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Development of a preliminary scale of counterproductive experiences in supervision: attitudes of experts in clinical supervision

Heleya Kakavand

Pepperdine University

Graduate School of Education and Psychology

DEVELOPMENT OF A PRELIMINARY SCALE OF COUNTERPRODUCTIVE EXPERIENCES IN SUPERVISION: ATTITUDES OF EXPERTS IN CLINICAL SUPERVISION

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by

Heleya Kakavand, M.A.

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

This clinical dissertation, written by

Heleya Kakavand

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.

Aaron Aviera, Ph.D.

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VITA

HELEYA KAKAVAND

EDUCATION

Psy.D. Candidate, Clinical Psychology, May 2014
Pepperdine University, Los Angeles, CA

Master of Arts, Clinical Psychology, September 2008
New York University, New York, NY

Bachelor of Arts, Psychology, June 2006
University of California Irvine, Irvine, CA

CLINICAL INTERNSHIP

New York University Langone Medical Center, Rusk Institute, New York, NY
Psychology Intern
September 2013- September 2014

FORMAL PRACTICA TRAINING

UCLA Medical Psychology Assessment Center, Los Angeles, CA
Pre-intern
July 2012- July 2013

VA Long Beach Healthcare System, Long Beach, CA
Pre-intern
August 2012- July 2013

Harbor UCLA Medical Center, Torrance, CA
Doctoral Practicum Trainee
August 2010- August 2012

Kaiser Permanente Los Angeles Medical Center, Los Angeles, CA
Doctoral Practicum Trainee
March 2011- June 2012

Pepperdine University Psychological and Educational Clinic, Los Angeles, CA
Doctoral Practicum Trainee
September 2009- February 2013

SUPERVISORY EXPERIENCE

Pepperdine University Psychological and Educational Clinic, Los Angeles, CA
Peer Supervisor
September 2011- August 2013

RESEARCH EXPERIENCE

Harbor UCLA Medical Center, Torrance, CA
Research Assistant
July 2011- July 2012

Center for Autism and Related Disorders (C.A.R.D.), Torrance, CA
Research Assistant
June 2009 – September 2010

TEACHING EXPERIENCE

Pepperdine University, Los Angeles, CA
Teaching Assistant
September 2010 – May 2013

ABSTRACT

Clinical supervision serves as the centerpiece in clinical training in which client welfare is assured and professional development is facilitated (Falender & Shafranske, 2004). While it is expected that clinical training be of high quality, some events or experiences may occur in clinical supervision that strain the supervisory alliance, hinder supervisees' growth, and contribute to a poor experience of supervision, adversely affecting its effectiveness. These events or experiences are considered to be counterproductive experiences (CEs). This study explored the beliefs of 8 experts in clinical supervision regarding CEs in supervision. The study employed Q-sort methodology and completed the first four steps necessary for the development of a preliminary scale of CEs. The results of this study suggest that each of the counterproductive experiences identified in the literature negatively impact supervision in the opinions of the experts. While specific items pertaining to ethical lapses and boundary crossings were found to have the greatest impact on supervision, events involving a mismatch between the supervisor's and supervisee's approach to learning were also believed to significantly impact the process of supervision.

Introduction

Graduate education in clinical psychology provides the foundation on which the understanding of mental illness and its treatment is based. Whereas course work aims to facilitate acquisition of knowledge, clinical training affords doctoral students and interns the opportunity to apply such knowledge and to learn clinical techniques leading to the development of clinical competence. Such development is multifaceted and involves the integration of knowledge, skills and attitudes or values applied in psychological assessment and treatment to solve human problems. In addition to developing technical clinical skills, supervisees enhance abilities in self-awareness and metacompetence. Such training incorporates the principles of evidence-based professional practice (APA, 2006) in which individual and cultural differences and values as well as the empirical literature are taken into consideration. All of this learning and skill development occurs within clinical supervision. While emphasis is often placed on the training dimension, clinical supervision has its first responsibility to maintain client welfare (Cheon, Blumer, Shih, Murphy, & Sato, 2009) while the supervisee is learning and practicing clinical skills. In sum, clinical supervision serves as the centerpiece in clinical training in which client welfare is assured and professional development is facilitated (Falender & Shafranske, 2004).

The quality of direct supervision of clinical work provided by supervisors is a critical element for the development of psychotherapy trainees (Hutt, Scott, & King, 1983; Moskowitz & Rupert, 1983; Nelson, Grey, Friedlander, Ladany, & Walker, 2001) and its impacts may have career-long effects since supervised clinical work provides the foundation of professional practice. Further, experiences of supervision likely impact trainees' future practice of supervision, since their conduct of supervision may be modeled on their personal experiences as

a supervisee and on identifications with past supervisors (Falender & Shafranske, 2004). Therefore, supervision has both immediate and potentially career long impacts on client care, clinical competence, and future conduct of supervision.

While it is expected that clinical training be of high quality, some events may occur in the supervisory relationship that hinder the supervisee's growth, potentially compromise client welfare, and contribute to a poor experience of supervision. These events are considered to be counterproductive and have been identified to be harmful to the supervisee, the process of supervision, and to the supervisory relationship and supervisory working alliance (Hutt et al., 1983). In light of the potential impacts of counterproductive experiences (CEs) on training and client welfare, it is important to explore and identify the events that occur in supervision that are considered counterproductive.

Background

This section presents the background and context of the study. We begin with a brief discussion of the common elements in clinical supervision. Supervision can be defined as a collaborative and integrative process (Falender & Shafranske, 2004) in which an experienced supervisor monitors the competence and professional development of a trainee as he or she gains practical experience (Cheon et al., 2009). Supervisors must ensure that clinical supervision is conducted in a competent manner, in which ethical standards and practices are used to protect the welfare of the client, the public at large, and the profession (Falender & Shafranske, 2012) as well enhance the professional functioning of the trainee (Knox, Burkard, Edwards, Smith, & Schlosser, 2008). Therefore, supervisors need to have an understanding of the factors that contribute to a successful supervisory experience (as well as factors that have been found to negatively effect the supervisory relationship) in order to assist the individual trainee in their

professional development as well as to maintain the integrity of the field. The interaction between the supervisee and the supervisor, specifically as understood in terms of the supervisory working alliance, largely influence the variables that lead to satisfaction in supervision (Cheon et al., 2009; Westefeld, 2009), contribute to its effectiveness, and, it is hypothesized, influence the future supervision practice of the trainee when licensed as a psychologist (Falender & Shafranske, 2004).

In addition to their contributions to supervisory alliance, there are supervisor qualities that contribute to a positive supervision experience. Some of these traits include: supervisor supportiveness, skills in providing instruction, interpretation of clinical interactions (Kennard, Stewart, & Gluck, 1987), empathy, and nonjudgmental, validating and non-defensive attitudes (Nelson & Friedlander, 2001). To support the development of positive alliance and effective supervision, supervisors should be willing to examine their own assumptions (Nelson & Friedlander, 2001) and should encourage self-efficacy in supervisees (Falender & Shafranske, 2004). Both supervisor and supervisee should incorporate observation, evaluation, and problem solving, which have been found to be qualities of good supervision (Falender & Shafranske, 2004) and, similar to any evaluative situation where power differences exist, there are a multitude of factors that impact the alliance that need to be acknowledged and managed effectively.

In addition to factors that contribute to development of a strong supervisory alliance, there are factors or events that likely weaken the alliance and contribute to ineffective or poor supervision (Falender & Shafranske, 2004). Counterproductive experiences (CEs) may occur in supervision that result in a poor supervisory alliance (Cheon et al., 2009; Hutt et al., 1983; Sterner, 2009). Specifically as conflict increases (related to CEs), satisfaction with the

supervisory working alliance decreases (Cheon et al., 2009), which in turn compromises the effectiveness of supervision. For example, disagreements or misunderstandings in supervision, which are not effectively addressed, can contribute to alliance *ruptures* (Falender & Shafranske, 2004), which may affect supervisee disclosure and inhibit forthright discussion of clinical challenges. In such circumstances, oversight and management of cases as well as supervisee training are compromised. Gray, Ladany, Walker, and Ancis (2001) in a study on counterproductive events in supervision found that in all cases, trainees believed that the CEs weakened the supervisory relationship. The findings show that when CEs occur trainees had negative thoughts about their supervisory relationship and about their competence. This is consistent with findings from a study by Hutt et al., (1983), which found that some events that occur in the supervisory relationship significantly contribute to poor supervision and evoke intense negative feelings in the supervisee. Given the serious impacts that such counterproductive events may have on supervision, it is important to obtain a clear understanding of these experiences. Efforts to understand CEs requires a means by which such events can be identified, reported, and measured. At present no systematic method or empirically validated instrument exists to examine CEs in supervision. This study aims to address this lack by completing a first step in the development of a scale to measure counterproductive experiences in clinical supervision. The following section provides an overview of what is known about counterproductive experiences in supervision.

