skills including coping, self-regulation, and activities of daily living
- Actively monitored and documented children's behavior for the purpose of enhancing the current body of literature in the field of Autism research.
- Recorded and presented detailed accounts of children's behavior in order to track progress and develop future therapeutic strategies.

SUPERVISORY EXPERIENCE

Pepperdine University Community Counseling Center, West Los Angeles, CA

Peer Supervisor

September 2011-July 2012

Supervisor: Aaron Aviera, Ph.D.

- Selected to provide guidance and mentorship for first-year and second-year doctoral trainee therapists at the Union Rescue Mission and the Pepperdine University Community Counseling Clinic.
- Met with trainees for weekly one-hour supervision sessions in order to foster the development of clinical skills including diagnosis, treatment planning, and the application of cultural, ethical, and legal issues, and critical reflection upon the therapeutic process.
- Assisted supervisees with articulating clear training goals for the year in terms of knowledge, skills, and competencies as a trainee therapist.
- Developed and reviewed case conceptualizations for supervisees' clients based on various theoretical orientations, including psychodynamic and cognitive-behavioral therapy.
- Co-facilitated a weekly case conference and provided feedback to a group of eight therapists in order to increase their diagnostic and case conceptualization skills.
- Performed weekly chart review and quality assurance of supervisees' progress notes and administration and scoring of clinic measures; additionally reviewed audio and DVD-recorded sessions of supervisees and their clients.

POSTERS AND PRESENTATIONS

Martinez Reyes, D. A., Yeh, D.-A., Legenkaya, A., Lucas, C. T., Carr, D. R., Meier, A. M., Shiney, S. S., Yu, A. M., Horowitz, A., Gomez, M. E., Brogdon, L., Kim, J., Miller, K. J., & Small, G. W. (2012, February). *Monolingual and multilingual performance differences on tests of unstructured visuoconstruction ability and contextual memory*. Poster presented at the 40th annual meeting of International Neuropsychological Society. Montreal, Canada.

PROFESSIONAL EXPERIENCE

Pepperdine Graduate School of Education and Psychology, West Los Angeles, CA

Recruitment Department for Education

Graduate Assistant

July 2009-October 2010

- Directly participated in the development and organization of recruitment, graduate fairs, and conferences
- Worked with the executive team to insure the accuracy of materials as well as ascertain the most effective means by which to disseminate them
- Provided extensive information and continued support to prospective students interested in various Education degrees and programs

Robbins-Madanes Center for Strategic Intervention, La Jolla, CA

Program Coordinator/Personal Assistant to the President

November 2006-August 2007

- Maintained elevated levels of organization and efficiency for a very high-powered company which helped propel developing projects forward
- Assisted in the coordination of large conferences in the U.S. in addition to working at the conferences in various capacities (e.g., lecture preparation, marketing, merchandise sales)
- Utilized critical problem-solving skills and ingenuity for the purpose of reducing stress on the President so she could remain focused on her numerous priorities

ABSTRACT

Clinical supervision serves as the indispensable heart of clinical training and professional development (Falender & Shafranske, 2004). While it is expected that clinical supervision be of high quality, some events or experiences may occur in clinical supervision that strain the supervisory alliance, hinder the supervisee's growth, and contribute to a poor experience of supervision, adversely affecting its effectiveness. A Q-sort methodology was used in this study to examine the opinions of five directors of clinical training regarding the impact of 50 counterproductive experiences (CEs) in supervision. The results suggested that each of the CEs drawn from the literature was believed to have an impact on supervision; however, events involving *a failure to address the needs of the supervisee* were opined to have the greatest potential for significant negative effects on the process of supervision. The findings of this study point to the significant role counterproductive experiences play in clinical supervision; the findings additionally contribute to the development of the Counterproductive Experiences in Supervision scale (CES).

Introduction

Supervision is an essential component of doctoral training in the field of psychology (Britt & Gleaves, 2011; Falender & Shafranske, 2004); it directly impacts the personal and professional development of graduate students and lays the foundation upon which they become competent clinicians (Falender & Shafranske, 2010). While academic coursework in doctoral education lends itself to the acquisition of fundamental knowledge regarding mental disorders, psychotherapy, and treatment planning, clinical supervision specifically provides the context in which students build specialized clinical skills; develop advanced judgment; enhance self-awareness; become acclimated to professional culture; and navigate through a myriad of unique legal, ethical, and cultural challenges (Falender & Shafranske, 2007; Hutt, Scott, & King, 1983; Ladany, Hill, Corbett, & Nutt, 1996).

Clinical supervision serves the function of integrating knowledge, skills, and values/attitudes (Falender et al., 2004; Kaslow, 2004) in graduate education; this leads to the acquisition of clinical acumen, which is in turn is theorized to enhance therapeutic outcomes (Bambling, King, Raue, Schweitzer, & Lambert, 2006; Stein & Lambert, 1995). Effective supervision is the mechanism by which trainees develop as competent practitioners (Bucky, Marques, Daly, Alley & Karp, 2010) and, most importantly, is the primary means through which patient care is ensured (Cheon, Blumer, Shih, Murphy & Sato, 2009; Falender & Shafranske, 2004; O'Donovan, Halford, & Waters, 2011; Ramos-Sánchez et al., 2002).

Clinical supervision is unique in the sense that it can create an environment whereby supervisees come to understand various skills, values, ethics, and interpersonal dynamics as the normative standards of clinical work; as supervision is generally provided by a more experienced clinician to a more novice student (Bernard & Goodyear, 2004), the initial training guidelines

that one is exposed to can shape the standards of his or her practice throughout the course of his or her career (Falender & Shafranske, 2010). As such, supervisory experiences serve as integral influences on professional development and practice, and further influence future practice as a licensed supervisor, as many supervisors harken back to their personal training experiences as a guide for current conduct as a supervisor (Falender & Shafranske, 2004). Experiences in supervision, either facilitative or deleterious, therefore play a crucial role in the professional development of the supervisee, overall clinical care of the patient, and future efficacy of the supervisee as a clinical supervisor.

Given the vitally important nature of supervision, much research has been conducted to evaluate what contributes to positive, effective supervision and what events lend themselves to negative, ineffective supervision (Hutt et al., 1983). In terms of the latter, negative experiences, or counterproductive experiences (CEs), can largely stifle the clinical development of the trainee and subsequently lead to reverberating effects that impact the trainee throughout his or her career as well as the clients he or she serves (Ramos-Sánchez et al., 2002). As such, exploration and identification of such counterproductive events and experiences in supervision would be instrumental in bolstering the overall quality of clinical training and patient care, and in maintaining the integrity of the discipline (Gray, Ladany, Walker, & Ancis, 2001).

Background

This section will provide a brief discussion of the common elements associated with clinical supervision, in order to provide background and contextual information of the study. Though there are a number of ways supervision can be defined, it is generally understood as a clinical and professional practice whereby a more experienced member of the field monitors the clinical competence and professional development of a supervisee, or less experienced member

of the same field (Bernard & Goodyear, 2004; Knox, Burkard, Edwards, Smith, & Schlosser, 2008). The process is intended to be collaborative and integrative (Falender & Shafranske, 2004), and is ultimately intended to provide an environment whereby competence can be developed while foundational attitudes and values of the profession can be instilled (Falender & Shafranske, 2007).

Falender and Shafranske (2004) place emphasis on supervisor competence in order to ensure that clinical supervision and practices are being conducted within ethical parameters, so as to protect the welfare of the client, the profession, and the supervisee. As such, it is essential that supervisors possess a working knowledge of factors that contribute to effective supervision, as trainee development, client welfare, and professional integrity hinge upon such knowledge and competence. Among the factors that have been studied, the supervisory working alliance, which involves the relationship formed between the supervisor and supervisee, has been identified as a principal factor in determining whether or not supervision is experienced as effective, positive, and successful (Ladany, Ellis, & Friedlander, 1999; Worthen & McNeill, 1996); the supervisory alliance has also been hypothesized to be as vital to supervision as it is to psychotherapy (Ladany & Friedlander, 1995). Further, the supervisory alliance has been shown to influence the supervisee's ability to work competently with clients and to later act as an effective supervisor in his or her own career (Falender & Shafranske, 2004; Ramos-Sánchez et al., 2002).

Given the integral function of supervisory alliance in supervision outcome (Ellis & Ladany, 1997), attention has been dedicated to identify and explore factors that contribute to an effective supervisory relationship. A high-quality supervisory relationship has been found to embody qualities such as warmth, understanding, mutual trust, and respect (Hutt et al., 1983;

Ladany & Friedlander, 1995). It has been noted to involve support; instruction; and interpretation (Kennard, Stewart, & Gluck, 1987), as well as positive events that were facilitative; non-judgmental; and task-oriented (Hutt et al., 1983). Such qualities and experiences appear to forge a sense of teamwork (Henderson, Cawyer, & Watkins, 1999), which ultimately supports the supervisee's professional development and clinical work with clients. The confluence of these factors, in addition to the supervisor's perceptive and supportive abilities, fosters an environment where the trainee's anxiety regarding client conflicts can be allayed and resources can be allocated to working through clinical struggles, instead of being utilized fearing reproach or poor evaluation by the supervisor (Hutt et al., 1983). During positive supervision, supervisees not only gain technical skill and clinical experience, but they also gain an increased sense of professional competence and confidence in their decision-making and performance as a clinician.

While many studies have been dedicated to the identification of factors and events that lead to positive supervisory experiences (Lochner & Melchert, 1997), there are relatively few investigations of the nature and consequences of negative events that occur in supervision (Ramos-Sánchez et al., 2002). Close examination of these negative events is crucial, as they can have a direct impact on the effectiveness of supervision, the trainee's professional development, and his or her clinical work with clients (Bordin, 1983; Goodyear & Bernard, 1998). Unless counterproductive experiences are effectively addressed by the supervisor (Falender & Shafranske, 2004), these events can lead to a poor working alliance, which ultimately compromises the efficacy of supervision (Cheon et al., 2009; Gray et al., 2001). For example, Hutt et al., (1983) found that a negative supervisory relationship tended to elicit intense negative feelings from the supervisee and resulted in a sense of anxiety, anger, and frustration. An unproductive environment may develop, characterized by mistrust and inauthenticity, leading to

withholding of disclosures by both supervisors and supervisees. Further, the supervisee would likely not feel supported by the supervisor in this type of atmosphere, and may anticipate or experience criticism or disapproval, hindering the ability to be honest. Failure to disclose personal reactions to clinical challenges can ultimately lead to poor treatment outcomes, ethical violations, and injurious countertransference reactions (Ladany et al., 1996). Trainees may learn to cope with interpersonal challenges with their supervisors through avoidance as a means of self-preservation, as opposed to open, vulnerable exploration, which is necessary for effective supervision (Hutt et al., 1983).

Given the significant impact that counterproductive events and experiences may have on the supervisory process, it is important to acquire a clearer understanding of these experiences. A more thorough understanding of these processes may serve as an invaluable resource for supervisors and training programs, as such awareness may foster great care and commitment to best practices in supervision and eliminate to the extent possible counterproductive events (Gray et al., 2001). Efforts to understand CEs requires a means by which such events can be identified, reported, and measured. At the present time, no such construct or systematic method exists to evaluate CEs in supervision. This study aims to address this deficit by completing a first four steps in the development of a scale to measure counterproductive experiences and events in clinical supervision. The following section provides an overview of what is known about counterproductive events in supervision.

Theoretical and empirical review of counterproductive events in supervision.

