

Theses and Dissertations

2014

Development of a preliminary scale of counterproductive experiences in supervision : attitudes of clinical psychology doctoral students

Nina Grayson

Follow this and additional works at: <https://digitalcommons.pepperdine.edu/etd>

Recommended Citation

Grayson, Nina, "Development of a preliminary scale of counterproductive experiences in supervision : attitudes of clinical psychology doctoral students" (2014). *Theses and Dissertations*. 715.
<https://digitalcommons.pepperdine.edu/etd/715>

This Dissertation is brought to you for free and open access by Pepperdine Digital Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Pepperdine Digital Commons. For more information, please contact bailey.berry@pepperdine.edu.

Pepperdine University
Graduate School of Education and Psychology

DEVELOPMENT OF A PRELIMINARY SCALE OF COUNTERPRODUCTIVE
EXPERIENCES IN SUPERVISION: ATTITUDES OF CLINICAL
PSYCHOLOGY DOCTORAL STUDENTS

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Nina Grayson, M.A.

July, 2014

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

This clinical dissertation, written by

Nina Grayson

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.

© Copyright by Nina Grayson (2014)

All Rights Reserved

TABLE OF CONTENTS

LIST OF TABLES	vi
ACKNOWLEDGMENTS	vii
VITA	viii
ABSTRACT	ix
INTRODUCTION	1
BACKGROUND	2
Counterproductive Experiences in Supervision	6
Theoretical and Empirical Scholarship on Counterproductive Events in Supervision	8
PURPOSE AND IMPORTANCE OF STUDY	19
METHOD	21
Scale Development	21
Research Approach and Design	23
Participants	24
Instrumentation	26
Research Procedure	28
Recruitment	29
DATA COLLECTION AND ANALYSIS	35
RESULTS	36
Counterproductive Experiences in Supervision	37
DISCUSSION	43
LIMITATIONS	46
IMPLICATIONS FOR CLINICAL TRAINING	48

RECOMMENDATION FOR FUTURE RESEARCH.....	48
CONCLUSION.....	50
REFERENCES	51
TABLES	66
APPENDIX A: Counterproductive Experiences in Supervision Identified in the Literature.....	72
APPENDIX B: Demographic Questionnaire.....	85
APPENDIX C : Counterproductive Experiences in Supervision Based on Theoretical and Empirical Findings: 50 Items.....	87
APPENDIX D: Letter to Dr. DeMayo: Permission to Recruit Doctoral Students	91
APPENDIX E: Phase I Recruitment: Letter to Clinic Directors/Permission to Leave Packets ..	94
APPENDIX F: Phase I Recruitment: Center Letter.....	97
APPENDIX G: Phase I Recruitment: Letter to Doctoral Students	99
APPENDIX H: Phase II Recruitment: Letter to Practicum Instructors.....	102
APPENDIX I: Phase II Recruitment: Presentation/Letter to Doctoral Students.....	104
APPENDIX J: Phase II Recruitment: Follow-up Letter to Doctoral Students.....	107
APPENDIX K: Administration Instructions for Q-sort	110
APPENDIX L: IRB Exemption Notice	112

LIST OF TABLES

	Page
Table 1. Counterproductive Experiences in Supervision	66
Table 2. Top Quartile of Experiences Perceived to be Most Counterproductive in Supervision .	71

ACKNOWLEDGEMENTS

The completion of this doctoral degree and dissertation could not have been possible without the support of the following people. First and foremost, I'd like to thank my parents for seeing me through this journey and never losing faith in me. I would like to extend my gratitude to my dissertation committee for their efforts in seeing this research project come to fruition. Dr. Shafranske, your scholarly expertise has proven to be a valuable resource. Dr. Falender, your unflagging commitment to this study is greatly appreciated. Dr. Aviera, you are that *rara avis*, a truly special supervisor. I feel fortunate to have been mentored and guided by you over the years. A sincere thank you is in order to my first research mentor, without whom my career path as a psychologist would never have been taken. Dr. Shemesh, you recognized my eagerness to learn and gave me a great gift by providing me the opportunity to assist with your research protocols. Dr. Schafer, a wonderful clinical supervisor, many thanks for your encouragement and valuable advice. I am also grateful to the following GSEP faculty members for promoting my academic and scholarly development: Drs. Shelly Harrell, Darryl Rowe, Susan Himmelstein, Carolyn Keatinge, and Drew Erhardt- thank you for imparting your wisdom and knowledge. I would like to acknowledge Cheryl Saunders for her thorough responses to my countless administrative inquiries over the years. Similarly, I must extend my appreciation to Jay Carson, who has provided career guidance during and beyond my doctoral studies. My dear friends and fellow cohort members: Jenny, Katy, and Michelle...thank you for providing me with much appreciated moments of levity over the years. Shana, you are the very definition of a true friend... this dissertation could not have come to fruition without your unwavering support. Finally, my deepest gratitude and appreciation goes out to H. and J. Thank you both for linking arms with me along this journey and for giving me reason to smile every day.