Theoretical and Empirical Scholarship on Counterproductive Experiences in Supervision

Counterproductive experiences in supervision can be described as any experience that trainees view as hindering, unhelpful, or harmful in regards to their progress as therapists (Gray et al., 2001). There are several factors in supervision that have been theoretically identified as

CEs, some of which have also been empirically measured, such as role-confusion, supervisee and supervisor non-disclosure, supervisor style, cultural sensitivity, and ethical concerns (Appendix A). A systematic review of theoretical and empirical literature was conducted to identify counterproductive experiences in supervision, such as role confusion, supervisor's use of self-disclosure, supervisor style, cultural sensitivity, and ethical concerns (Appendix B). The following discussion provides a summary of the findings of this review.

Inadequate understanding of performance expectations for supervisee and supervisor. One key contributor to conflict in the supervisory relationship is noted when supervisors fail to clarify the specific performance expectations of the supervisee, especially when supervisees are uncertain about their role as a trainee and fail to use role invocation (Appendix A).

Role conflicts. In clinical supervision, a trainee must be prepared to learn new, challenging tasks, while assuming several professional roles involving varying degrees of autonomy and power. For example, graduate students play the role of therapists in positions of authority with their clients and serve as clinical subordinates with their supervisors while simultaneously functioning as students completing coursework and conducting research under supervision (Nelson & Friedlander, 2001). Specifically within clinical training, issues related to the hierarchical arrangement and evaluation naturally create tension between the supervisor and supervisee and can potentially produce relational conflict (Nelson, Barnes, Evans, & Triggiano, 2008). Additionally, supervisors may have different undisclosed expectations for the record keeping, charting, and level of trainee's preparedness for supervision (Appendices A & B). Example of counterproductive experiences regarding role conflict:

- Supervisee disagrees with supervisor about implementing a specific technique but implements it to avoid conflict or negative evaluation (Olk & Friedlander, 1992)

Inappropriate supervisor self-disclosure. Supervisor self-disclosures can be defined as statements regarding personal information, experiences in their own therapy or in their conduct of therapy, professional experiences, reactions to the trainee's clients, and supervision experiences (Falender & Shafranske, 2004; Knox, Edwards, Hess, & Hill, 2011; Ladany & Walker, 2003). The supervisor's use of self-disclosure can be beneficial or harmful to the process of supervision, depending on the quality and frequency of the disclosure. Certain supervisor disclosures have been found to create an environment that helps supervisees feel comfortable addressing their concerns, therefore increasing supervisee's willingness to disclose (Knox et al., 2008). Supervisor disclosure of mistakes may help normalize supervisee's struggles (Ladany, & Lehrman-Waterman, 1999) and teach them that recovery from errors is possible (Knox et al., 2008). When supervisee's concerns are normalized, the may be more receptive to future supervision processes and interventions, thus enhancing their work with clients (Knox et al., 2011). Additionally, supervisee reports have found that when supervisors do not disclose personal information, it can impede communication and negatively impact the supervisory relationship (Knox et al., 2008). However, certain disclosures will likely be counterproductive, such as those that are inappropriate or ineffective or include either too much or too little information. Ladany & Walker (2003) found that continual self-disclosures of personal information, in service of the supervisor's needs, could be detrimental to the supervisee's experience of supervision (Appendices A & B).

Supervisor supervision approach and supervisee learning approach mismatch. The interpersonal styles of supervisors and trainees influence the supervisory relationship.

Supervisors vary in style and the manner in which they interact with supervisees and their approach to supervision (e.g., interpersonal sensitivity, task orientation, personality, goals; Allen, Szollos, & Williams, 1986; Hutt et al., 1983; Knox et al., 2008). Supervisor styles can be harmful or counterproductive to the process of supervision and conflicts arise over issues of 'fit' between supervisor and supervisee (Cheon et al., 2009; Gray et al., 2001; Moskowitz & Rupert, 1983). Supervisor styles that are associated with positive supervisee experiences and supervisee's willingness to disclose in supervision include supervisors that are viewed as supportive, collaborative, and challenging at times. Harmful interpersonal styles have been described as critical, less instructional, evaluative, and viewed the supervisor as lacking investment in the supervisory relationship (e.g., frequently rescheduled or missed appointments, supervisor was impatient, not empathic; Gray et al., 2001; Hess et al., 2008; Kennard et al., 1987).

Examples of counterproductive supervisory styles (Appendices A & B):

- Supervisor has developed an authoritarian style, whereas trainee seeks a more collaborative relationship (Allen et al., 1986; Barrett & Barber, 2005)
- Inflexibility in supervisor approach or supervisor consistently uses one approach in working with supervisees, regardless of their developmental level (Watkins, 1997)

Supervisor/supervisee theoretical orientation mismatch. Supervisors and supervisees may hold different theoretical orientations, which at times may produce strains in their alliance. Supervisees may feel discounted when their clinical opinions vary from their supervisors, and supervisors may experience conflict when attempting to support the supervisee's autonomy in treatment selection, yet simultaneously having the responsibility of case management (Appendices A & B).

Examples of conflicts that arise from theoretical orientations include:

- Supervisor and supervisee differ in their case conceptualization and treatment planning, objectives, and means to achieve the objectives (Hess et al., 2008)
- Differences in styles of communication, e.g., autonomous, directive, and collaborative, which may be associated with different theoretical orientations (Allen et al., 1986; Hess et al., 2008; Kennard et al., 1987)

Cultural insensitivity. Beyond attention to power dynamics in the supervisory relationship, multicultural issues play a significant role in supervision as well as in treatment. Cultural differences between supervisor, supervisee, clients and differences in attitudes and sensitivity to diversity can compromise the supervisory relationship. Singh & Chun (2010) add that when supervising queer people of color, there is a need for intentional self-reflection of assumptions, biases, and stereotypes held about this group in regards to their resilience and oppressive experiences. Cultural responsiveness by the supervisor can help supervisees feel more at ease in supervision and can have a positive effect on their work with diverse clients as well as within the supervisory relationship (Appendix B).

Examples of counterproductive experiences surrounding cultural issues:

- Cultural issues were ignored or dismissed by supervisor (Burkard et al., 2006)
- Supervisor demonstrates insensitivity to cultural identities of the supervisee or supervisee's clients (Burkard et al., 2006)
- Supervisor is viewed as lacking multicultural expertise (Jernigan, Green, Helms, Perez-Gualdron, & Henze, 2010; Killian, 2001)

Failure to address needs of the supervisee. Trainee satisfaction is significantly affected by the extent to which supervision meets the professional and developmental needs of trainee

(Inman, 2006). Trainee's needs include basic competencies, development of therapeutic skills, multicultural competence, professional and personal needs, and supervisor regard for the developmental stage of the trainee (Barrett & Barber, 2005; Magnuson, Wilcoxon, & Norem, 2000). Negative supervisory experiences may result from the inability of a supervisor to meet the trainee's needs and can make supervision a frustrating experience (Appendix A).

Example of counterproductive experiences in regards to trainee's needs:

- Supervisor inattention to trainee's developmental needs (Barret & Barber, 2005; Chung, Basking, & Case, 1998; Magnuson et al., 2000)

Inadequate attention to ethics, ethical lapses and unethical behavior. Ethical violations by supervisors in clinical supervision can impact supervisees' training experience, their work with clients, and the process of supervision. Areas of supervision in which ethical guidelines need to be followed include performance evaluations, confidentiality, expertise, multicultural sensitivity, crisis coverage (Ladany, Lehrman-Waterman, Molina, & Wolgast, 1999), and maintaining appropriate relationship boundaries (APA, 2010; Falender & Shafranske, 2007). Such violations can weaken the working alliance in the supervisory relationship, can contribute to conflict, and can be harmful to the supervisee. It is important to differentiate counterproductive experiences from serious ethical and legal violations that are harmful and illegal. Counterproductive experiences regarding ethics include events that are known to impact supervision and the trainee's growth, but are not illegal (Appendix A; Appendix B).