Counterproductive events or experiences in clinical supervision are discussed in the professional literature; however, a glaring omission is found in that there does not appear to be a unifying or consensually agreed upon definition that encompasses the wide spectrum of events

and experiences that may occur in supervision which lead to suboptimal outcomes (Ellis, 2001). Further, distinctions between events that are simply unhelpful or ineffective are blurred with experiences that are frankly harmful, injurious, or illegal. Distinctions between counterproductive experiences and harmful experiences are warranted given that the gravity of consequence is not commensurate for both groups of events. Further, they should not all be categorized equally without proper mention made to the range of severity that exists among *counterproductive experiences and events*.

In this study, we acknowledge the distinction between ineffective and injurious events in supervision, as detailed by Ellis (2001), as well as provide an operational definition of experiences that likely compromise the effectiveness of clinical supervision. *Harmful* events in supervision can be considered ones that cause psychological, emotional, and/or physical harm to the supervisee or clients due to the supervisor's direct actions or inactions. Harmful supervision can be differentiated from *inadequate* (or poor) supervision. Inadequate supervision may fail to sufficiently meet the trainee's needs or result in harm to client care, but does not necessarily cause psychological, emotional, and/or physical harm (Ellis, 2001). For the purpose of this study, we define a counterproductive experience in supervision as, *events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder the supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness*.

A number of counterproductive experiences and events in supervision have been identified in supervision theory, and some have been empirically studied, such as disclosure/nondisclosure by both supervisor and supervisee, role conflict and role ambiguity, ethical concerns, supervisor style, and multicultural insensitivity (Appendix A). Appendix B

summarizes the findings of a systematic review of the empirical literature. The following discussion provides a summary of the findings of this review.

Supervisor self disclosure. Ladany and Lehrman-Waterman (1999) looked at supervisor disclosure, and found that effective/satisfying supervision was facilitated by self-disclosure relating to supervisor's personal reactions to clients, their previous challenges and successes conducting psychotherapy, direct feedback on the supervisory relationship, general professional experiences, and didactic mentoring. In another study by Ladany and Melincoff (1999), nondisclosure was examined and it was found that 98% of supervisors reported they had withheld some form of information from their supervisee. In nearly three-fourths of the cases, the withheld information pertained to the supervisor's negative reaction to the supervisee's professional performance or therapeutic work. Other reasons for nondisclosure included trainee personal issues; negative self-efficacy of the supervisor; trainee conduct; and attraction to the trainee. Supporting the positive findings of supervisor disclosure in the supervisory process (Knox, Edwards, Hess, & Hill, 2011), Ladany and Lehrman-Waterman (1999) additionally found that supervisees reported that supervisors who disclosed personal experiences, such as struggles and difficulties with clients, were seen as creating meaningful emotional connections with supervisees, thereby increasing supervisee disclosure. Supervisor self-disclosure appears to play a prominent role in normalizing supervisees' struggles and conflicted feelings, and may improve the supervisory working alliance. Such disclosures may also assuage supervisees' feelings of vulnerability, help them set realistic expectations, open up rich discussions about how to navigate challenging situations, and thus facilitate supervisee disclosure (Ladany & Walker, 2003).

Supervisee self disclosure. An inferred assumption in most psychotherapy supervision models is that for the supervisor to facilitate the development of therapeutic competence in the supervisee, the supervisee must disclose detailed and honest information about the client, the therapeutic relationship, the supervisory interaction, and personal information about his or herself. Conversely, nondisclosure would theoretically interfere with the supervision process and thus hamper trainee learning. As supervisors cannot assist with matters they are unaware of, it would seem as though the efficacy of supervision largely hinges upon the supervisee's willingness to express various concerns to his or her supervisor (Ladany et al., 1996).

When determining what to disclose, a supervisee may be inclined to select items that will reflect well upon his or her competence, or otherwise make choices that will minimize the risk of creating a negative impression (Ward, Friedlander, Schoen, & Klein, 1985) which may be translated into a negative evaluation of his or her clinical work (Ladany et al., 1996). As such, it seems feasible to suspect that much of what is not disclosed in supervision may carry as much weight as, or carry more weight than, what *is* disclosed. The study conducted by Ladany et al. (1996) found that circumstances prompting supervisee nondisclosures were largely related to negative reactions to the supervisor, personal issues, concerns regarding personal evaluation, clinical mistakes, or general clinical observations. Regardless of the influencing factors, supervisee nondisclosure has ultimately been found to hinder the supervisee's professional growth and therapeutic competency.

Role conflict and role ambiguity. In supervision, a trainee must be prepared to learn new and difficult tasks and to manage a number of disparate roles. Supervisees assume a more dominant role while conducting psychotherapy with clients, yet stand lower on the power

hierarchy in relation to their supervisor. Additionally, supervisees devote a portion of time yielding to the academic demands of their graduate program and requirements of their desired license (Nelson & Friedlander, 2001). For a number of trainees, role delineation can become nebulous; pursuant role conflict or ambiguity can traverse into greater issues, such as anxiety, general dissatisfaction with the supervisory process (Olk & Friedlander, 1992), and dislike for clinical work or the profession (Ramos-Sánchez et al., 2002).

Nelson and Friedlander (2001) conducted a study looking at trainees' experience of role confusion, and found that power struggles between the supervisor and supervisee ranked as one of the cardinal factors associated with trainee confusion and supervision dissatisfaction. Frequently, participants described their supervisors as authoritarian in nature, often asserting their supervisory and therefore superior status as a means to resolve supervisory conflict, in lieu of utilizing a more disarming style whereby collaboration and change could be accorded. Results from the literature (See Appendix B) suggest that supervisors need to effectively manage the inherent power differential found in the supervisory relationship in order to safeguard against injurious and unethical supervisory practices.

Ethical issues. Ethical violations by supervisors in clinical supervision can impact supervisees' training experience, their work with clients, and the process of supervision (Wall, 2009). Areas of supervision in which ethical guidelines need to be followed include performance evaluations, confidentiality, expertise, multicultural sensitivity, crisis coverage (Ladany et al., 1999), and maintaining appropriate relationship boundaries (Falender & Shafranske, 2004; Heru, Strong, Price, & Recupero, 2004). Any violations in these domains can weaken the working alliance in the supervisory relationship, contribute to conflict, and be detrimental to the supervisee (See Appendices A & B). Examples of counterproductive events in regards to ethics:

- Supervisee's observation of unethical conduct by supervisor (Ladany, Friedlander, & Nelson, 2005)
- Supervisor fails to adhere to ethical guidelines regarding evaluation and monitoring supervisee's activities (e.g., suicide risk assessment, child abuse reporting) (Ladany et al., 1999)
- Sexual relationship between supervisor and supervisee (Heru, 2006)

Supervisor style. Like any interpersonal relationship, the unique styles of supervisor and trainee interact and create a specific dynamic that impacts the supervisory relationship. Since supervisor style is multidimensional (Falender & Shafranske, 2004), there are an infinite number of permutations that can emerge from any given dyad. Various approaches (e.g., interpersonally sensitive or attuned, task/goal-oriented; Friedlander & Ward, 1984; Hess et al., 2008) will determine how the supervisor responds to and generally interacts with the supervisee; major stylistic differences often yield a strained relationship (Moskowitz & Rupert, 1983), whereas a strong supervisory alliance is generally borne from a more flexible supervisory style, whereby the supervisor tailors his or her approach based on supervisee needs (Ladany, Walker, & Melincoff, 2001; Gray et al., 2001).

Cultural considerations. The development of multicultural competence in clinical practice is considered an imperative to effective and ethical client treatment (Burkard et al., 2006). Supervision is hypothesized to play a particularly important role in learning and integrating a multicultural and diversity perspective into practice (Falender, Shafranske, & Falicov, in press); supervision also provides first-hand experiences that actively promote growth as a culturally competent therapist (Pope-Davis & Coleman, 1997; Constantine, 1997). In general, responsiveness to cultural issues has been associated with positive effects in supervision,

and unresponsiveness or insensitivity to cultural issues has been correlated with negative effects (See Appendices A & B).

Examples of counterproductive experiences or events pertaining to multiculturalism:

- Cultural issues were ignored, actively discounted, or dismissed by supervisors (Burkard et al., 2006)
- Negative cultural stereotyping of clients or supervisee (Singh & Chun, 2010; Toporek, Ortega-Villalobos, & Pope-Davis, 2004)
- Supervisor challenging the use of specific interventions with culturally diverse clients (Fukuyama, 1994)
- Supervisor viewed as lacking multicultural expertise (Burkard et al., 2006; Jernigan, Green, Helms, Perez-Gualdron, & Henze, 2010).

Additional events. While a number of counterproductive events in supervision have been identified, it is likely that there remain a number of experiences that constitute CEs in clinical supervision. For example, lack of respect for supervisor/supervisee, perceived clinical mistakes/inadequacy (Ladany et al., 1996), unaddressed miscommunications, differing levels of professionalism, logistics of supervision (Veatch, 2001), and impression management (Gray et al., 2001; Hess et al., 2008; Nelson & Friedlander, 2001) may negatively impact the supervisory experience and consequently compromise oversight and clinical management of cases under supervision.

Purpose and Importance of the Study

Given the indispensable role that clinical supervision plays in the development of competence in graduate students as well as the protective role it plays in client welfare, it seems necessary to develop a more comprehensive understanding of the counterproductive experiences

and events that occur in supervision that compromise the supervisory alliance and the overall effectiveness of supervision (Ramos-Sánchez et al., 2002; Ladany et al., 1999). While research on factors associated with effective supervision is relatively abundant, the paucity of literature analyzing the nature and extent of CEs has beckoned further investigation (Ladany et al., 2001). This study investigated beliefs about the impacts of counterproductive events in supervision as reported by clinical supervisors, and aimed to contribute to the empirical literature. It also sought to complete the preliminary steps required to develop a scale of CEs in supervision (CES). The development of a scale can provide a means to reliably identify the nature and frequency of CEs in supervision and to study their effects. Increased knowledge of the impacts of counterproductive experiences may serve to enhance supervisor-supervisee relations by careful attention to refrain from CEs as well as to provide information useful in psychotherapy training programs in which training in supervision is included (Gray et al., 2001).

Method

The purpose of this study was to contribute to the understanding of counterproductive experiences in supervision, including completion of the initial steps in the development of a scale of CEs. The formulation of a scale of CEs (CES) will provide one means for investigators to look more carefully into the nature and frequency of such events and their impact on factors such as the supervisory alliance, supervisee disclosure, and therapy outcome. We continue this discussion with an overview of the method and procedures that were utilized when developing this scale, as well as delineation of the steps that were accomplished in this study.

Scale Development

The measurement of a construct such as *counterproductive experiences in clinical supervision* began with an operational definition and then proceeded through a series of steps to identify items that accurately and reliably measured the construct. In this study, a counterproductive experience in supervision was defined as: *events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder the supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness.* We turn now to a discussion of the stages involved in developing a scale as well as discussion of the specific contributions of this study to this endeavor.

DeVellis (2012) outlined the following stages in scale development:

- (1) Determine the purpose of the scale;
- (2) Generate a pool of items that are candidates for eventual inclusion in the scale;
- (3) The investigator then determines the format for measurement (i.e., checklist, declarative items, or scales with equally weighted items);

- (4) A group of clinical supervisors, who are knowledgeable in the content area, review the item pool and rate how relevant they believe each item is to what is intended to be measured;
- (5) Validation items may be added to assess motivations influencing responses;
- (6) Administer items to a development sample that is representative of the population for which the scale is intended;
- (7) Evaluate the items so that appropriate ones can be identified to constitute the scale. Determine which groups of items, if any, constitute a unidimensional set, by factor analysis. Compute the reliability coefficient, alpha, in order to determine the scale's quality by weeding out the poor items and retaining the good items; and
- (8) Optimize scale length. At this point the investigator has a pool of items that demonstrate acceptable reliability. If the development sample is sufficiently large, it may be possible to split it into two subsamples. One can serve as the primary development sample and the other can be used to cross-check the findings.