VITA

EDUCATION

DOCTOR OF PSYCHOLOGY, Clinical Psychology
Pepperdine University, Graduate School of Education and Psychology,
Los Angeles, CA (APA Accredited Program)

MASTER OF ARTS, Creative Arts in Therapy, Drexel/MCP Hahnemann University,
Philadelphia, PA

BACHELOR OF ARTS, New York University,
New York, NY

CLINICAL & PROFESSIONAL EXPERIENCE

- 8/09 – 8/10 THE MAPLE COUNSELING CENTER,
Beverly Hills CA, *Doctoral Intern*
- 8/08 – 8/09 VETERANS AFFAIRS (VA) SEPULVEDA AMBULATORY CARE CENTER,
Outpatient Mental Health (OPMH) and Neuropsychology Clinic, Los Angeles, CA,
Pre-Intern
- 9/06 – 9/09 PEPPERDINE UNIVERSITY, WEST LOS ANGELES COMMUNITY
COUNSELING CENTER, Los Angeles, CA, *Clinic Therapist (9/06 – 9/09),
Assessment Clinician (5/08-8/09), Peer Supervisor (9/08 – 8/09)*
- 8/06 – 7/07 CHILDRENS HOSPITAL LOS ANGELES, Los Angeles, CA
STAR PROGRAM, School/Social Transition and Re-entry Program
Clinician/Pre-Intern and Group Therapist
- 9/05 – 7/06 EL RINCON ELEMENTARY SCHOOL- THE FAMILY CENTER, Culver City,
CA, *Clinician/ Pre-Intern*
- 1/05 – 8/05 LA METROPOLITAN MEDICAL CENTER, Locked psychiatric unit for acutely
mentally ill adult patients. Hawthorne, CA, *Psychiatric Rehabilitation Therapist*
- 9/03 – 8/04 HATHAWAY CHILDREN AND FAMILY SERVICES, Sylmar, CA
Level 12 residential facility for severely emotionally disturbed children and
adolescents, *Full-Time Day Treatment Clinician and Dance/Movement Therapist*
- 9/02 – 8/03 HAHNEMANN UNIVERSITY HOSPITAL, Philadelphia, PA
Psychiatric Medical Care Unit, 20-bed acute medical psychiatric unit
Dance/Movement Therapist
- 1/02 – 7/02 FAMILY LIFE EDUCATION COUNSELING SERVICES, Norristown, Pa
Partial hospitalization program for children and adolescents with behavioral issues,
Dance/Movement Therapist

- 9/01 – 12/01 GIRARD MEDICAL CENTER, Philadelphia, PA, *Dance/Movement Therapist*
- 9/99 – 8/00 MOUNT SINAI MEDICAL CENTER, New York, NY, *Sexual Assault and Violence Intervention Program Advocate*

RESEARCH EXPERIENCE

- 9/11 – 6/14 PEPPERDINE UNIVERSITY, Los Angeles, CA
“Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Clinical Psychology Doctoral Students.” *Principal Investigator*
- 9/06 – 4/08 CHILDRENS HOSPITAL LOS ANGELES, Los Angeles, CA
“Psychosocial outcomes in adolescent cancer survivors during the first five years of survivorship: A longitudinal study.” Principal Investigator: Kathy Meeske, Ph.D., *Research Assistant*
- 9/99- 8/00 MOUNT SINAI MEDICAL CENTER, New York, NY
“Assessment of emotional trauma in children who present to the emergency department.” Principal Investigator: Eyal Shemesh, M.D.
Research Coordinator, Co-Investigator

ABSTRACT

Clinical supervision is pivotal to the assurance of client welfare and in the development of clinical competency in the supervisee. In the process of guiding the professional and clinical development of supervisees, the supervisor monitors the provision of ethical and appropriate psychological care in order to promote the most successful clinical outcome for the client (Falender & Shafranske, 2004). However, there may be events or experiences that can lead to negative outcomes. Any event or experience that hinders the supervisee's exercise and development of clinical competence, potentially endangers the welfare of the client, and contributes to a poor experience of supervision is thought to be counterproductive (Ladany et al., 1999). A Q-sort methodology was used in this study to examine the beliefs, opinions, and viewpoints of fifteen doctoral students regarding the impact of 50 counterproductive experiences (CEs) gathered from theoretical and empirical literature in supervision practices. While some variability existed among participants, CEs from all categories of counterproductive events were found to have a moderate to significant major effect on supervision. In particular, items related to the supervisor's empathic and respectful treatment of supervisees were opined to have a significant impact on the process of supervision as well as experiences concerning the supervisor's lack of cultural sensitivity. The findings of this study have contributed to the development of a preliminary scale of counterproductive experiences in supervision.