Examples of counterproductive experiences in regards to ethics:

- Supervisee observes unethical conduct by supervisor (Ladany, Friedlander, & Nelson, 2005)

- Supervisor fails to follow ethical guidelines regarding monitoring and evaluating supervisee's conduct (e.g., child abuse reporting; Ladany et al., 1999)
- Supervisor does not maintain confidentiality in supervision (Ladany et al., 1999)

Additional counterproductive experiences. A number of experiences have been identified as CEs in supervision; however, it is likely that there are other experiences that may result in a CE. For example, unaddressed miscommunications, administrative constraints, lack of respect for supervisor/supervisee, motivational issues (Veach, 2001), professionalism, inadequate environment/office space for supervision (Magnuson et al., 2000), and documentation of supervision (Appendices A & B). Some CEs are more ambiguous in nature (supervisor acts as though they are threatened by supervisee) and some are not fully conscious (transference or countertransference issues). Additionally, there are several dimensions that contribute to the severity of CEs, such as the intentionality (deliberate versus unintentional), frequency, and timing of the event (beginning, middle, or end of the supervisory relationship; Veach, 2001).

Purpose and Importance of Study

Given the role of clinical supervision in safeguarding the welfare of clients as well as fostering the development of clinical competence in graduate students and interns, obtaining a better understanding of counterproductive experiences that compromise the supervisory alliance and supervisory effectiveness is important (Ladany et al., 1999; Mehr, Ladany, & Caskie, 2010). Previous studies have called for further investigation (Ladany Walker, & Melincoff, 2001) of CEs. This study intended, through empirical research, to investigate counterproductive experiences and experiences in supervision as reported by experts in clinical supervisors and complements studies concurrently being conducted with practicing clinical supervisors, psychology interns and trainees as well as expands upon the findings from previous research. In

addition, this study served to complete the preliminary step in creating a scale of CEs in supervision. The scale, when fully developed, can facilitate supervisee and supervisor growth by providing the means to examine the frequency of CEs as well as to provide valuable information for psychotherapy training programs concerning the experiences in training their students receive (Gray et al., 2001).

Method

The purpose of this study is to contribute to the understanding of counterproductive experiences in supervision through the completion of the initial steps in the development of scale of CEs. The development of a scale of CEs will provide a means for investigators to look more carefully into the nature and frequency of such experiences and their impact on factors such the supervisory alliance, supervisee disclosure, and therapy outcome. We continue this discussion with an overview of the method and procedures to be employed when developing a measure as well as a delineation of the steps to be accomplished in this study.

Scale Development

The measurement of a construct such as *supervision counterproductive experience* begins with an operational definition of the construct and then proceeds through a series of steps to identify items that accurately and reliably measure the construct. For purpose of this study, a counterproductive experience in supervision is defined as: Events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisees' growth, and contribute to a poor experience of supervision adversely affecting its effectiveness.

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 that is knowledgeable in the subject matter, will review the pool of items and rate how relevant they believe each item is to what it intends to measure.

(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. Compute the descriptive statistics in order to determine the scale's quality by weeding out the poor items and retaining the good items.

(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 crosscheck the findings.

The current study completed the first four steps necessary for preliminary scale development involving the following: experts, licensed clinical supervisors, and psychology interns. This specific study focused on experts in clinical supervision. The development of scale items began with a literature search for published articles using specific search items (Appendix C). This review of the theoretical and empirical literature resulted in the identification of a comprehensive list of events that have been identified as CEs. This pool of items and the method used as the basis for the development of the instrument will be discussed in the following section. Following the development of this list, items were given to a small number of doctoral supervisors in the clinical psychology program at Pepperdine University to examine the

effectiveness of the Q-sort method as well as to sort the preliminary list of CEs based on their knowledge of CEs. Items were sorted to determine which experiences had the most significant effect on supervision and served as a *working list* of CEs. The following sections present the research design, participants, instrumentation, procedures, data analysis plan, and assumptions and delimitations.

Research Approach and Design

A Q-sorting approach was utilized for this study to obtain opinions about the impacts that counterproductive experiences (CEs) have on supervision. The participants were given a set of stimuli, which they compared and sorted according to their point of view, a process referred to as 'Q-sorting.' Through utilization of the Q-sorting 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) Identify a 'concourse' on the topic of interest

(2) Develop a representative set of statements (known as a Q-sample)

(3) Specify the participants for the study (P-set) and 'conditions of instructions'

(4) Administer the Q-sort (the sorting of the statements; Ellingsen, Størksen, & Stephens, 2010)

(5) Analyze and interpret results using descriptive statistics

This procedure provides a useful way to gather vantage points on CEs in supervision by allowing participants to express their opinions on a topic not hypothesized by the researcher (Dziopa, & Ahern, 2011). The Q-sort self-administration technique provides a useful way to collect data, it has been found to be highly congruent to in-person interviews, and it provides participants with a brief, yet valid manner of expressing their standpoint with minimal

interference by the researcher (Ellingsen et al., 2010; Shemmings, 2006). In addition, the instructions for self-administration are relatively straightforward, confidentiality can be assured, and the approach allows for standardized gathering of information.

Participants

The participants in this study, known as the P-set, include a panel of experts in the field of clinical supervision. For the purpose of this study, an expert is defined as a psychologist that has practiced clinical supervision in their professional careers and has contributed to the theoretical or empirical literature on supervision.

The experts were contacted directly by mail, using publicly available addresses that were obtained through the American Psychological Association (APA) membership directory and through an Internet search by name based on a literature search of those who publish in clinical supervision. The advantage of incorporating experts into this study is to acquire sound, expert knowledge of the subject matter, and also to provide a range of opinions that may exist between various professionals in the field. Differences in opinion likely exist amongst the groups (i.e., experts, practicing clinical supervisors, supervision researchers, etc.), and it is expected that the expert group may have a more academic and research-based perspective, which likely influences their clinical judgment and opinions. It is not posited that their opinions are therefore representative of all supervisors; however, their opinions (in light of their expertise) is important. Studies of practicing clinical supervisors, interns and trainees are concurrently being conducted by other investigators and complement and employ similar methodology.

A Q-methodological study requires a limited number of participants, as the basis of the methodology is to clarify key opinions of the participant group and access a range of viewpoints on the topic of investigation (Dziopa & Ahern, 2011; Stainton Rogers, 1995). Breadth and

diversity of viewpoints can be achieved by having 4 to 5 participants defining each anticipated viewpoint, however, highly relevant results can be obtained with 2 to 4 participants per viewpoint (Dziopa & Ahern, 2011; Ellingsen et al., 2010).

Based on the four viewpoints on CEs (significant major effect, moderate effect, minimal effect, no effect) that will be assessed, this study aimed to recruit between 8 and 16 experts in an attempt to gather distinct viewpoints regarding CEs in supervision.

Instrumentation

Identifying a concourse. The concourse refers to the communication of all possible aspects, or 'viewpoints' on an issue (Dziopa & Ahern, 2011; Ellingsen et al., 2010). In this study, the concourses are identified as counterproductive events or experiences in supervision. An extensive review of the theoretical and empirical literature was conducted to identify qualities (i.e., supervisor/supervisee events, behaviors, and characteristics) considered to produce or contribute to counterproductive experiences.

Developing a Q-sample. The Q-sample consists of a smaller set of statements that represents the various features of the concourse. The number of statements can vary; with Q-sets ranging from 10 to 100 have been found to be efficient (Dziopa, & Ahern, 2011; Ellingsen et al., 2010; Kállay, 2007). The most important aspect of selecting statements is the representativeness, meaning they have to be different enough to represent different attitudes and opinions (Dziopa, & Ahern, 2011). The items selected for this study were based on existing theoretical and empirical findings on CEs and harmful experiences in supervision (Appendix D).

Specifying the P-set and the conditions of instruction. Researchers identified the targeted population that receives the Q-sort. As noted above, the P-set in this portion of the

study are the experts in supervision. Also, the respondents were given instructions (known as conditions of instruction) for the Q-sorting process.

Consultation study. In an attempt to determine if the scale items have face validity and to provide a critique of the items, a 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 indicate if any item was confusing or unclear and to make suggestions regarding the revision of those items. Feedback from the group was used to modify item content and wording. Six CEs were added to capture phenomena that were not identified in the literature. Also, some items were expanded upon to include an example to better illustrate the experience or event.

Research Procedure

This section will include discussion of recruitment, instructions, human subjects protections, and consent for participation. The self-administration Q method is an important assessment tool that can be used efficiently to gather subjective opinions, attitudes, and beliefs and succeeds to combine the qualitative and quantitative approaches in research (Kállay, 2007; Stainton Rogers, 1995; Stephenson, 1953). They are more cost effective and require less effort to administer compared to Q-sorts administered in-person (Dziopa, & Ahern, 2011).