The research program in which this study is associated includes studies of opinions of experts and psychology graduate students. These studies taken together will complete the first four steps necessary to create a scale of counterproductive experiences.

The development of scale items involved a literature search of the theoretical and empirical literature; from this literature, a comprehensive list of events and experiences that had been identified as a CE was compiled. Following the development of this list, a sample of directors of training of clinical psychology internship sites were recruited to sort the list of CEs using a Q-sort method. The findings of this study intended to provide the information necessary

to create an initial scale of CEs in supervision. The following sections present the research design, participants, instrumentation, procedures, and data analysis plan.

Research Approach and Design

This study obtained opinions about the impacts of counterproductive experiences (CEs) on supervision from directors of training of psychology internships through the use of a Q-sorting approach. The participants were given a set of stimuli, which they compared and sorted according to their point of view. Through this technique, subjective accounts of behavior can be reliably transformed into an objective assessment of behavior (Stephenson, 1953). The Q-sorting technique follows a 5-step structure:

- (1) Identifying a concourse on the topic of interest
- (2) Developing a representative set of statements (Q-sample)
- (3) Specifying the respondents for the study (P-set) and ‘conditions of instructions’
- (4) Administering the Q sort (rank ordering of statements) (Ellingsen, Størksen, & Stephens, 2010)
- (5) Analyze and interpret using descriptive statistics

This type of procedure is conducive to gathering a diversity of viewpoints on CEs in supervision by allowing participants to express their uncensored opinions on a topic not explicitly hypothesized by the researcher (Dziopa, & Ahern, 2011).

Participants

The participants in this study were directors of training of clinical psychology internships. The researcher aimed to obtain Q-sort data from approximately eight to sixteen directors of training, referred to as the P-set; however, only five directors participated in the study. Potential participants were recruited from internship sites throughout the Los Angeles

Metro Area listed in the Association of Psychology Postdoctoral and Internship Centers (APPIC) Directory website. Directors of training are in a unique position to assist in identifying counterproductive experiences and events that occur in supervision and complement other studies in the research program that are eliciting opinions of experts in the field of supervision as well as doctoral students in clinical psychology. While *experts* in supervision, i.e., published researchers in the field, might provide opinions about CEs based on foundational research and academic pursuit, and students' accounts represent opinions as 'consumers' of supervision, directors of training can provide opinions based on first-hand, current experience supervising supervisees as well as overseeing the entire training process. Their perspectives usefully complement data provided by experts and supervisees thus identifying discrepancies and potential blind spots.

A Q-methodological study requires only a limited number of respondents, as the purpose is to explain key opinions of the participant groups. The aim is to have four to five participants defining each anticipated viewpoint. A variety of viewpoints can be achieved when a participant group contains four to five participants defining each anticipated viewpoint, however, clinically significant results can be obtained with two to four participants per viewpoint (Dziopa & Ahern, 2011; Ellingsen, Størksen, & Stephens, 2010). Based on the four viewpoints on CEs (Significant Major Effect, Moderate Effect, Minimal Effect, No Effect) that were assessed, this study aimed to recruit between eight and 16 clinical supervisors in an attempt to gather distinct viewpoints regarding CEs in supervision.

Four of the five participants (directors of training) returned the demographic questionnaire that was included in the mailed package. The demographic characteristics of the participants were: 1) All participants were White (non-Hispanic); 2) Three of the participants

were male and one participant was female; 3) Average age of the participants was 52.25 years; and 4) The participants have supervised, on average, 25 students each within the last five years.

Instrumentation

Demographics questionnaire. The questionnaire obtained information regarding participant demographics, including gender, age, ethnicity, and total number students supervised. This section contained both forced response and open-ended items, with an additional section provided for participants to include additional information related to responses coded as *other* (See Appendix D).

Q-Sort: Identifying a concourse. *Concourse* refers to the communication of all possible aspects or ‘viewpoints’ on an issue (Ellingsen, Størksen, & Stephens, 2010; Dziopa & Ahern, 2011). In this study, the concourses were defined as counterproductive events and experiences in supervision. A comprehensive review of the theoretical and empirical literature was conducted to identify elements (i.e., supervisor/supervisee events, behaviors, and characteristics) considered to produce or contribute to counterproductive events.

Developing a Q-sample. The Q-sample consists of an abbreviated set of statements that represents the various features of the concourse. While the number of statements can vary, Q-sets ranging from 10 to 100 have been shown to be efficient and effective (Dziopa, & Ahern, 2011; Ellingsen, Størksen, & Stephens, 2010). Dziopa and Ahern (2011) noted that the most important aspect of selecting statements is the representativeness, meaning they have to be different enough to portray varying attitudes and opinions. The items selected were based on existing theoretical and empirical findings on CEs and harmful events in supervision (Appendix E).

Specifying the P-set and the conditions of instruction. Researchers identified the targeted population that received the Q-sort. As previously noted, directors of training of clinical psychology internships represented the P-set in this study. Additionally, the respondents were given instructions (known as *conditions of instruction*) for the Q-sorting process (Appendix H).

Consultation study. In an attempt to determine if the CES had face validity and to provide a critique of the items and method, a consultation study was conducted with a small group of doctoral supervisors in the clinical psychology program at Pepperdine University. The nature of their task was to comment on the clarity and comprehensiveness of the items. Participants were invited to provide any suggestions or revisions that might improve the overall fluidity and quality of the study.

Research Procedure

This section included discussion of recruitment, instructions, human subjects protections, and data collection. The self-administration Q-method is a valuable assessment tool in that it can be utilized to efficiently gather subjective opinions, attitudes, and beliefs. Furthermore, it is relatively concise, and allows for the qualitative and quantitative approaches in research to successfully merge (Block, 2008; Stephenson, 1953). In addition to being more cost effective, self-administered Q-sorts require less effort than in-person administrations (Dziopa, & Ahern, 2011; Tubergen & Olins, 1978).

Recruitment. Directors of training were directly mailed an invitation to participate along with a package containing all participant materials. The package included a recruitment letter with an introduction describing the nature of the study (See Appendix G), an informed consent letter (See Appendix H), a stack of cards each containing an item from the Q-sample, and two self-addressed paid-postage envelopes for directors of training to mail back the Q-sort stack as

well as the informed consent should they chose to link their participation with the research. The package also included a cover letter from Drs. Edward Shafranske and Carol Falender to introduce the study (See Appendix F). The participants were offered a copy of the study's abstract upon completion; they could request a copy using the email address provided in the recruitment letter (Appendix G). The study and recruitment for the study were conducted in accordance with accepted ethical, federal, and professional standards of research to ensure confidentiality and to make every effort to eliminate any potential risks to participants.

Instructions. A counterproductive experience is defined as events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder the supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. Participants were provided with instructions that explained where the CEs were generated from, as well as instructions regarding how to sort each counterproductive experience. Directors of training were given four envelopes marked (a) *Significant Major Effect*, (b) *Moderate Effect*, (c) *Minimal Effect*, and (d) *No Effect*. The participants were asked to compare each item and rank them by placing each card in a designated envelope (See Appendix I). Participants were also provided with a blank card, and if applicable, they could identify an additional element of supervision that was not included, ultimately maximizing the content validity of the scale (DeVellis, 2012).

Protection of human subjects. Prior to recruitment, an application was submitted to the Institutional Review Board of Pepperdine University for approval. An application for a claim of exemption was submitted under IRB policy under the category of research involving the use of interview procedures, as the Q-sort methodology is found to be highly congruent to in-person interviews (Tubergen & Olins, 1978). In addition, the study posed no greater than minimal risk

to participants and no personal or identifying information was asked from participants. The information obtained was recorded in such a manner that the subjects could not be identified directly or through identifiers linked to the clinical supervisors. Any disclosure of the participants' responses outside of the research would not place the participants at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

The study's purpose, intent, and potential risks and benefits were delineated in the recruitment letter (Appendix G). The informed consent document informed participants that the data that was obtained would be confidential, and their identities would not be known. They were also informed that their participation was voluntary, and they may withdraw their participation at any point during the study. Participants were asked to read the informed consent and were given the option to provide written consent. A statement was included in the recruitment letter and the informed consent document to inform the participants that they may keep the informed consent for their records or they may sign and return the informed consent and link their participation with the research (See Appendix H).

Potential risks and benefits. The study presented no more than minimal risk to the human subjects; no personally identifiable data was collected. The current study posed no more than minimal risk in light of the following conditions: (a) the subjects were asked about hypothetical scenarios and were *not* asked to reflect or disclose on counterproductive events they have personally experienced, (b) the subjects are experienced in the field of supervision and have likely engaged in discussion and self-reflection regarding events that are harmful in supervision, (c) the contents under study were considered areas of professional competence for clinical psychologists, and (d) confidentiality of subjects was ensured.

There were no direct benefits to all participants. However, participants might derive satisfaction from the understanding that their participation contributed to the current body of supervision literature, and would serve to enhance the overall quality of clinical training in the field of psychology. In addition, participants could elect to receive a copy of the study's abstract upon completion.

Regarding potential risks to participants, attempts were made to minimize these effects. Although the administration of the Q-sort is brief, approximately 15 minutes, the primary risk was potential boredom or fatigue in completing the task. Even though participants were not instructed to reflect on personal experiences related to counterproductive events or negative supervision experiences, the participants might have been reminded of counterproductive events they may have engaged in or were subject to as trainees. Recalling such experiences might have elicited a range of emotional reactions, and therefore the study posed a risk. However, it posed no greater than minimal risk due to the extensive training and experience directors of training have ostensibly received regarding self-awareness and self-monitoring. If any distress arose, the participant could have spoken to a trusted colleague, clinician, or could have contacted Dr. Edward Shafranske, dissertation advisor, to help mitigate any potential negative consequences as a result of participating in this study. A statement was included in the recruitment letter and the informed consent documents that participation was voluntary and participants may have discontinued at any point if they choose.

Consent for participation. Participation in this study provided implicit consent and implied that participants fully understood the nature and potential risks and benefits of the study. Participants were provided with the option to keep the informed consent for their records or sign and return the informed consent in the separate pre-paid self-addressed envelope marked *consent*

(Appendix H). A waiver of documentation of consent was requested and approved by the Institutional Review Board of Graduate Schools at Pepperdine University.

Data Collection and Analysis

Directors of training were contacted by mail and invited to participate. The directors were mailed a cover letter, recruitment letter, informed consent form, instructions, demographic questionnaire, the Q-sort stack of cards, instructions, and two pre-paid and self-addressed envelopes. The recruitment letter and informed consent informed the directors of training of the study's purpose and intent, the potential benefits and risks of participation, and participation procedures. Each card in the provided stack contained an item from the Q-sample with instructions on how to sort each card. Data was collected via postal mail and contained the Q-sort stacks (sorted in envelopes) and the demographic questionnaire. Once the materials were received, the researcher performed raw frequency counts and obtained means and a frequency for each item. First, the researcher reviewed each card within each Q-sort stack category, and assigned a number (or score) based on the participant's ranking (0 = No Effect; 1 = Minimal Effect; 2 = Moderate Effect; 3 = Significant Major Effect). The scores for each item were then summed and then divided by the total number of participants to obtain a mean value. Once this was complete for each item, the category means were computed and ranked using a Likert scale. The data was entered into an Excel spreadsheet. The results of this study contributed to the foundational set of CEs that will be utilized in a larger study in order to propel further scale development. The final scale will need to include a range of CEs based on likely frequency. The data remains confidential and will be stored in an electronic file for five years, after which the file will be deleted. The hard copies of the materials are stored in a locked file cabinet and will also be destroyed after five years.