Recruitment. The experts were directly mailed an invitation to participate along with a package with participant materials. Due to the experts' pre-existing relationship with dissertation committee members, the package included a cover letter from Drs. Edward Shafranske and Carol Falender to introduce the study (Appendix E). The package also included a recruitment letter with an introduction describing the nature of the study (Appendix F), an informed consent letter (See Appendix G), a stack of cards containing items from the Q-sample, and a self-addressed paid-postage envelope for experts to mail back the Q-sort stack. The

experts were offered a copy of the study's abstract upon completion. The study and recruitment for the study were conducted in accordance with accepted ethical, federal, and professional standards of research to ensure confidentiality and every effort was made to eliminate any potential risks to participants.

Instructions. Counterproductive experiences in supervision can be described as events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisees' growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. For example, events that may impact your trust, rapport, confidence, respect, willingness to disclose, and alliance with your supervisor.

Participants were provided instructions that state the following:

You have received cards, each with a statement of counterproductive experiences in supervision based on empirical and theoretical literature. These may or may not be events/experiences you have specifically experienced yourself. Imagine that the following event/experience occurred in supervision. Please sort each card in stacks in order of the impact of the counterproductive event/experience on the process of supervision between a clinical supervisor and a trainee/ supervisee. You can put as many cards in each category as you wish. The categories are as follows:

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

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

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

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

The participants were asked to read through all the cards. The experts were also provided with a blank card, and if applicable, pointed out additional ways of capturing the phenomenon of CEs that were not included, ultimately maximizing the content validity of the scale (DeVellis, 2012). The experts were given four envelopes marked *significant major effect, moderate effect, minimal effect,* and *no effect*. The participants were asked to compare each item and sort them by placing each item in an envelope (Appendix H).

Human subjects protection. Prior to recruitment, an application was submitted to the Institutional Review Board of Pepperdine University for approval. This ensured that the proposed study would be performed in accordance with the Belmont Report, U.S. Code of Regulations, DHHS (CFR) Title 45 Part 46, Entitled Protection of Human Subjects. Specifically, an application for a claim of exemption was submitted under IRB policy authorized by 45 CFR 46.101(b)(2) 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 (Dziopa, & Ahern, 2011). In addition, the study posed no greater than minimal risk to participants and no personal or identifying information was collected from participants. The information obtained was recorded in such a manner that the subjects cannot be identified directly or through identifiers linked to the experts. Any disclosure of the experts' 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.

Participants were informed of the study's purpose and intent in the participant recruitment letter in addition to the potential risks and benefits (Appendix F). The informed

consent document informed participants that the data that is obtained will be confidential, and their identities will not be known. They were also informed that their participation was voluntary, and they were able to 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 (Appendix G). The study presented no more than minimal risk to the human subjects; no personally identifiable data was collected. The study involved 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 experts in the field of supervision and have likely engaged in discussion and reflection regarding events that are harmful in supervision; (c) the contents under study are considered areas of professional competence for clinical psychologists; and (d) confidentiality of data was ensured by not collecting any identifying information from the participants.

There were no direct benefits to all participants. However, participants may have derived satisfaction from the knowledge that their participation contributed to the field and the literature and had an opportunity to share their expertise on supervision. In addition, participants could elect to receive a copy of the study's abstract upon completion.

Regarding risks to potential participants, attempts were made to minimize these effects. Although the administration of the Q-sort is brief and engaging, and takes approximately 15 minutes, the primary risk was possible 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 may have been reminded of counterproductive events they may have engaged in or were subject to as trainees. Remembering such experiences may have evoked a range of emotional responses and therefore the study posed a risk. However, it posed no greater than minimal risk due to the rigorous research and training that psychologists have received in supervision. If any distress were to arise, a recommendation was included in the informed consent for such a participant to speak to a trusted colleague, clinician, or they could contact Dr. Edward Shafranske, dissertation advisor, to help mitigate any potential negative consequences that resulted from participating in this study. A statement was included in the recruitment letter and the informed consent document that participation is voluntary and participants could discontinue 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 are 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 G). 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

Experts were contacted by mail and invited to participate. The experts were mailed a cover letter, recruitment letter, informed consent, the Q-sort stack of cards with instructions, and two pre-paid self-addressed envelopes. The recruitment letter and informed consent informed the experts of the study's purpose and intent, the potential benefits and risks of participation, and participation procedures. The stack of cards contained items from the Q-sample with instructions on how to sort the cards. Data was collected via postal mail and contained the Q-

sort stacks (sorted in the envelopes). 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 sorting (*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 mean values were computed for each item, the category means and standard deviations were computed and ranked following a Likert scale. The data was entered into an excel spreadsheet. The results will contribute to the formulation of initial set of CEs that will go on to a larger study and be used for further scale development. The final scale will need to include a range of CEs based on likely frequency. Upon the study's completion, the data will remain confidential and will be stored in an electronic file for 5 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 5 years.

Results

Packets were mailed to 28 experts. Eight experts (28%) participated in the study. Table 1 shows the frequencies for each counterproductive event, as rated by experts. There are nine categories that comprise the 50 CEs that occur in supervision. Participants were asked to sort each event based on how counterproductive they believe 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 sorting (*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. After a score was assigned to the CEs, the category means and standard deviations were computed and ranked following a Likert scale.

Table 1

Counterproductive Experiences in Supervision

CEs in Supervision	*NoE*=0	*MinE*=1	*ModE*=2	*SigE*=3	Mean (*N*=8)
Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflicts					
Supervisor does not encourage the development of mutually agreed upon goals of supervision.		1	6	1	16/*N*=2 *SD*=0.53
Supervisor fails to clearly communicate performance expectations to the supervisee.			6	2	18/*N*=2.25 *SD*=0.46
Supervisor's performance expectations are developmentally inappropriate, i.e., too high or too low in light of the supervisee's experience and competence.			5	3	19/*N*=2.37 *SD*=0.52
Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations.			5	3	19/*N*=2.37 *SD*=0.52
					Category *M* 72/4=18 *SD*=1.41
Inappropriate Supervisor Self-disclosure					
Supervisor often discloses information about his/her personal life.		2	5	1	15/*N*=1.87 *SD*=0.64
Supervisor discloses negative opinions about the supervisee's clients.		1	4	3	18/*N*=2.25 *SD*=0.70
Supervisor discloses negative opinions about the profession.		3	3	2	15/*N*=1.87 *SD*=0.83
Supervisor discloses personal disillusionment about his/her career as a psychologist.		3	1	4	17/*N*=2.12 *SD*=0.99
Supervisor discloses negative opinions about colleagues, staff or the training site.		2	4	2	16/*N*=2 *SD*=0.75
					Category *M* 81/5=16.2 *SD*=1.30
Supervisor Supervision Approach and Supervisee Learning Approach Mismatch					
Supervisee and supervisor do not agree about the steps to achieve the supervisory goals.			6	2	18/*N*=2.25 *SD*=0.46
Supervisor is inflexible in his/her approach to supervision.		1	6	1	16/*N*=2 *SD*=0.53
Supervisor often makes critical judgments of supervisee without providing constructive feedback.			2	6	22/*N*=2.75 *SD*=0.46

(*continued*)

Counterproductive Experiences in Supervision

CEs in Supervision	*NoE*=0	*MinE*=1	*ModE*=2	*SigE*=3	Mean (*N*=8)
Supervisor is often insensitive when giving feedback.			2	6	22/*N*=2.75 *SD*=0.46
Supervisor does not address strains or conflicts between supervisee and supervisor.			1	7	23/*N*=2.87 *SD*=0.35
Supervisor does not appropriately structure the supervision session (either too much or too little structure).		3	5		13/*N*=1.62 *SD*=0.52
					Category *M* 114/6=19 *SD*=4
Supervisor/Supervisee Theoretical Orientation Mismatch					
Supervisor and supervisee often differ in their conceptualization of cases.		2	5	1	15/*N*=1.87 *SD*=0.64
Supervisor and supervisee differ in which therapeutic approach is best suited to achieve the treatment goals.		4	3	1	13/*N*=1.62 *SD*=0.74
Supervisor lacks knowledge of the psychotherapy procedures that the supervisee has been taught in graduate school.		4	4		12/*N*=1.5 *SD*=0.53
Supervisor has limited knowledge about supervisee's theoretical orientation.		3	5		13/*N*=1.62 *SD*=0.52
Supervisor criticizes supervisee's primary theoretical orientation.		1	3	4	19/*N*=2.37 *SD*=0.74
					Category *M* 72/5=14.4 *SD*=2.79
Cultural Insensitivity					
Supervisor does not consider the impact of the client's cultural identities.	1		6	1	15/*N*=1.87 *SD*=0.83
Supervisor does not consider the impact of his/her own and supervisee's cultural identities.		1	4	3	18/*N*=2.25 *SD*=0.71
Supervisor does not encourage the use of culturally appropriate interventions.		3	5		13/*N*=1.62 *SD*=0.52
Supervisor assumes cultural/racial stereotypes when discussing clients.			3	5	21/*N*=2.62 *SD*=0.52
					Category *M* 67/4=16.75 *SD*=3.5
Failure to Address Needs of the Supervisee					
Supervisor does not consider the developmental needs of the trainee.		1	6	1	16/*N*=2 SD=0.53
Supervisor is unresponsive to supervisee's verbalized training/supervision needs.			4	4	20/*N*=2.5 SD=0.53
Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his/her professional performance.		2	2	4	18/*N*=2.25 SD=0.88
Supervisor appears to be distracted in supervision.		1	7		13/*N*=1.87 *SD*=0.35

(*continued*)

Counterproductive Experiences in Supervision

CEs in Supervision	*NoE*=0	*MinE*=1	*ModE*=2	*SigE*=3	Mean (*N*=8)
					Category *M* 69/4=17.25 *SD*=2.22
Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior					
Supervisor provides minimal feedback on the midyear evaluation.	1	3	3	1	12/*N*=1.5 *SD*=0.93
Supervisor directs the supervisee not to file a child abuse when the supervisee reports clear instances of neglect and abuse.				8	24/*N*=3 *SD*=0
Supervisor speaks about clients in a recognizable way, e.g., using their names, in public areas.		1	2	5	20/*N*=2.5 *SD*=0.76
Supervisor does not consistently observe or review audio/videotapes or provide live supervision of supervisee.	1	2	5		12/*N*=1.5 *SD*=0.76
Supervisor does not consistently sign off on charts/progress notes of supervisee.		4	3	1	13/*N*=1.62 *SD*=0.74
Supervisor is unavailable to discuss clinical emergencies outside of regularly scheduled supervision.	1		5	2	16/*N*=2 *SD*=0.93
Supervisor sometimes ignores agency policies.	1	1	5	1	14/*N*=1.75 *SD*=0.89
Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained.		2	5	1	15/*N*=1.87 *SD*=0.64
					Category *M* 126/8=15.75 *SD*=4.23
Boundary Crossings/Violations					
Supervisor invites supervisee to attend a personal event outside of supervision.		3	2	3	16/*N*=2 *SD*=0.93
Supervisor asks supervisee to edit a journal article the supervisor has written for publication.	1	3	2	2	13/*N*=1.62 *SD*=1.06
Supervisor discusses other supervisees' performance in supervision.		1	2	5	20/*N*=2.5 *SD*=0.76
Supervisor inquires about the supervisee's personal life (e.g., Are you dating anyone?)	1		2	5	19/*N*=2.37 *SD*=1.06
Supervisor attempts to help the supervisee to resolve a personal conflict.	3	2	2	1	9/*N*=1.12 *SD*=1.13
Supervisor makes jokes/comments with sexual innuendos.			1	7	23/*N*=2.87 *SD*=0.35
Supervisor expresses attraction to supervisee.			1	7	23/*N*=2.87 *SD*=0.35
					Category *M* 123/7=17.57 *SD*=5.22
Additional Counterproductive Experiences					
Inadequate environment/office space is provided for supervision.		7	1		9/*N*=1.12 *SD*=0.35

(*continued*)

Counterproductive Experiences in Supervision

CEs in Supervision	*NoE*=0	*MinE*=1	*ModE*=2	*SigE*=3	Mean (*N*=8)
Supervisee's professional responsibilities (e.g., nature of work, workload, time) were not accurately represented during the application process.	1		5	2	16/*N*=2 *SD*=0.93
Supervisor demonstrates inflexibility in scheduling.	1	4	3		10/*N*=1.25 *SD*=0.71
Supervisor is frequently late for supervision.		1	4	3	18/*N*=2.25 *SD*=0.71
Supervisor does not provide guidance about professional development as a psychologist.	1	3	4		11/*N*=1.37 *SD*=0.74
Supervisor does not demonstrate empathy for the supervisee.			5	3	19/*N*=2.37 *SD*=0.52
Supervisor does not demonstrate respect for the supervisee.			2	6	22/*N*=2.75 *SD*=0.46
					Category *M* 105/7=15 *SD*=5.03

Counterproductive Experiences in Supervision

The counterproductive events and experiences from each category were given a score and the means for each category were computed. Overall, each category contained CEs that the experts believe has the potential to significantly impact supervision. The results of the sorted CEs from each domain are outlined below.

Supervisor supervision approach and supervisee learning approach mismatch.

Based on the Q-sort from the 8 experts, counterproductive experiences related to a mismatch with the supervisor's approach and the supervisee's learning approach were generally found to have a moderate to significant major effect on the impact of supervision. There was some variability, for instance 1 expert believes the CE *Supervisor is inflexible in his/her approach to supervision* has a minimal impact on supervision, whereas the other experts believe this has the potential for a moderate to significant major effect on supervision (Table 1). All of the experts believe the CE *Supervisor does not address strains or conflicts between supervisee and supervisor* has a moderate to significant major effect (*ModE*=1; *SigE*=7).

Inadequate understanding of performance expectations for supervisee and supervisor/role conflicts. Based on the Q-sorts from the 8 experts, within this category, the CE *Supervisor has changing performance expectations of the supervisee* and Supervisor's performance expectations are developmentally inappropriate were found to have a moderate to significant impact on supervision (Table 1). Most of the experts believe that when a supervisor fails to clearly communicate performance expectations to the supervisee, it can have a moderate to significant impact on supervision. One expert believes that the CE *Supervisor does not encourage the development of mutually agreed upon goals of supervision* has a minimal impact on the process of supervision.

Boundary crossings/violations. The experts believe that the CE *Supervisor expresses attraction to supervisee* can have a moderate to significant major effect on supervision (Table 1). In addition, 7 out of the 8 experts believe that when a supervisor inquires about the supervisee's personal life and when a supervisor makes jokes/comments with sexual innuendos, there is potential for a significant major effect on supervision. One expert believes the CE *Supervisor asks supervisee to edit a journal article the supervisor has written for publication,* has no effect on the process of supervision, whereas 4 experts believe it has a moderate to severe impact (*ModE*=2; *SigE*=2). There was also some variability in regards to the CE *Supervisor attempts to help the supervisee to resolve a personal conflict*, as 3 experts believe it has no impact on supervision, 2 believe it as a minimal effect, 2 believe it has a moderate effect, and 1 expert believes it has a significant major effect on the process of supervision.

Failure to address needs of the supervisee. In general, the experts believed that the events in this category have a minimal to severe impact on the process of supervision. There was some variability in regards to the experts' Q-sorts within this category. For instance, 2 experts

believe that the CE *Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his/her professional performance* has a minimal impact, whereas 6 experts believe it has a moderate to significant major impact on supervision (Table 1). In addition, 1 expert believes that the event *Supervisor appears to be distracted in supervision,* has a minimal impact on the supervision, and 7 experts believe it has a moderate effect. The event, *Supervisor is unresponsive to supervisee's verbalized training/supervision needs,* was believed to have a moderate to significant impact on supervision.

Cultural insensitivity. There was some variability in the experts' sorting of the CE *Supervisor does not consider the impact of the client's cultural identities,* as 1 expert believes that there is no effect on supervision, and 7 experts believe this CE has the potential for a moderate to significant impact on supervision (Table 1). One expert believes that the CE, *Supervisor does not consider the impact of his/her own and supervisee's cultural identities,* has a minimal impact on supervision, whereas 7 experts believe it has a moderate to significant major effect on supervision (*ModE*=4; *SigE*=3). All of the experts believe that there is a moderate to significant strain or rupture of the supervisory alliance when a supervisor assumes cultural/racial stereotypes when discussing clients.

Inappropriate supervisor self-disclosure. The experts ranged in their beliefs about the events related to supervisors' self-disclosure. For instance, 3 experts believe that when a supervisor discloses negative opinions about the profession, it has a minimal impact on supervision, whereas 4 experts believed it has a moderate to significant major effect (Table 1). Additionally, 3 experts believe that the CE *Supervisor discloses personal disillusionment about his/her career as a psychologist* has a minimal impact on supervision and 5 experts believe it has a moderate to significant major effect. Seven experts believe the CE, *Supervisor discloses*

negative opinions about the supervisee's clients, has the potential for a moderate to significant major effect on supervision.