Results

The frequencies for each counterproductive event, as rated by the directors of training, are summarized below in Table 1. There are nine categories that comprise the 50 counterproductive events that occur in supervision. Participants were asked to rank each event based on how counterproductive they believed each event to be. The choices were no effect, minimal effect, moderate effect, and significant major effect or strain on the supervisory alliance and on the process of supervision. Each CE was assigned a score based on the participant's ranking (No Effect = 0, Minimal Effect = 1, Moderate Effect = 2, Significant Major Effect = 3). The scores for each item were summed and then divided by the total number of participants to obtain a mean value. Once the CEs were assigned a score, the category means and standard deviations were computed and ranked using a Likert scale.

Counterproductive Events in Supervision

The counterproductive events in each category were given a score (No Effect = 0, Minimal Effect = 1, Moderate Effect = 2, Significant Major Effect = 3); the means for each event were calculated, and then the means for each category were calculated and ranked based on a Likert scale. Based on the analyses of findings of the Q-sort procedure, the category *Failure to Address Needs of the Supervisee* was believed to have the greatest overall effect on the process of supervision. Table 1 highlights that the participants believed events related to *Cultural Insensitivity* were also very likely to negatively affect the supervisory process. The CEs from the category, *Supervisor/Supervisee Theoretical Orientation Mismatch*, were believed to have at least a minimal negative impact on supervision, but overall were believed to have the least effect on supervision. The results of the ranked CEs from each domain are outlined below.

Failure to address needs of the supervisee. Based on the Q-sort data from the five directors of training, counterproductive events related to a failure to address the needs of the supervisee were believed to have the most significant major effect on the process of supervision. While there was some variability in regard to the directors' rankings, by and large, the directors of training believed that the events in this category had a minimal to severe impact on the process of supervision. For example, one director believed that the CE, *Supervisor does not consider the developmental needs of the trainee*, had a minimal impact, whereas four directors believed that it had a moderate to significant major impact on supervision (ModE = 2; SigE = 2). Similarly, one director believed the CE, *Supervisor is unresponsive to supervisee's verbalized training/supervision needs*, had only a minimal effect on supervision, in contrast to the four directors of training who believed this CE had a significant major effect (SigE = 4). All directors agreed that the CE, *Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting their professional performance*, had a significant major effect on the process and outcome of supervision (SigE = 5), and all directors deemed that the CE, *Supervisor appears to be distracted during supervision*, had a moderate to significant major effect on the supervisory process (ModE = 3; SigE = 2).

Cultural insensitivity. Based on the rankings of the five directors of training, within this category, the CEs, *Supervisor does not encourage the use of culturally appropriate interventions*, and, *Supervisor assumes cultural/racial stereotypes when discussing clients*, were largely deemed as having a significant major effect on the process of supervision, and a minimal effect at the very least (MinE = 1; SigE = 4). Further, the CE, *Supervisor does not consider the impact of his/her own and supervisee's cultural identities*, was judged to have a moderate to significant major effect by all five of the directors of training (ModE = 3; SigE = 2). Overall, inattention to

the inherent cultural components embedded within clinical work was appraised as having a negative impact on the supervisory process.

Additional counterproductive events. The directors of training all believed that the CEs, *Supervisor does not demonstrate empathy for the supervisee*, and, *Supervisor does not demonstrate respect for the supervisee*, had a significant major effect on the process and outcome of supervision (SigE = 5). There was variability within this category of CEs, with directors endorsing that the remainder of items yielded a minimal to significant major effect on the process of supervision. For example, one director thought that the CE, *Supervisor is frequently late for supervision*, had a minimal effect on the supervisory process, whereas the remainder believed it had a moderate to significant major effect (ModE = 1; SigE = 3). Similarly, only one director of training believed that the CE, *Inadequate environment/office space is provided for supervision*, had a minimal impact, whereas the remaining participants endorsed that this event had a moderate to significant effect on the supervisory process (ModE = 3; SigE = 1).

Supervisor supervision approach and supervisee learning approach mismatch. Among the CEs that pertained to a mismatch between supervisory style and supervisee's preferred mode of learning, *Supervisor often makes critical judgments of supervisee without providing constructive feedback*, and, *Supervisor is often insensitive when giving feedback*, were judged to have the greatest negative impact on the process of supervision (ModE = 2, SigE = 3; MinE = 1, SigE = 4, respectively). Directors of training all agreed that the CEs within this domain had at least a minimal effect on the process and outcome of supervision.

Inadequate understanding of performance expectations for supervisee and supervisor/role conflicts. In general, the participants' responses indicated that when a supervisor fails to clearly communicate performance expectations to the supervisee, it could have a moderate to significant impact on supervision. The CE, *Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations*, was documented to effect the greatest negative impact [moderate to significant major effect] on the supervisory process (ModE = 2; SigE = 3). *Supervisor does not encourage the development of mutually agreed upon goals of supervision*, was similarly deemed to pose a threat to effective supervision (ModE = 3; SigE = 2).

Inadequate attention to ethics, ethical lapses, and unethical behavior. All of the directors of training ranked the CE, *Supervisor directs the supervisee not to file a child abuse report when the supervisee reports clear instances of neglect and abuse*, as having a significant major impact on the process of supervision (SigE = 5). One of the participants believed that the CE, *Supervisor is unavailable to discuss clinical emergencies outside of regularly scheduled supervision*, had a moderate effect on supervision, whereas the other participants believed that such an event had a significant major effect (SigE = 4). While the majority of the directors believed that the CE, *Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained*, had a moderate to significant major effect on supervision (ModE = 1; SigE = 3), only one participant reported that the CE, *Supervisor sometimes ignores agency policies*, had a significant major effect on the supervisory process (MinE = 3; ModE = 1).

Boundary crossings/violations. Directors of training unanimously reported that supervisors making jokes/comments with sexual innuendos and supervisors expressing attraction to the supervisee fostered the potential for a significant major [negative] effect on the process and outcome of supervision (SigE = 5). Conversely, participants deemed inquiring about the supervisee's personal life (e.g., *Are you dating anyone?*) as less impactful or injurious to the supervisory process (NoE = 2; MinE = 1; ModE = 2). Similarly, directors of training did not believe that attempting to help a supervisee resolve a personal conflict was particularly hindering to the process and outcome of supervision (NoE = 1; MinE = 3; ModE = 1). In terms of a supervisor asking a supervisee to attend a personal event outside of supervision, one director endorsed that no effect would be wrought from such an action, whereas the remainder of the participants ranked such an event as having a moderate to significant impact on supervision (ModE = 2; SigE = 2).

Inappropriate supervisor self-disclosure. The directors of training provided a span of viewpoints in terms of events related to supervisor self-disclosure. For example, for the CE, *Supervisor discloses personal disillusionment about their career as a psychologist*, one director believed that this caused no effect on supervision, one director believed it would have a minimal effect, and the remaining participants believed such an event had a moderate to significant major effect (ModE = 1; SigE = 2). In terms of supervisors [often] reporting personal information about their lives, one director of training felt this would have no effect, while the remainder believed a mild to moderate effect could result from this scenario (MinE = 1; ModE = 3). The event in this category that was found to have the greatest impact was *Supervisor discloses negative opinions about the supervisee's clients* (See Table 1).

Supervisor/supervisee theoretical orientation mismatch. While the directors of training were variable in their responses, the events within this category were primarily judged to have at least a minimally negative effect on the supervisory process. The directors' responses were particularly split on the CE, *Supervisor and supervisee differ in which therapeutic approach is best suited to achieve the treatment goals* (See Table 1), with beliefs ranging from *No Effect* to *Significant Major Effect*. The participants believed that when a supervisor has limited knowledge about the supervisee's theoretical orientation, this could have a minimal to significant impact on the process of supervision. The CE that was found to have the most significant impact on supervision was, *Supervisor criticizes supervisee's primary theoretical orientation*.

Additional CE provided by participant. One participant included one additional CE on the blank card that was provided:

- “Supervisor provides inaccurately high ratings of supervisee's performance secondary to fear of being assertive with supervisee.” (SigE=3)

Discussion

The results of this study suggest that all of the CEs were believed to have some negative impact; however, some specific kinds of experiences are opined to have greater potential for negatively impacting the process of supervision. Further, analysis of the participants' responses revealed that while specific counterproductive events or categories of events may have been statistically identical or close in range, there was actually a significant degree of variability in the distribution of the responses for any given CE/category; identical means for various CEs were often generated from highly variable permutations of the supervisors' categorization of CEs into *No Effect*, *Minimal Effect*, *Moderate Effect*, and *Significant Major Effect*.

Full consensus among the five supervisors occurred on items that indicated the crossing of boundaries (e.g., *Supervisor makes jokes/comments with sexual innuendos*) and the violation of common legal/ethical events (e.g., *Supervisor directs the supervisee to not file a child abuse report when the supervisee reports clear instances of neglect and abuse*). Further, a consensus was noted among items that appeared to have a higher level of social desirability (e.g., *Supervisor does not show respect for the supervisee*, and *Supervisor does not show empathy for the supervisee*); it is not surprising that there was a high level of agreement on items that are characteristically admonished against within the profession of psychology (e.g., *Supervisor expresses attraction to the supervisee*). Lastly, the participants all believed that the item, *Supervisor is unresponsive to supervisees' disclosures about personal difficulties affecting their professional performance*, would have a significant major effect on the supervisory process. It is possible that this unanimous belief is reflective of the well-researched notion that the supervisory relationship/alliance is an essential feature of effective supervision (Falender & Shafranske, 2010).

Conversely, a majority of the 50 CEs (27) were ranked over three of the four viewpoints, indicating little consensus on these particular items. The categories that most notably showed this pattern of variability were: Inappropriate Supervisor Self-Disclosure; Supervisor Supervision Approach and Supervisee Learning Approach Mismatch; Supervisor/Supervisee Theoretical Orientation Mismatch; Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior; Boundary Crossings/Violations; and Additional Counterproductive Events. These results might suggest that beliefs regarding these specific elements of supervision are highly subjective in nature, and that the guidelines surrounding the management of various events within these categories are either nebulous or nonexistent. Additionally, there were two counterproductive events whereby participants ranked responses over all four viewpoints (*Supervisor discloses personal disillusionment about their career as a psychologist*, and *Supervisor and supervisee differ in which therapeutic approach is best suited to achieve the treatment goals*). It can again be conjectured that such variability is a product of personal preference and/or a lack of codified supervision guidelines, or it is possible that these particular questions were worded poorly and therefore caused the variability in responses.

In conclusion, the results of this study elucidate the subjective nature of opinions regarding the salience of events impacting supervision, and call attention to the high variability of attitudes, beliefs, and practices surrounding clinical supervision. This study sought to acquire the viewpoints of supervising psychologists in order to develop the foundational set of items that would ultimately be used to create a scale of counterproductive experiences/events in supervision. As clinical supervision is making a shift towards competency-based practice, such a scale, or instrument, is central to aiding in the teaching and implementation of defining guidelines of supervisory practice. While it is not the intention to create uniform practice, it

seems apropos in the face of this cultural shift to create and maintain a set of standards tantamount to the existing standards which govern legal and ethical practice.

Limitations

A limitation of this study includes the sample of directors of training. The directors of training were selected based on a local search of the APPIC website. The directors that were used were ones who worked at internship sites within the Los Angeles/Orange County Metro area. While we accounted for a small range of opinions that exist between directors, there likely would have been greater variability in the perspectives of those directors residing in other parts of California or in other parts of the United States. For example, this sample of supervisors may hold a bias based on the exposure to training they have commonly experienced by virtue of living and working in this particular region.