Inadequate attention to ethics, ethical lapses, and unethical behavior. All of the experts believe the CE, *Supervisor directs the supervisee not to file a child abuse when the supervisee reports clear instances of neglect and abuse,* has a significant major impact on the process of supervision. One of the experts believes that the CE *Supervisor is unavailable to discuss clinical emergencies outside of regularly scheduled supervision* has no negative effect on supervision, whereas the other experts believe it has a moderate to significant major effect. Four of the experts believe that when a supervisor does not consistently sign off on charts/progress notes, there is a minimal negative effect and 4 experts believe there is a moderate to significant impact on supervision (Table 1).

Additional counterproductive experiences. The experts believe that there is a minimal to moderate negative effect on supervision when there is inadequate environment/office space for supervision. The findings show that there is a moderate to significant negative effect when a supervisor does not demonstrate empathy and respect for the supervisee. There was some variability in the experts' Q-sorts, such that 1 expert believes that there is a no effect when a supervisee's professional responsibilities were not accurately represented during the application process, whereas 7 of the experts believe that this CE has the potential for a moderate to significant impact on supervision (Table 1).

Supervisor/supervisee theoretical orientation mismatch. In general, all of the events in this category were found to have at least a minimal negative impact on the process of supervision. The experts believe that the CEs, *Supervisor has limited knowledge supervisee's theoretical orientation* and *Supervisor and supervisee differ in their beliefs about which*

therapeutic approach is best suited to achieve the treatment goals, can have a minimal to moderate impact on the process of supervision. Four experts believe the CE *Supervisor criticizes supervisee's primary theoretical orientation* has a significant major impact on supervision.

Counterproductive experiences experts provided on blank cards.

Five of the experts included additional CEs on the blank card that was provided. These CEs include:

- Supervisor comes unprepared for supervision
- Sexual attraction of supervisor to supervisee
- Supervisor not prepared, does not spend time in preparation (e.g., has not reviewed type of counseling session submitted by the supervisee)
- Supervisor does not help/is not available/tries to avoid involvement with ethical dilemmas
- Supervisors attitude toward doing supervision
- The supervisor gives the supervisee a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision, depriving the supervisee of an opportunity to improve
- Supervisor gets drunk with supervisee (or uses drugs)
- Supervisor has a sexual relationship with supervisee
- Supervisor abuses authority/power with supervisee (other boundary violations)
- Supervisor violates supervisee's confidentiality (personal disclosures relevant to professional development)

Discussion

This study examined the beliefs of 8 experts in clinical supervision about 50 counterproductive experiences in supervision through the use of a process known as Q-sorting. The Q-sort is an assessment tool used to gather subjective opinions by comparing and sorting items according to one's point of view. This study also completed the first four steps necessary for preliminary scale development. The counterproductive experiences that were sorted were gathered from theoretical and empirical literature on supervision practices. The results of this study suggest that all of the CEs have some implication for negatively impacting the supervision.

There were specific counterproductive experiences that were found to have the greatest potential for negatively impacting the process of supervision. In this study, the most impactful CE includes the ethical lapse of a supervisor directing the supervisee not to file a child abuse when the supervisee reports clear instances of neglect and abuse. This is consistent with the findings of Ladany and colleagues who reported that it could be harmful when a supervisor fails to follow ethical guidelines regarding the monitoring of the supervisee's conduct (Ladany et al., 1999). The next most impactful CE included the boundary violation of a supervisor expressing attraction to supervisee and the supervisor making jokes or comments with sexual innuendo. This finding supports the current literature that emphasizes the importance of maintaining appropriate relationship boundaries (Falender & Shafranske, 2004) and the harm it could have when a supervisor fails to maintain boundaries (Ladany et al., 1999). It is important to reiterate that counterproductive experiences differ from violations that are harmful and illegal, which impact supervision. The other notably significant CEs are based on the learning styles of supervisors and supervisees. These include supervisors that are insensitive when giving feedback, supervisors that often make critical judgments of supervisee without providing

constructive feedback and supervisors that do not address strains or conflicts between supervisee and supervisor. These findings are consistent with the study from Gray and colleagues (2001) that found that supervisees who experienced a counterproductive event and were generally satisfied with their supervision also wished that their supervisors had addressed and processed the conflict.

The results of this study suggest that a mismatch between the supervisor and supervisee in respect to learning approach to supervision can significantly strain or rupture the alliance and have a major impact on the process of supervision. Experts also generally agreed that supervisor's style can also negatively impact supervision. These findings are consistent with the literature that states that supervisor styles can be harmful or counterproductive and conflicts arise over issues of 'fit' between supervisor and supervisee (Cheon et al., 2009).

Experiences within the category *Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflicts* were identified by the experts to significantly impact supervision. This is another important area of exploration as role conflict and ambiguity can create anxiety and dissatisfaction both with supervision and with clinical work (Nelson & Friedlander, 2001). In general, the experts agreed that there is a potential for a moderate to significant major effect when the performance expectations of a supervisee are inadequately communicated, inconsistent, or developmentally inappropriate. Current literature indicates that supervisees' satisfaction is largely affected by the extent to which supervision meets the professional and developmental needs of trainee (Inman, 2006).

Overall, the findings illustrate that all of the categories contain events that have the potential to significantly impact supervision. It is important to note that there are several dimensions that contribute to the severity of a CE, such as intentionality, frequency, and timing

of the event (Veach, 2001). Despite the varying perspectives that may exist about the CEs, it is important to assist supervisors and clinical psychology programs in becoming more aware of and adept in the practice of supervision.

Limitations

A potential limitation of this study includes limitations or a lack of representativeness in the sample of experts who participated. The experts were selected based on purposive sampling through an Internet search by name and based on a literature search of those who publish in clinical supervision. The experts that were accessible via mail reside in the United States. While we likely accounted for a small range of opinions that exist between experts, there may have been greater variability in the perspectives of those experts residing in different countries.

A second limitation concerns the experts' personal research backgrounds. Although this study focused on experts who are knowledgeable in practices of clinical supervision, the experts may be invested in a specific focus area of research, which ultimately may influence their perspective and sorting of Q-sort items. Additionally, although the experts in the study were given the opportunity to provide CEs that were not included, it is likely impossible to be able to capture every phenomenon of CEs. Further, while the items were intended to provide discrete and unambiguous descriptions of experiences and events, it is likely that some variance exists in the ways in which individual participants personally interpreted the meaning of the item.

Another limitation of the study is the generalizability of the sample; the experts 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 expertise on supervision or considered supervision from a different perspective than did the nonparticipants. In addition, there are factors that cannot be accounted for such as the time of day the expert

completed the Q-sort, or whether it was completed at one sitting. Although this specific study focused on experts in clinical supervision, taken together with the results from the sample of licensed clinical supervisors and psychology interns this study provides a more systemic perspective on CEs in supervision.

Implications for Clinical Training

This study provides information regarding experts' perspectives about counterproductive events or experiences in supervision. The study succeeded in completing the first four steps of scale development on CEs. 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 CEs and features and outcomes of supervision, such as alliance, supervision effectiveness, treatment outcome, and supervisee confidence. The final scale can facilitate supervisee and supervisor growth and can provide valuable information for psychotherapy training programs (Gray et al., 2001). In hope that by highlighting events in supervision that can be hindering to the supervisee's experience of supervision, this study will prompt further discussion and investigation into reasons for the CEs so that education and training can address these issues. This research also provides support for the assertion that in addition to ethical issues, more ambiguous events, such as learning styles or supervisor/supervisee approach to supervision, can also negatively impact supervision. While previous literature is useful and informative to the field of clinical supervision, this study has clinical utility by providing awareness of CEs that are inherent in supervision.

Recommendations for Future Research

This study completed the first four steps necessary for scale development using the population of experts. The results from this study should be combined with the results gathered

from the sampled population of clinical supervisors and interns to compare the perspectives of each population and assist with item selection. 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 to constitute the scale. This study investigated expert opinion regarding the effects of counterproductive experiences on the supervision; however, what is unknown is the frequency of occurrence of these events. Future investigations of supervisee experiences are required to ascertain frequency and to develop the CES. Lastly, the scale length needs to be optimized. At this point the investigator will have a pool of items that demonstrates acceptable reliability (DeVellis, 2012). In addition to scale development, a more in depth look into the personal and professional styles of successful supervisors is suggested, as these are known to be of great importance to the supervisory relationship and functioning of supervision. Also, the counterproductive experiences that the experts provided on the blank cards may be incorporated in a replication of this study.

Conclusion

The purpose of this study was to contribute to the understanding of counterproductive experiences in supervision by completing the initial steps in the development of scale of counterproductive experiences. This specific study focused on experts in clinical supervision and their beliefs about CEs in supervision. Eight experts in clinical supervision completed a Q-sort of 50 CEs that were gathered from theoretical and empirical literature on supervision practices. While some variability existed among the experts, high frequencies of CEs with a *significant major effect* on supervision were found to exist in all of the categories of CEs.

Several events within the categories *Supervisor Supervision Approach and Supervisee Learning Approach Mismatch* and *Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflicts* were found to significantly impact supervision. The present study succeeded in completing the four steps necessary for the preliminary development of a scale on CEs and has contributed to the expanding field of supervision by highlighting events and experiences that negatively impact the process of supervision.

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APPENDIX A

Counterproductive Experiences in Supervision Identified in Literature Based on Theory

CE	Study	Conclusion
Role conflict	Nelson et al. (2008). Working with conflict in clinical supervision: Wise supervisors' perspectives.	Supervisor fails to clearly identify supervisee goals and expectations; Supervisors indicated that their failure to communicate about expectations early on had been a mistake that led to difficulties in their relations with supervisees.
	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.
Supervisee non-disclosure	Tsong (2004). The roles of supervisee attachment styles and perception of supervisors' general and multicultural competence in supervisory working alliance, supervisee omissions in supervision, and supervision outcome.	When supervisee does not discuss an issue in supervision or intentionally omits information, the effectiveness of supervision can be compromised.
	Hess, Knox, Schultz, Hill, Sloan, Brandt, Kelley, & Hoffman (2008). Predoctoral interns' nondisclosure in supervision.	Nondisclosure can be due to concerns about evaluation and negative feelings, power dynamics, inhibiting demographic or cultural variables, and differences in theoretical orientation.
	Teitelbaum (1990). Supertransference: The role of the supervisor's blind spots.	Transference reactions on the part of the therapist toward the supervisor may lead to supervisor counter-reactions to the therapist's transferences to the supervisor strongly influence the course, flow, and outcome of the supervisory experience.
Supervisor self-disclosure	Ladany & Walker (2003). Supervision self-disclosure: Balancing the uncontrollable narcissist with the indomitable altruist.	Supervisor does not disclose any personal information; Supervisor self-disclosure can have mild to moderate effects on supervision outcome;

(*continued*)

CE	Study	Conclusion
		Chronic self-disclosure of personal material can be detrimental to the supervisee's training experience.
	Knox et al. (2008). 'Supervisors' reports of the effects of supervisor self-disclosure on supervisees.'	Supervisor disclosure can influence supervisees and the supervisory relationship.
	Knox et al. (2011). Supervisor self-disclosure: Supervisees' experiences and perspectives.	Supervisor's personal disclosures made supervisee feel uncomfortable with the supervision boundaries.
Supervisor style	Hutt, Scott, & King (1983). A phenomenological study of supervisees' positive and negative experiences in supervision.	Supervisor demonstrates inflexibility in style that interferes with meeting the supervisee's unique needs to learn and grow professionally; Supervisor makes frequent judgments/criticisms of supervisee.
	Knox et al. (2008). 'Supervisors' reports of the effects of supervisor self-disclosure on supervisees.'	Supervisor focuses on supervisee's personal issues.
	Nelson & Friedlander (2001). A close look at conflictual supervisory relationships: The trainee's perspective.	Supervisees that described their supervisors as not attempting to make emotional connections endorsed more conflict in their supervisory relationship; Unresolved conflict affects supervisee's training experience.
	Barret & Barber (2005). A developmental approach to the supervision of therapists in training.	Supervisor does not attend to supervisee's needs: Negative supervisory experience may result from supervisor's inattention.
	Chung, Baskin, & Case (1998). Positive and negative supervisory experiences reported by counseling trainees	Supervisor does not attend to supervisee's needs; Supervisor is inattentive to the trainee's developmental needs or is distracted while in supervision.
	Nelson et al. (2008). Working with conflict in clinical supervision: Wise supervisors' perspectives.	Unresolved conflict between supervisee and supervisor.

(*continued*)

CE	Study	Conclusion
	Watkins (1997). 'The Ineffective Psychotherapy Supervisor': Some reflections about bad behaviors, poor process, and offensive outcomes.	Supervisors consistently use one approach in working with supervisees; Defines bad, poor, and ineffective supervision.
	Magnuson, Wilcoxon, & Norem (2000). Exemplary supervision practices: Retrospective observations of experienced counselors.	Factors contributing to a negative supervision experience include: inadequate attention to all aspects of supervision, developmentally inappropriate, intolerance of differences, poor model of professional attitudes, untrained supervisor, professionally apathetic, equitable environment for supervision.
Cultural sensitivity	Burkard, Johnson, Madson, Pruitt, Contreras-Tadyeh, Kozlowski, & Hess, (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.
	Hess et al. (2008). Predoctoral interns' nondisclosure in supervision.	Power imbalances were often tied to differences between the supervisors' and supervisees' style of conducting therapy and their demographic or cultural characteristics (e.g., gender, sexual orientation, age), with the supervisor representing the culturally dominant aspect of the dichotomy (e.g., male, heterosexual, older).
	Jernigan et al. (2010). An examination of people of color supervision dyads: Racial identity matters as much as race.	Trainee reported the stressful and burdened sense of obligation to educate their supervisors about race and culture; Despite when supervisees reported that their supervisors appeared to validate the importance of talking about race, supervisees also reported that their supervisors were not always skilled at integrating racial factors into treatment planning or supervisory conversations.

(*continued*)

CE	Study	Conclusion
	McClure (2005). Preparing a laboratory-based thesis: Chinese international research students' experiences of supervision.	Chinese international students' perceptions of negative experiences of the supervisory relationship were stronger in the students who reported language difficulties; Students require different supervisory relationships, ranging from a high level of dependency to a high level of autonomy.
	Priest (1994). Minority supervisor and majority supervisee: Another perspective of clinical reality.	Issues may arise when supervisor is an ethnic minority and the supervisee is an ethnic majority, there may be a perceived threat or expectation of negative supervision outcomes by the supervisee.
Ethical concerns	Falender & Shafranske (2004). Clinical supervision: A competency-based approach.	Supervisor fails to maintain appropriate relationship boundaries.
	Ladany, Friedlander & Nelson (2005). Critical events in psychotherapy supervision: An interpersonal approach.	Trainees who are less satisfied with their experience of supervision tend to report a greater occurrence of non-ethical practice by their supervisors.

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APPENDIX B

Counterproductive Experiences in Supervision Identified in Literature Based on Empirical Findings

CE	Study	Methods	Participants	Findings
Role conflict	Olk & Friedlander, (1992). Trainee's experiences of role conflict and role ambiguity in supervisory relationships.	Semi-structured Interview	6 supervisors, 9 trainees	Role conflict and ambiguity can result from conflicting expectations or when the expectations for behavior are unclear.
	Ramos-Sanchez, et al. (2002). Negative supervisory events: Effects on supervision satisfaction and supervisory alliance.	Survey	126 respondents (54%predoctoral interns and 46% practicum students)	Inconsistent expectations of supervisee contribute to negative experiences in supervision.
Supervisee non-disclosure	Ladany, Hill, Corbett, & Nutt (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors.	Self-report measure, SSI, *Supervisory Satisfaction Questionnaire (SSQ)*	108 trainees	Non-disclosures due to negative reactions to the supervisors, respect for the supervisor, and fear of political suicide; A weak supervisory alliance is related to supervisees' withholding information.
	Mehr, Ladany, & Caskie (2010). Trainee nondisclosure in supervision: What are they not telling you?	Survey, self-report questionnaire	204 therapists	The greater the anxiety experienced by the trainee, the greater amount of trainee nondisclosure and a lower overall willingness to disclose in the supervision session.

(*continued*)

CE	Study	Methods	Participants	Findings
Supervisor self-disclosure	Ladany, & Lehrman-Waterman (1999). The content and frequency of supervisor self-disclosures and their relationship to supervisor style and the supervisory working alliance.	Surveys, self-report measures	105 trainees	Supervisor does not disclose any personal information; The more frequently a supervisor self-disclosed, the greater the agreement on the goals and tasks of supervision and the stronger the emotional bond between the two.
	Ladany, Walker, & Melincoff, (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure.	Self-report measures	137 counselors	Supervisor self-disclosure can facilitate trainee self-disclosure that would ordinarily be difficult to discuss in supervision.
	Ladany & Melincoff (1999). The nature of counselor supervision nondisclosure.	Self-report measures	90 supervisors	When supervisors did not self-disclose, communication was impeded, potentially imperiling the supervisory working alliance and supervisees' clinical work and development.
Supervisor Style	Ladany, Walker, & Melincoff, (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure.	Self-report measures	137 counselors	Supervisor demonstrates inflexibility; Flexible supervisors that tailor their style with different trainees facilitate the development of a strong supervisory working alliance; Supervisor style predicted working alliance.