A second limitation concerns the number of supervisees each director has supervised, as well as nature and intensity of the supervision. For example, two directors may have supervised the same number of trainees; however, one director may have been conducting supervision multiple times per week/providing *on-the-spot* supervision, whereas the other director may have supervised biweekly or acted as a delegated supervisor. While this is just one example, there are a number of factors that could account for variance in experience and therefore color one's perspective and ranking of the Q-sort items.

Another limitation of the study is the generalizability of the sample; the directors who took the time to complete the Q-sort may be different from those who elected not to complete the Q-sort in that the participants may have been more invested in sharing their opinions on supervision or considered supervision from a different perspective than did the nonparticipants.

This study aimed to recruit eight internship directors of training in an attempt to gather

distinct viewpoints regarding CEs in supervision, but was only successful in recruiting five participants. Although this specific study focused on directors of clinical training [of clinical psychology internship sites], taken together with the results from the sample of *experts* in the field of supervision as well as the sample of psychology interns, this study will provide a more comprehensive perspective on CEs in supervision.

Implications for Clinical Training

This study succeeded in completing the first four steps of scale development for the CES. The development of such a scale is necessary to better understand the phenomenon of counterproductive experiences, and it also serves as a research tool for future use in investigating the relationship between CEs and features and outcomes of supervision, such as alliance, efficacy of supervision, treatment outcomes, and supervisee's development of clinical competence. As clinical supervision is undergoing a paradigm shift, from practice-as-usual to a competency-based profession (Falender & Shafranske, 2010), the CES can serve as a fundamental instrument in facilitating the teaching and implementation of supervisory guidelines. For example, psychotherapy training sites may use the CES when training an incoming set of supervisors; the use of this tool (the scale itself, or a Q-sort using final CEs) can promote conversation surrounding various occurrences in supervision, which can create awareness and subsequent prevention of deleterious events in the supervisory process. Such awareness and prevention [of CEs] would theoretically lead to a more fulfilling experience of the supervisory process [for both parties], greater skill development and competency in the supervisee, and ultimately, enhanced client care.

The final scale can eventually serve many purposes. In addition to being utilized for clinical training of supervisors, the content of the scale can be administered to trainees in order to

identify the occurrence of such negative events or experiences. While moving towards competency-based practice begins with the definition and teaching of guidelines, those guidelines are only useful if they are being implemented and result in the desired effect. In this scenario, it would be prudent to have supervisees assess the frequency and degree to which they experience various counterproductive events at their current training site. This information could be used not only as a representation of current supervisory practices [from the perspective of the trainee], but could also be used in comparison to views of supervisors in order to identify discrepancies between viewpoints and perceived practices. With this information, greater efforts can be made to address and amend such discrepancies, ultimately bolstering the quality of supervision that is being disseminated to the upcoming generation of clinicians.

Recommendations for Future Research

The results of this study should be expanded upon, as well as combined with the results gathered from the sampled populations of *experts* and interns. Conducting further research with larger samples, as well as an analysis of the combined results, would provide the opportunity to not only strengthen the relevance and representativeness of the CES, but such analysis could spotlight areas of concurrence/disagreement between the populations. Identifying various patterns of responses among the groups could unearth crucial elements of the supervisory process that are seen as particularly harmful to all parties involved, as well as indicate events that are viewed differently based on one's role (e.g., supervisor versus supervisee). Looking at the data from a more comprehensive perspective would produce immensely valuable information that could be incorporated into the refinement of the final scale (e.g., assist with item selection and discrimination). In addition, exploring specific frequencies of each CE would be highly beneficial for final scale development. While there may be a resounding consensus that it is of

grave detriment for a supervisor to express attraction to a supervisee, it would be clinically relevant to also identify the frequency with which this event occurred; while a number of negative/egregious/illegal acts could be included in the CES, it is of less clinical importance that there is a high consensus rate if it is for an event that rarely occurs.

In order to expand on this study, validation of the items may be necessary to assess motivations influencing responses. The items should then be administered to a sample of trainees in order for the scale to be representative of the population for which it is intended. The items need to be reevaluated so that appropriate ones can be identified and less relevant or poorly worded items can be eliminated. Lastly, the scale length needs to be optimized. At this point, the investigator will have a pool of items that demonstrates acceptable reliability (DeVillas, 2010). In addition to scale development, a more detailed look into the personal and professional styles of successful supervisors is suggested, as these are known to be of cardinal importance to the supervisory relationship and overall effectiveness of supervision. Lastly, additional counterproductive events that participants provided on the blank cards may be incorporated into a replication of this study to provide for a more inclusive range of viewpoints.

Conclusion

The purpose of this study was to contribute to the understanding of counterproductive events in supervision by completing the initial steps in the development of a scale of counterproductive experiences/events (CES); such a scale is intended to inform specific guidelines for the highly specialized profession of clinical supervision. This specific study focused on directors of training [at clinical psychology internship sites] and their beliefs and opinions about CEs in supervision. Five directors of training completed a Q-sort of 50 CEs that were gathered from theoretical and empirical literature on supervision practices. While

variability existed among the participants, CEs from all categories of counterproductive events were deemed to have a moderate to significant major effect on supervision. The variability that was noted on any particular CE or category precisely speaks to the need for such a tool [CES], and the need to develop a comprehensive set of standards for the immeasurably essential profession of clinical supervision. The present study has succeeded in contributing to the broadening field of supervision by calling attention to crucial events that negatively impact the process and quality of supervision; it is the hope that such attention lends itself to the development and implementation of a set of guidelines and standards by which professionals conduct clinical supervision, which will ultimately cultivate the professional development and competency of aspiring clinicians, ensure client welfare, and protect the ongoing integrity and credibility of the mental health profession.

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Table 1

Counterproductive Events in Supervision

	NoE=0	MinE=1	ModE=2	SigE=3	Mean (N=5)
<i><u>Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflicts</u></i>					
Supervisor does not encourage the development of mutually agreed upon goals of supervision.			3	2	12/N=2.4 SD=0.55
Supervisor fails to clearly communicate performance expectations to the supervisee.		1	3	1	10/N =2 SD=0.71
Supervisor's performance expectations are developmentally inappropriate, e.g., too high or too low.		1	2	2	11/N =2 SD=0.84
Supervisor has changing performance expectations of the supervisee, e.g., inconsistent expectations.			2	3	13/N =2.6 SD=0.55
					Category M 46/4=11.5 SD=1.29
<i><u>Inappropriate Supervisor Self-disclosure</u></i>					
Supervisor often discloses information about his/her personal life.	1	1	3		7/N =1.4 SD=0.89
Supervisor discloses negative opinions about the supervisee's clients.		1	3	1	10/N =2 SD=0.71
Supervisor discloses negative opinions about the profession.		2	2	1	9/N =1.8 SD=0.84
Supervisor discloses personal disillusionment about his/her career as a psychologist.	1	1	1	2	9/N =1.8 SD=1.3
Supervisor discloses negative opinions about colleagues, staff or the training site.		2	2	1	9/N =1.8 SD=0.84
					Category M 44/5=8.8 SD=1.10

(continued)

Table 1

Counterproductive Events in Supervision

	NoE=0	MinE=1	ModE=2	SigE=3	Mean (N=5)
<u><i>Supervisor Supervision Approach and Supervisee Learning Approach Mismatch</i></u>					
Supervisee and supervisor do not agree about the steps to achieve the supervisory goals.		1	3	1	10/N =2 SD=0.71
Supervisor is inflexible in his/her approach to supervision.		1	1	3	12/N =2.4 SD=0.89
Supervisor often makes critical judgments of supervisee without providing constructive feedback.			2	3	13/N =2.6 SD=0.55
Supervisor is often insensitive when giving feedback.		1		4	13/N =2.6 SD=0.89
Supervisor does not address strains or conflicts between supervisee and supervisor.		1	1	3	12/N =2.4 SD=0.89
Supervisor does not appropriately structure the supervision session.		1	3	1	10/N =2 SD=0.71
					Category M 70/6=11.67 SD=1.37
<u><i>Supervisor/Supervisee Theoretical Orientation Mismatch</i></u>					
Supervisor and supervisee often differ in their conceptualization of cases.	1	3		1	6/N =1.2 SD=1.10
Supervisor and supervisee differ in which therapeutic approach is best suited to achieve the treatment goals.	1	1	2	1	8/N =1.6 SD=1.14
Supervisor lacks knowledge of the psychotherapy procedures that the supervisee has been taught in graduate school.	1	3	1		5/N =1 SD=0.71
Supervisor has limited knowledge about supervisee's theoretical orientation.		2	2	1	9/N =1.8 SD=0.84

(continued)

Table 1

Counterproductive Events in Supervision

	NoE=0	MinE=1	ModE=2	SigE=3	Mean (N=5)
Supervisor criticizes supervisee's primary theoretical orientation.		1	2	2	11/N =2.2 SD=0.84
					Category M 39/5=7.8 SD=2.39
<i>Cultural Insensitivity</i>					
Supervisor does not consider the impact of the client's cultural identities.			3	2	12/N =2.4 SD=0.55
Supervisor does not consider the impact of his/her own and supervisee's cultural identities.		2		3	11/N =2.2 SD=1.10
Supervisor does not encourage the use of culturally appropriate interventions.		1		4	13/N =2.6 SD=0.89
Supervisor assumes cultural/racial stereotypes when discussing clients.		1		4	13/N =2.6 SD=0.89
					Category M 49/4=12.25 SD=0.96
<i>Failure to Address Needs of the Supervisee</i>					
Supervisor does not consider the developmental needs of the trainee.		1	2	2	11/N =2.2 SD=0.84
Supervisor is unresponsive to supervisee's verbalized training/supervision needs.		1		4	13/N =2.6 SD=0.89
Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his/her professional performance.				5	15/N =3 SD=0
Supervisor appears to be distracted in supervision.			3	2	12/N =2.4 SD=0.55
					Category M 51/4=12.75 SD=1.71

(continued)

Table 1

Counterproductive Events in Supervision

	NoE=0	MinE=1	ModE=2	SigE=3	Mean (N=5)
<i><u>Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior</u></i>					
Supervisor provides minimal feedback on the midyear evaluation.			3	2	12/N =2.4 SD=0.55
Supervisor directs the supervisee not to file a child abuse when the supervisee reports clear instances of neglect and abuse.				5	15/N =3 SD=0
Supervisor speaks about clients in a recognizable way, e.g., using their names, in public areas.		1	1	3	12/N =2.4 SD=0.89
Supervisor does not consistently observe or review audio/videotapes or provide live supervision of supervisee.		4		1	7/N =1.4 SD=0.89
Supervisor does not consistently sign off on charts/progress notes of supervisee.		1	3	1	10/N =2 SD=0.71
Supervisor is unavailable to discuss clinical emergencies outside of regularly scheduled supervision.		1		4	14/N =2.8 SD=0.45
Supervisor sometimes ignores agency policies.		3	1	1	8/N =1.6 SD=0.89
Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained.		1	1	3	12/N =2.4 SD=0.89
					Category M 90/8=11.25 SD=2.76
<i><u>Boundary Crossings/Violations</u></i>					
Supervisor invites supervisee to attend a personal event outside of supervision.	1		2	2	10/N =2 SD=1.22
Supervisor asks supervisee to edit a journal article the supervisor has written for publication.		1	4		9/N =1.8 SD=0.45
Supervisor discusses other supervisees' performance in supervision.		1		4	13/N =2.6 SD=0.89

(continued)

Table 1

Counterproductive Events in Supervision

	NoE=0	MinE=1	ModE=2	SigE=3	Mean (N=5)
Supervisor inquires about the supervisee's personal life.	2	1	2		5/N =1 SD=1
Supervisor attempts to help the supervisee to resolve a personal conflict.	1	3	1		6/N =0.86 SD=0.90
Supervisor makes jokes/comments with sexual innuendos.				5	15/N =3 SD=0
Supervisor expresses attraction to supervisee.				5	15/N =3 SD=0
					Category M 72/7=10.29 SD=4.27
<i>Additional Counterproductive Events</i>					
Inadequate environment/office space is provided for supervision.		1	3	1	10/N =2 SD=0.71
Supervisee's professional responsibilities were not accurately represented during the application process.		1	2	2	11/N =2.2 SD=0.84
Supervisor demonstrates inflexibility in scheduling.		1	2	2	11/N =2.2 SD=0.84
Supervisor is frequently late for supervision.		1	1	3	12/N =2.4 SD=0.89
Supervisor does not provide guidance about professional development as a psychologist.		2	1	2	10/N =2 SD=1
Supervisor does not demonstrate empathy for the supervisee.				5	15/N =3 SD=0
Supervisor does not demonstrate respect for the supervisee.				5	15/N =3 SD=0
					Category M 84/7=12 SD=2.16

APPENDIX A

Counterproductive experiences and events in supervision identified in literature based on theory

Counterproductive Event	Study	Conclusion
Supervisor Disclosure/Nondisclosure	Hess et al. (2008). Predoctoral interns' nondisclosure in supervision.	Supervisor disclosure can influence supervisees and the supervision relationship. Supervisor disclosure can foster a safe environment to explore possible issues, whereas no disclosure can result in interns feeling unsafe. Addressing any conflict in the supervisory relationship may not occur if the intern feels it is too risky to raise any number of concerns he/she may have.
	Ladany & Walker (2003). Supervision self-disclosure: Balancing the uncontrollable narcissist with the indomitable altruist.	Supervisor nondisclosure can affect supervisee's level of disclosure, and may damage the establishment of trust and bond in the working alliance. Excessive disclosure by supervisor can also be detrimental to the training of the supervisee
	Knox, Edwards, Hess, & Hill (2011). Supervisor self-disclosure: Supervisees' experiences and perspectives.	Supervisees generally found it facilitative to their training when supervisors made personal disclosures; the disclosures were seen as helpful due to the already positive relationship and because the supervisee understood the supervisors disclosures as a method of assisting the supervisee.
Supervisee	Hess et al. (2008).	Nondisclosure can be due to:

Disclosure/Nondisclosure	Predoctoral interns' nondisclosure in supervision.	concerns about evaluation and negative feelings, power dynamics, inhibiting demographic or cultural variables, and differences in theoretical orientation.
	Ladany, Hill, Corbett, & Nutt (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors.	<p>Trainees may not disclose due to the evaluative and involuntary nature of supervision. The evaluative element may influence nondisclosures due to impression management and fear of political suicide; involuntary nature of supervision may cause nondisclosures due to negative feelings towards supervisor and/or deference.</p> <p>Supervisee withholding can hinder clinical growth and jeopardize client welfare.</p>
	Farber (2003). Self-disclosure in psychotherapy practice and supervision: An introduction.	Nondisclosure is a common occurrence in supervision. There are a number of factors that affect the decision to openly discuss particular thoughts and feelings, or to withhold due to fear of shame or being inappropriate.
Role Conflict & Ambiguity	Ladany & Friedlander (1995). The relationship between the supervisory working alliance and trainees' experience of role conflict and role ambiguity.	Trainees traditionally rely on their supervisors for accurate guidance regarding their roles in supervision. Supervisors are advised to develop a collaborative and trusting work environment in which expectations for the trainee's behavior are discussed and mutually agreed on early in the relationship; such confusion may lead to work-related

		anxiety, dissatisfaction with supervision, and interference with competency acquisition.
	Olk & Friedlander (1992). Trainee's experiences of role conflict and role ambiguity in supervisory relationships.	Role conflict can arise from competing expectations and responsibilities, such as the many roles a trainee plays simultaneously (e.g., student, therapist, supervisee, etc.) Role conflict is greater for beginning trainees versus more advanced trainees.
	Nelson & Friedlander (2001). A close look at conflictual supervisory relationships: The trainee's perspective.	Role difficulties are associated with anxiety, work dissatisfaction, and dissatisfaction with supervision.
Ethical Concerns	Falender & Shafranske (2004). <i>Clinical supervision: A competency-based approach.</i>	Attention to legal and ethical issues is essential to the competent practice of supervision. Boundary violations can interfere with trainee development and lead to overall dissatisfaction, in addition to causing harm to the welfare of the clients served.
Supervisor Style	Falender & Shafranske (2004). <i>Clinical supervision: A competency-based approach.</i>	Training is influenced by both professional and personal factors; these include values, beliefs, interpersonal biases, and conflicts that are considered to be sources of countertransference
	Nelson & Friedlander (2001). A close look at conflictual supervisory relationships: The trainee's perspective.	Trainees are susceptible to poor judgment on behalf of the therapist. Injurious interactions can be wrought when the supervisor

		inadequately manages both evaluative and therapeutic tasks.
	Ladany, Ellis, & Friedlander (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction.	When the supervisory working alliance is strong, the trainee and supervisor share a strong emotional bond and agree on the goals and tasks of supervision.
	Hess et al. (2008). Predoctoral interns' nondisclosure in supervision.	<p>Interns who deemed their relationship with their supervisor as positive felt safe in the supervisory relationship; they felt as though the atmosphere was nonjudgmental, unthreatening, and respectful. Interns felt comfortable disclosing personal and professional issues as they characterized their supervisor's style as supportive, collaborative, and challenging.</p> <p>Interns citing negative relationships reported feeling guarded or uncomfortable disclosing information. These interns described detrimental supervisor characteristics such as being critical and evaluative, and lacking investment in supervising, as well as lacking general competency.</p>
	Hutt, Scott, & King (1983). A phenomenological study of supervisees' positive and negative experiences in supervision.	Supervisor does not demonstrate the flexibility necessary to meet supervisee's at their varying developmental levels. Application of a standardized teaching style can be detrimental to the development of the

		supervisee.
	Nelson & Friedlander (2001). A close look at conflictual supervisory relationships: The trainee's perspective.	Unresolved conflict affects supervisee's overall training experience, and can stifle general skill development and competency.
Multicultural Sensitivity	Burkard et al. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision.	Supervisor does not demonstrate cultural competency: culturally unresponsive events can disrupt the relationship and cause emotional distress. Culturally responsive supervision fosters supervisees' sensitivity and ability to include multicultural issues in their clinical work and the development of positive supervision relationships.
	Falender et al. (2004). Defining Competencies in Psychology Supervision: A Consensus Statement.	Supervisors need to turn to expanded conceptions of diversity to ensure competency (e.g., multi-ethnic considerations not just "African American" or "White"). Also include worldview congruence or lack of such for client, therapist/supervisee, and supervisor, including dimensions such as concepts of time, and beliefs such as independence versus interdependence, as they are also critical components of the supervisory process
	Constantine (2001). Multiculturally-focused counseling supervision: Its relationship to trainees' multicultural counseling self-efficacy.	Many theorists believe that inclusion of multicultural issues in supervision is important to the growth and development of supervisees. Supervisors who attend to

		<p>cultural issues in supervision and encourage supervisees to attend to such issues may be successful in helping students work with culturally diverse groups in the long-term.</p>
	<p>Ancis & Ladany (2001). A multicultural framework for counselor supervision.</p>	<p>The multiple ethnic and cultural identities of both the supervisor and the supervisee work in concert and can influence multicultural competency in supervision. Great value can be derived when supervisor and supervisee have honest, open discussions about their own multicultural/multiethnic identities and views.</p>
	<p>Christiansen et al. (2011). Multicultural supervision: Lessons learned about an ongoing struggle.</p>	<p>Multicultural issues in supervision often get intentionally or unintentionally overlooked. While there is an abundance of literature addressing more “intellectual” exercises to promote multicultural competence in supervision, there is a poverty of literature elaborating on what multicultural competence “looks” like and also on the emotional aspects (e.g. actually dealing with multicultural issues, teaching about them etc.)</p>

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APPENDIX B

Counterproductive experiences and events in supervision identified in literature based on empirical findings

Counterproductive Event	Study	Methods	Participants	Findings
Supervisor Disclosure/ Nondisclosure	Ladany, & Lehrman-Waterman (1999). The content and frequency of supervisor self-disclosures and their relationship to supervisor style and the supervisory working alliance.	<i>Supervisor Self-Disclosure Questionnaire (SSDQ), Supervisor Self-Disclosure Index (SSDI), Supervisory Styles Inventory (SSI), WAI-T</i>	105 counselor trainees	Supervisor style is correlated with the amount of disclosures made (more ‘attractive’ style correlates to more disclosures); supervisor self-disclosure predicts the strength of the supervisory working alliance (greater agreement on goals and tasks of supervision as well as stronger emotional bond)
	Ladany, Walker, & Melincoff (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure.	SSI, WAI-S, SSDI	137 supervisors: 110 with doctoral degrees, 27 with master’s degrees	There is a relationship between supervisory style and supervision process and outcome variables. Supervisors who perceived that they used both attractive and interpersonally sensitive styles were more likely to see themselves as self-disclosing.

	Knox, Burkard, Edwards, Smith, & Schlosser. (2008). Supervisors' reports of the effects of supervisor self-disclosure on supervisees.	Semi-structured interview	16 Supervisors	Supervisors tended to use self-disclosure in order to enhance supervisee training and to normalize many experiences. Disclosure tended to occur in good working relationships, was often prompted by supervisee struggle, and was intended to teach or help.
	Ladany & Melincoff (1999). The nature of counselor supervision nondisclosure	Self-report measures	90 supervisors	Supervisor non-disclosure has a significant effect on communication in the supervisory relationship. Suboptimal communication can hinder the supervisee's development and impair the supervisory relationship.
Supervisee Disclosure/ Nondisclosure	Ladany, Hill, Corbett, & Nutt (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors.	Self-report measure (Supervisee nondisclosure survey), SSI, <i>Supervisory Satisfaction Questionnaire (SSQ)</i>	108 trainee therapists	A weak supervisory alliance is related to supervisees withholding information. Nondisclosures are often due to negative reactions to the supervisors, deference to the supervisor, and fear of political suicide. Nondisclosures were also found to be related to

				personal issues, concerns regarding personal evaluation, clinical mistakes, or general clinical observations.
	Knox, Edwards, Hess, & Hill (2011). Supervisor self-disclosure: Supervisees' experiences and perspectives	Semi-structured interview	12 graduate-level trainees	Most participants viewed supervisor disclosure as positive and facilitative to the supervisory relationship. For some, intent of the disclosures were unclear and problematic; the latter was more likely when the supervisory relationship was weaker.
	Mehr, Ladany, & Caskie (2010). Trainee nondisclosure in supervision: What are they not telling you?	Survey, <i>Trainee Disclosure Scale</i> (TDS), WAI-S/Short	204 trainees	Greater willingness to disclose in supervision when working alliance viewed as positive; higher trainee anxiety correlated with higher rates of nondisclosure.
	Gray, Ladany, Walker, & Ancis (2001). Psychotherapy trainees' experience of counterproductive events in supervision.	Semi-structured interview, SSQ inventory	13 trainees in graduate counseling psychology	Trainees typically did not disclose their experience of a counterproductive event to their supervisors. Most attributed their nondisclosure to a poor supervisory relationship. Supervisor self-disclosure can

				facilitate trainee self-disclosure that would ordinarily be difficult to discuss in supervision.
	Reichelt et al. (2009). Nondisclosure in psychotherapy group supervision: The supervisee perspective.	Eleven-item questionnaire, with space for examples	55 student therapists working in a group format	Study highlighted a number of areas supervisees withheld information in supervision. Some areas included: discussing topics related to the supervisory relationship, fearing that they would hurt their supervisor or be met with criticism or interpretation; professional matters, particularly related to the perceived incompetence of their supervisors and their expectancy of non-constructive criticism.
Role Conflict & Ambiguity	Olk & Friedlander, (1992). Trainee's experiences of role conflict and role ambiguity in supervisory relationships.	Semi-structured interview	6 supervisors 9 graduate-level psychology trainees	Unprocessed countertransference in supervision is a contributing factor to role conflict and ambiguity in supervision (and largely affects overall working alliance).
	Ladany & Friedlander (1995). The relationship	Questionnaire, WAI-T, RCRAI	123 counseling trainees	The supervisory working alliance was significantly related to trainees'