(*continued*)

CE	Study	Methods	Participants	Findings
	Moskowitz & Rupert (1983). Conflict resolution within the supervisory relationship.	Survey	158 graduate students in clinical psychology	Supervisor's orientation conflicted with trainee; major differences in personality styles of the supervisee and supervisor led to a strained relationship and conflict.
	Cheon et al. (2009). The influence of supervisor and supervisee matching, role conflict, and supervisory relationship on supervisee satisfaction.	Survey	132 supervisees in academic programs	Working alliance was highly predictive of supervisee satisfaction.
	Ramos-Sanchez, et al. (2002). Negative supervisory events: Effects on supervision satisfaction and supervisory alliance.	Survey	126 respondents (54%predoctoral interns and 46% practicum students)	Supervisor does not support supervisee: not feeling support from a supervisor, lack of constructive feedback are important contributors to negative experiences in supervision.
	Kennard et al. (1987). The supervision relationship: Variables contributing to positive versus negative experiences.	Self-report measures, retrospective measures	68 trainee-supervisee pairs	Supervisee's reported a negative experience with supervisors that were instructional, interpretive, and unsupportive.

(*continued*)

CE	Study	Methods	Participants	Findings
Cultural sensitivity	Inman (2006). Supervisor multicultural competence and its relation to supervisory process and outcome.	Self-report measures	147 MFT trainees	Supervisor multicultural competence was related to supervision satisfaction, but did not adequately contribute to trainee multicultural competence and was negatively related to multicultural case conceptualization ability in etiology.
	Killian (2001). Differences making a difference: Cross-cultural interactions in supervisory relationships.	Interviews	6 supervisors 6 supervisees	Trainees may experience the supervisory process as ineffective due to supervisor's lack of culturally diverse experiences and limited multicultural training, or when trainees perceive their supervisors as lacking in multicultural competence.
Ethical Concerns	Ladany, Lehrman-Waterman, Molina, & Wolgast (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines and supervisee satisfaction.	Survey, open ended and close-ended measures	151 trainees; majority counseling and clinical)	Supervisor fails to administer performance evaluations; Supervisor fails to provide supervisee with regular feedback on performance; Supervisor does not maintain confidentiality in supervision; Supervisor does not provide crisis coverage; Supervisor fails to maintain appropriate relationship boundaries.

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APPENDIX C

Sample Search Terms Entered into PsychInfo and PsychArticles Databases

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Counterproductive Events <AND> Supervision

Counterproductive <AND> Supervision <OR> Supervisory Relationship

Trainee <AND> Poor Supervision

Negative Experience <AND> Supervision

Negative <AND> Supervisory

Negative <AND> Supervision

Poor <AND> Supervisor <AND> Psychology

Conflict <AND> Supervision

Conflictual supervision <AND> Supervision

Harmful <AND> Supervision

Harmful Supervisor

Harmful Supervisor <AND> Orientation

Supervision <AND> Ethical

Supervisory Relationship <AND> Harmful <OR> Counterproductive

Ethical <AND> Supervision

Ethical <OR> Ethics <AND> Supervision

APPENDIX D

Q-sort item list: Counterproductive Experiences 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, i.e., too high or too low in light of the supervisee's experience and competence.

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

Inappropriate Supervisor Self-disclosure

Supervisor often discloses information about his/her personal life.

Supervisor discloses negative opinions about the supervisee's clients.

Supervisor discloses negative opinions about the profession.

Supervisor discloses personal disillusionment about his/her 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/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/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 not to 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 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.

Supervisor makes jokes/comments with sexual innuendos.

Supervisor expresses attraction to supervisee.

Additional Counterproductive Experiences

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 E

Cover Letter

CLINICAL SUPERVISION, TRAINING AND PROFESSIONAL DEVELOPMENT RESEARCH CENTER

Graduate School of Education and Psychology
Pepperdine University

Dear [Name of Expert]:

Based on your expertise in clinical training and supervision, you are invited to participate in a research project 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 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 experiences 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 F

Recruitment Letter: Experts in Clinical Supervision

Dear [Name of Expert]:

I am a student in the Doctor of Psychology Program at Pepperdine University. For my clinical dissertation, I have chosen to study counterproductive events that occur in the supervision between a licensed clinical supervisor and a trainee. This research project, *Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Experts in Clinical Supervision*, 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 expertise in supervision, 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. Participation in the study is voluntary and you may withdraw your participation at any point during the study.

Counterproductive experiences are events that may hinder the supervisee's growth, potentially compromise client welfare, and contribute to a poor experience of supervision (Hutt et al., 1983). The purpose of this study is to gather the information necessary for creating an initial scale of counterproductive 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, stack of cards with instructions, and two pre-paid self-addressed envelopes. I ask that you read the instructions, complete the Q-sort ranking, and mail the package using the 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 you participation will contribute to the field and the literature and will have an opportunity to share your expertise on supervision. While participation in the study was judged 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

my email address if 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 and your participation is greatly appreciated. Thank you, again, for your assistance with this research project.
Sincerely,

Heleya Kakavand, M.A.
Doctoral Student
Pepperdine University
6100 Center Drive
Los Angeles, CA 9004

APPENDIX G

Informed Consent for Participation in Research Activities

I, _____, authorize Heleya Kakavand 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 Experts in Clinical Supervision*. My participation in the study will take approximately 15 minutes to complete.

I understand that 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 I may choose to stop participating in the study at any time, for any reason, and there will be no adverse consequences to me. 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 events 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 based on my expertise in 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.

I understand that there are no direct benefits to all participants in the study, and I may benefit by knowing that my participation has contributed to a greater understanding of counterproductive experiences 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 you are reminded of events you may have engaged in or were 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 the principal investigator, Heleya Kakavand, M.A. I do not need to participate in this study to receive a copy of the abstract. I may also contact Heleya Kakavand, 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.

_____

Name of Participant (please print)

_____ _____

Participant's Signature Date

I have explained and defined in detail the research procedures in which the participant has consented to participate. Having explained this and answered any questions, I am co-signing this form and accepting this person's consent.

_____ _____

Principal Investigator's Signature Date

APPENDIX H

Instructions

You have received cards, each with a statement of counterproductive experiences (CEs) in supervision based on empirical and theoretical literature. These may or may not be events/experiences you have specifically experienced yourself. Imagine that the following event/experience occurred in supervision. Please sort each card in stacks in order of the impact of the counterproductive event/experience on the process of supervision between a clinical supervisor and a trainee supervisee. You can put as many cards in each category as you wish. The categories are as follows:

> Significant major effect: I believe this event/experience will significantly strain or rupture the alliance and have a major impact on the process of supervision
>
> Moderate effect: I believe this event/experience will produce a moderate strain on the alliance and have a moderate impact on the process of supervision
>
> Minimal effect: I believe this event/experience will minimally strain the alliance and have a minimal impact on the process of supervision
>
> No effect: I believe this event/experience will not strain the alliance and has no impact on the process of supervision

Step 1. Prior to placing the cards in the 4 envelopes, please read all the cards.

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

Step 3. You have been provided with a blank card. If applicable, please include in writing, a phenomenon of a 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 white pre-paid, addressed envelope you were provided with.

Step 5. Mail the white envelope, in its entirety, using United States Postal Service (USPS) mail.

APPENDIX I

Exemption Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

May 20, 2013

IRB# P0413D06
Study Title: Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Experts in Clinical Supervision

Dear Ms. Kakavand,

Thank you for submitting your application, Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Experts in Clinical Supervision, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Edward Shafranske, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.nihtraining.com/ohsrsite/guidelines/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

> (b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:
>
> **Category (2) of 45 CFR 46.101**, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

In addition, your application to waive documentation of consent, as indicated in your **Application for Waiver or Alteration of Informed Consent Procedures** form has been **approved**.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Doug Leigh, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University
Graduate School of Education & Psychology
6100 Center Dr. 5th Floor
Los Angeles, CA 90045
Doug.Leigh@pepperdine.edu
W: 310-568-2389
F: 310-568-5755

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Ms. Alexandra Roosa, Director Research and Sponsored Programs
Edward Shafranske, Graduate School of Education and Psychology