	<p>between the supervisory working alliance and trainees' experience of role conflict and role ambiguity.</p>			<p>perceptions of role conflict and role ambiguity. Supervisees who perceived a stronger supervisory alliance tended to experience less role conflict and ambiguity. Conversely, trainees who perceived the supervisory alliance to be weaker, tended to experience more role conflict and role ambiguity.</p> <p>When supervisors and trainees discuss expectations, set goals, and agree on the tasks of supervision within the context of a positive relationship, trainees are less likely to experience confusion or conflict in supervision.</p>
	<p>Cheon, H., Blumer, M. C., Shih, A., Murphy, M. J., & Sato, M. (2009). The influence of supervisor and supervisee matching, role conflict, and supervisory</p>	<p>Inventories: WAIS-S, Role Conflict and Role Ambiguity Inventory (RCARI)</p>	<p>132 graduate-level trainees</p>	<p>A strong, positive working alliance is more important in determining overall trainee satisfaction and role stability than matching on personal characteristics. Working alliance minimizes effects of role conflict and</p>

	relationship on supervisee satisfaction.			facilitates overall satisfaction.
	Olk & Friedlander (1992). Trainee's experiences of role conflict and role ambiguity in supervisory relationships.	Semi-Structured Interview	6 supervisors 9 graduate-level psychology trainees	Across training levels, role ambiguity is more present, but it tends to diminish with experience. Role conflict is more prevalent amongst advanced trainees. Role difficulties, when present, negatively affect the supervisory relationship.
Ethical Concerns	Ramos-Sánchez et al. (2002). Negative supervisory events: Effects on supervision and supervisory alliance.	Survey	126 respondents (54% predoctoral interns and 46% practicum students)	Legal and ethical violations are generally underreported, serve as poor models for trainees, and can lead to extremely detrimental consequences (for clients and trainee development).
	Ladany, Lehrman-Waterman, Molinaro, & Wolgast (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction.	<i>Supervisor Ethical Practices Questionnaire</i> <i>Supervisor Ethical Behavior Scale</i>	151 therapist trainees	Greater nonadherence to ethical guidelines was significantly related to a weaker supervisory alliance and lower supervisee satisfaction. Nonadherence included failing to: complete trainee evaluations, provide crisis coverage, consistently review performance and

				provide feedback, maintain confidentiality, and maintain appropriate relationship boundaries with supervisee.
	Wall, A. (2009). Psychology interns' perception of supervisor ethical behavior	Ethical Practices in Supervision Scale	180 psychology interns	A high frequency of non-adherence to ethical standards was seen in regard to the following: trainee performance and professional activities; confidentiality in supervision; administration of supervisory contracts; and supervisee use of clinical methods that the supervisor was not adequately trained in. Such non-adherence had an impact on the supervisory alliance, trust in the supervisor, willingness to disclose in supervision, motivation to be in the field, and overall emotional well-being.
Supervisor Style	Ladany et al. (2001). Supervisory style: Its relation to the supervisory working	SSI, WAIS, SSDI	137 supervisors 110 with doctoral degrees, 27 with master's	Supervisor demonstrates inflexibility: A flexible supervisor who tailors his/her style with different trainees with

	alliance and supervisor self-disclosure.		degrees	varying needs often facilitates the development of a strong supervisory working alliance.
	Britt & Gleaves (2011). Measurement and prediction of clinical psychology students' satisfaction with clinical supervision.	Checklist, Survey	212 trainees	The results support the use of the Supervision Checklist and indicate that "Collaboration and Mutual Understanding" was the best predictor of overall satisfaction with clinical supervision.
	Hutt, Scott, & King (1983). A phenomenological study of supervisees' positive and negative experiences in supervision	Open-Ended Interviews	6 post-master's level trainees	The results support the view that good supervision must integrate both relationship-oriented and task-oriented behavior.
	Worthen & McNeill (1996). A phenomenological investigation of 'good' supervision events.	Interview	8 doctoral trainees in counseling psychology	They found that trainees typically reported good supervision events when they shared feelings of inadequacy in supervision and then received acceptance and support from their supervisors, which bolstered their confidence.
	Bucky, Marques, Daly, Alley, & Karp (2010). Supervision characteristics	Questionnaire	87 doctoral students in a psychology program	Trainees who reported supervisors as espousing a more "interpersonally attractive" style reported better

	related to the supervisory working alliance as rated by doctoral-level supervisees.			supervisory experiences. Positive qualities included positive attitude, ethical integrity, and good listening.
	Kennard, Stewart, & Gluck (1987). The supervision relationship: Variables contributing to positive versus negative experiences.	Scale	26 clinical psychology trainees 47 supervisors	Trainees report positive experiences with supervisors who are more supportive, instructional, and interpretive. Positive experiences also came from similarities regarding theoretical orientation and behavioral style.
	Moskowitz & Rupert (1983). Conflict resolution within the supervisory relationship.	Questionnaire with structured and open-ended questions	158 graduate students in clinical psychology	Forty percent of the trainees they surveyed had experienced a major conflict with a supervisor related to personality issues, supervision style, or therapeutic techniques and approach. Major differences in personality styles of the supervisee and supervisor led to a strained relationship and conflict.
	Cheon et al., (2009). The influence of	Survey, WAIS, RCRAI	132 supervisees	The working alliance was highly predictive of

	supervisor and supervisee matching, role conflict, and supervisory relationship on supervisee satisfaction.			supervisee satisfaction, more so than matching characteristics between supervisor and supervisee.
	Ramos-Sánchez et al. (2002). Negative supervisory events: Effects on supervision and supervisory alliance.	Survey	126 respondents (54% predoctoral interns and 46% practicum students)	Supervisor fails to adequately support the trainee by providing inconsistent expectations, and by providing little or no constructive feedback. Such a lack of support fosters a negative experience of supervision.
Cultural Sensitivity	Ladany, Inman, Constantine, & Hofheinz (1997). Supervisee multicultural case conceptualization ability and self-reported multicultural competence as functions of supervisee racial identity and supervisor focus.	Scales, Inventories	116 counselor trainees (45% doctoral students, 55% master's students)	Supervisees from all racial groups (white and non-white) became more adept at conceptualizing treatment strategies when instructed to focus on multicultural issues (e.g., social support systems, integrating racial-identity into case conceptualization).
	Jernigan, Green, Helms, Perez-Gualdron, & Henze (2010). An examination of people of color supervision dyads: Racial	Semi-structured survey	3 master's and 3 doctorate-level psychology trainees who identified as a person of Color with a	Students of Color perceived that they introduced race and culture into supervisory conversations more often than their supervisors of Color. Supervisory dyads of the same

	identity matters as much as race.		supervisor who was also a person of Color	ethnicity are cautioned against the illusion that such a relationship will be conflict-free, as within-group racial conflicts can arise. Additionally, it should not be assumed that just because the supervisor is a person of Color, that he/she is more culturally competent or open to discussing cultural issues.
	Ramos-Sánchez et al. (2002). Negative supervisory events: Effects on supervision and supervisory alliance.	Survey	126 respondents (54% predoctoral interns and 46% practicum students)	Multicultural violations can be egregious in nature (e.g., mocking ethnicity of a client), are generally underreported, serve as poor models for trainees, and can lead to extremely detrimental consequences.
	Burkard et al. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision.	Survey, Semi-structured interview	26 doctoral students in clinical or counseling programs	Culturally unresponsive events cause a negative impact the supervisory relationship, satisfaction with supervision, and client outcomes.
	Inman (2006). Supervisor multicultural competence and	Self-report measures	147 MFT trainees	Supervisors' multicultural competencies were positively

	its relation to supervisory process and outcome			correlated with the working alliance and satisfaction. However, supervisors' multicultural competency did not necessary translate into increased multicultural competency in trainees.
	Ancis, & Marshall (2010). Using a multicultural framework to assess supervisees' perceptions of culturally competent supervision.	Semi-structured interview	4 doctoral psychology students	Culturally competent supervision is one way to increase the quality of the therapy that trainees provide with diverse clients. Trainees felt better equipped to work with diverse populations when their supervisors: actively explored multicultural issues with the goal of increased understanding of clients and of themselves; disclosed their limits of multicultural knowledge; and were open and genuine about their own cultural background, experiences, and biases.

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APPENDIX C

Sample search terms entered into PsychInfo and PsychArticles databases

Counterproductive Events <AND> Supervision

Counterproductive <AND> Supervision <OR> Supervisory Relationship

Disclosure <AND> Supervision<OR> Supervisor

Trainee <AND> Poor Supervision

Negative <AND> Supervision

Multicultural <AND> Supervision <OR> Supervisor

Cultural <AND> Supervision <OR> Supervisor

Professional Supervision

Supervision <AND> Ethical <AND> Boundaries

Negative <AND> Supervisory

Negative Experience <AND> Supervision

Poor <AND> Supervisor <AND> Psychology

Conflict <AND> Supervision

Conflictual supervision <AND> Supervision

Ethical <OR> Ethics <AND> Supervision

Psychotherapy <AND> Supervisor <OR> Supervision

Harmful <AND> Supervision

Theoretical <AND> Orientation <AND> Supervision

Harmful Supervisor <AND> Orientation

Supervisory Relationship <AND> Harmful <OR> Counterproductive

APPENDIX D

Demographics Questionnaire

Please check the answer that is most appropriate for you. If you find that there is not an answer that is applicable to you, please select “other”, and write your response in the space that is provided.

1. Which of the following best describes your racial/ethnic/cultural identification. Check all that apply
 - a. African-American/Black
 - b. American Indian/Alaska Native
 - c. Asian/Pacific Islander
 - d. Hispanic/Latino
 - e. White (non-Hispanic)
 - f. Other _____

2. With what gender do you identify?
 - a. Male
 - b. Female
 - c. Other _____

3. What is your age?

4. What is the total number of supervisees you have had within the last five years; if you have supervised less than five years, please indicate the total number of supervisees and the total number of years in which you’ve supervised.

APPENDIX E

Q-sort item list: Counterproductive events in supervision based on existing theoretical and empirical findings

Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflicts

Supervisor does not encourage the development of mutually agreed upon goals of supervision.

Supervisor fails to clearly communicate performance expectations to the supervisee.

Supervisor's performance expectations are developmentally inappropriate, e.g., too high or too low in light of the supervisee's experience and competence.

Supervisor has changing performance expectations of the supervisee, e.g., inconsistent expectations.

Inappropriate Supervisor Self-disclosure

Supervisor often discloses information about their personal life.

Supervisor discloses negative opinions about the supervisee's clients.

Supervisor discloses negative opinions about the profession.

Supervisor discloses personal disillusionment about their career as a psychologist.

Supervisor discloses negative opinions about colleagues, staff or the training site.

Supervisor Supervision Approach and Supervisee Learning Approach Mismatch

Supervisee and supervisor do not agree about the steps to achieve the supervisory goals.

Supervisor is inflexible in his or her approach to supervision.

Supervisor often makes critical judgments of supervisee without providing constructive feedback.

Supervisor is often insensitive when giving feedback.

Supervisor does not address strains or conflicts between supervisee and supervisor.

Supervisor does not appropriately structure the supervision session (either too much or too little structure).

Supervisor/Supervisee Theoretical Orientation Mismatch

Supervisor and supervisee often differ in their conceptualization of cases.

Supervisor and supervisee differ in which therapeutic approach is best suited to achieve the treatment goals.

Supervisor lacks knowledge of the psychotherapy procedures that the supervisee has been taught in graduate school.

Supervisor has limited knowledge about supervisee's theoretical orientation.

Supervisor criticizes supervisee's primary theoretical orientation.

Cultural Insensitivity

Supervisor does not consider the impact of the client's cultural identities.

Supervisor does not consider the impact of his/her own and supervisee's cultural identities.

Supervisor does not encourage the use of culturally appropriate interventions.

Supervisor assumes cultural/racial stereotypes when discussing clients.

Failure to Address Needs of the Supervisee

Supervisor does not consider the developmental needs of the trainee.

Supervisor is unresponsive to supervisee's verbalized training/supervision needs.

Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his or her professional performance.

Supervisor appears to be distracted in supervision.

Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior

Supervisor provides minimal feedback on the midyear evaluation.

Supervisor directs the supervisee to not file a child abuse when the supervisee reports clear instances of neglect and abuse.

Supervisor speaks about clients in a recognizable way, e.g., using their names, in public areas.

Supervisor does not consistently observe or review audio/videotapes or provide live supervision of supervisee.

Supervisor does not to consistently sign off on charts/progress notes of supervisee.

Supervisor is unavailable to discuss clinical emergencies outside of regularly scheduled supervision.

Supervisor sometimes ignores agency policies.

Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained.

Boundary Crossings/Violations

Supervisor invites supervisee to attend a personal event outside of supervision.

Supervisor asks supervisee to edit a journal article the supervisor has written for publication.

Supervisor discusses other supervisees' performance in supervision.

Supervisor inquires about the supervisee's personal life (e.g., Are you dating anyone?)

Supervisor attempts to help the supervisee to resolve a personal conflict.

Supervisory makes jokes/comments with sexual innuendos.

Supervisor expresses attraction to supervisee.

Additional Counterproductive Events

Inadequate environment/office space is provided for supervision.

Supervisee's professional responsibilities (e.g., nature of work, workload, time) were not accurately represented during the application process.

Supervisor demonstrates inflexibility in scheduling.

Supervisor is frequently late for supervision.

Supervisor does not provide guidance about professional development as a psychologist.

Supervisor does not demonstrate empathy for the supervisee.

Supervisor does not demonstrate respect for the supervisee.

APPENDIX F

CLINICAL SUPERVISION, TRAINING AND PROFESSIONAL DEVELOPMENT RESEARCH CENTER

Graduate School of Education and Psychology
Pepperdine University

[date]

«First_Name» «Last_Name», «Title»
«Institution»
«Dept»
«Address»
«City», «State» «Zip_»
«Country»

Dear «Salutation_Name»:

Based on your experience and expertise as the Director of Training at «Institution», we are inviting you to participate in a research project being conducted by Chelsea Lucas, M.A., under the supervision of Dr. Edward Shafranske, and developed in the *Clinical Supervision, Training and Professional Development Research Center*. The Center is dedicated to advance knowledge through applied research and publication. One of the aims of the Center is to contribute to the development of empirically-supported practices to enhance the quality and effectiveness of clinical supervision. The Center includes Drs. Edward Shafranske, Carol Falender, and Joan Rosenberg and psychology graduate students from Pepperdine University.

The enclosed letter describes the research project on counterproductive events in supervision in which you are invited to participate.

We appreciate your consideration of this request to participate in this research project. It is through all of our efforts that we hope to advance professional development and clinical and supervisory competence. Should you have any questions, please contact Dr. Ed Shafranske.

Sincerely,

Edward P. Shafranske, Ph.D., ABPP

Carol A. Falender, Ph.D.

APPENDIX G

Recruitment Letter: Directors of Training

Dear [Name of Director of Training]:

I am a student in the Doctor of Psychology Program at Pepperdine University. For my clinical dissertation, I have chosen to study counterproductive experiences and events that occur in the supervision between a clinical supervisor and a trainee. This research project, *Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Clinical Psychology Internship Directors of Training*, was developed in the Clinical Supervision, Training, and Professional Development Research Center at Pepperdine University, under the supervision of Edward Shafranske, Ph.D. Based on your experience as a Director of Training, you have been selected to participate in the study. I would greatly appreciate your contribution to the study and to the field of clinical supervision.

Counterproductive experiences are events or experiences that occur in clinical supervision that can strain the supervisory alliance, hinder supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. The purpose of this study is to gather the information necessary for creating an initial scale of counterproductive events and experiences in supervision. Development of such a scale is important to better understand the phenomenon as well as to provide a research tool for future use in investigating the relationship between counterproductive experiences and features and outcomes of supervision.

Enclosed you will find a consent form, demographics questionnaire, a stack of cards with instructions, and two pre-paid self-addressed envelopes. Participation in the study is voluntary and you may withdraw your participation at any point during the study. If you wish to participate, I ask that you sign the consent to participate in the study, complete the demographics questionnaire, and follow the procedures for the Q-sort ranking. The research packet should be returned via United States Postal Service using the addressed, pre-paid postage envelope included. After reviewing the informed consent document, you may (1) keep the informed consent for your records or (2) you may sign and return the informed consent to link your participation with the research. If you choose to sign the informed consent, you may make a photocopy of the consent for your records, and return the signed consent document in the provided separate pre-paid self-addressed envelope marked *consent*. The time to complete the Q-sort will be approximately 15 minutes.

While there is no direct benefit for you to participate in this study, satisfaction may be derived from the knowledge that your participation will contribute to the field and the literature, and the fact that you will have an opportunity to share your experiences in supervision. While participation in the study was deemed to pose no greater than minimal risk of harm, attempts have been made to minimize such effects. Although the administration of the Q-sort ranking is brief, the primary risk is possible boredom or fatigue in completing the task.

Upon the study's completion, the data will remain confidential and will be stored in an electronic file for five years, after which the file will be deleted. The hard copies of the materials will be

stored in a locked file cabinet and will also be destroyed after five years. If you would like an abstract of the study results, you may request to obtain a copy by sending me an email. You do not need to participate in this study to receive a copy of the abstract. You may contact me via email should you have questions or comments regarding this study. You may also contact Dr. Edward Shafranske, my dissertation advisor, or Dr. Doug Leigh, Chairperson of the Graduate and Professional Schools IRB, Pepperdine University.

This study intends to contribute to the empirical study of supervision; your participation is very much appreciated. Thank you, again, for your assistance with this research project.

Sincerely,

Chelsea Lucas, M.A.
Doctoral Student
Pepperdine University
6100 Center Drive
Los Angeles, CA 9004

APPENDIX H

Informed Consent for Participation in Research Activities

I, _____, authorize Chelsea Lucas, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, under the supervision of Edward Shafranske, Ph.D., to include me in the research project entitled *Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Clinical Psychology Internship Directors of Training*.

I understand my participation in this study is strictly voluntary. I understand that I have the right to refuse participation in, or withdraw from, the study at any time. I understand that the information will be obtained in a confidential manner; no identifying information will be asked and the findings will be reported as group data. I understand that the focus of this study is to explore experiences that are counterproductive to the process of supervision. I understand that I am being asked to complete a Q-sort that asks that I rate the impact of counterproductive experiences and events based on my experience and knowledge of clinical supervision practices. I understand that I am being asked about hypothetical scenarios and I am *not* being asked to reflect or disclose on counterproductive events that I have personally experienced.

Although there are no direct benefits to all participants in the study, I may benefit by knowing that my participation has contributed to a greater understanding of counterproductive experiences and events in clinical supervision. While participation in the study has been judged to pose no greater than minimal risk of harm, there is a potential for boredom, and the potential that some hypothetical situations may elicit a range of emotional responses if I am reminded of events I may have engaged in or was subject to as a trainee. I also understand that I will be provided contact information for the principal investigator and faculty supervisor should I have any concerns I want to discuss further. Additionally, in the unlikely event that emotional distress continues past the point of study participation, it is suggested that I discuss my reactions with a trusted colleague, clinician, or dissertation advisor, Dr. Edward Shafranske to receive additional support.

I understand that I have the option to: (1) keep this informed consent document for my records or (2) I may sign and return the informed consent to link my participation with the research. If I choose to sign the informed consent, I may make a photocopy of the consent for my records, and return the signed consent document in the provided separate pre-paid self-addressed envelope marked "consent." I understand that if I would like an abstract of this study, I may email a request indicating so to the principal investigator, Chelsea Lucas, M.A., via email. I do not need to participate in this study to receive a copy of the abstract. I may also contact Chelsea Lucas, M.A., should I have any questions or comments regarding this study. I understand that I can also contact Dr. Edward Shafranske, dissertation advisor, or Dr. Doug Leigh, Chairperson of the Graduate and Professional Schools IRB, Pepperdine University.

If the findings of the study are published or presented to a professional audience, no personally identifying information will be released. Upon the study's completion, the data will remain confidential and will be stored in an electronic file for five years, after which the file will be

deleted. The hard copies of the materials will be stored in a locked file cabinet and will also be destroyed after five years.

I understand, to my satisfaction, the information in the consent form regarding my participation in the research project. All of my questions have been answered to my satisfaction. I have received a copy of this informed consent, which I have read and understand. I hereby consent to participate in the research described above.

Participant's Signature

Date

Name of Participant (please print)

APPENDIX I

Instructions

Counterproductive experiences are defined as *events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness*. You have received cards and four envelopes labeled *Significant Major Effect, Moderate Effect, Minimal Effect, and No Effect*. Each card has a statement of a counterproductive experience in supervision based on empirical and theoretical literature. These may or may not be events you have specifically experienced yourself. Imagine that the following event occurred in supervision. Please sort each card in stacks in order of severity of counterproductive impact on the process of supervision between a clinical supervisor and a trainee. You can put as many cards in each category/envelope as you wish.

Step 1. Prior to placing the cards in the four envelopes, please read all the cards.

Step 2. Sort each of these cards and place them in any of the four categories/envelopes.

Significant Major Effect: I believe this experience/event will significantly strain or rupture the alliance and have a major impact on the process of supervision

Moderate Effect: I believe this experience/event will produce a moderate strain on the alliance and have a moderate impact on the process of supervision

Minimal Effect: I believe this experience/event will minimally strain the alliance and have a minimal impact on the process of supervision

No Effect: I believe this experience/event will not strain the alliance and have no impact on the process of supervision

Step 3. You have been provided with a blank card. If applicable, please include in writing, a phenomenon of a counterproductive event (CE) that was not included. If you choose to include a CE that was not captured by the cards you were provided with, please rank this card by placing it in one of the four categories, as noted above.

Step 4. Seal each envelope and place the sealed envelopes in the large pre-paid, addressed manila envelope you were provided with.

Step 5. Place the self-addressed and pre-paid manila envelope in the United States Postal Service (USPS) mail.