Introduction

Clinical psychologists must have an extensive understanding of theory and research and the ability to apply that knowledge in clinical situations. It is through coursework in clinical psychology that the acquisition of science-informed knowledge, related to the assessment, diagnosis and treatment of mental illness, is transmitted. However, it is in the vivo context of clinical practicum or internship setting where practicum students, interns, and post-doctoral trainees apply this knowledge experientially, leading to the development of clinical competence. Clinical training provides the setting to develop key competencies, to be socialized into the culture of the profession, and to appraise career choice and area of interest (Pelling, Barletta, & Armstrong, 2009).

While one of the central aims of clinical supervision is to develop the trainee's clinical competence, the most critical priority of supervision is to promote and protect the welfare of the client, profession, and society (Bernard & Goodyear, 1998; Falender & Shafranske, 2004). In the process of guiding the professional and clinical development of supervisees, the supervisor monitors the provision of ethical and appropriate psychological care in order to promote the most successful clinical outcome for the client (Falender & Shafranske, 2004). The role that supervision plays in the integrity of client services and in the development of clinical competency in the supervisee cannot be underestimated. It is therefore imperative to understand more about the quality and nature of supervision that is being provided.

Best practices in clinical supervision (Falender & Shafranske, 2008; Kaslow, Falender, & Grus, 2012), safeguard the client and facilitate quality training leading to the development of clinical competence. However, there may be events or experiences that can lead to negative outcomes. Any event or experience that hinders the supervisee's exercise and development of

clinical competence, potentially endangers the welfare of the client, and contributes to a poor experience of supervision is thought to be counterproductive (Ladany, Lehrman-Waterman, Molinaro & Wolgast, 1999). In addition, such experiences may not only be counterproductive but actually harmful to the supervisee (Ellis et al., 2014), the process of supervision, and to the supervisory relationship, or the supervisory working alliance (Hutt, Scott, & King, 1983). Studies have indicated that counterproductive experiences have been found to negatively affect the supervisees' self-efficacy, limit the supervisees' level of disclosure in supervision, lower the level of supervisees' satisfaction in supervision, and influence the therapeutic process and outcome (Ladany et al., 1999; Ramos-Sanchez et al., 2002.)

In light of the importance of clinical supervision to client welfare and supervisee professional development, it is essential that a deeper exploration be conducted into the nature, frequency, and outcomes of counterproductive experiences in supervision. Such experiences include specific events or interactions in supervision as well as more general qualities or features of the supervisory relationship.

Background

This section presents the background of the study. We begin by defining clinical supervision and follow with a discussion of factors that contribute to its effectiveness, including the supervisory alliance. We will then explore the variables and experiences that play a role in ineffective or counterproductive supervision. Supervision is defined as a process in which a more experienced, licensed professional (supervisor) acts a mentor or guide to the supervisee (student), who is in the process of learning and practicing psychotherapy as well as other professional functions, i.e., psychological assessment, consultation (Bernard & Goodyear, 1998). The central aim is to enhance the supervisee's professional functioning through the process of imparting of

knowledge, skills, theory, and practice. The intrinsically hierarchical structure guides the process of evaluation and monitoring by the supervisor and serves as a protective measure for clients and the mental health profession (Milne, 2007). This tiered relationship, however, is complex in light of the importance of a collaborative process (Falender & Shafranske, 2004). Supervisors also serve as gatekeepers to the mental health profession. This role refers to the evaluation of student suitability for professional practice (Brear, Dorrian, & Luscri, 2008), and helps ensure that students who are unable to meet the performance standards necessary for entry into professional life, be prevented from practicing in this capacity (Behnke, 2005; Forrest, Elman, Gizara, & Vacha-Haase, 1999). Establishing a collaborative supervisory relationship while serving as an evaluator and gatekeeper can be a complicated feat for the supervisor; the inherent duality of this relationship may cause strain and rupture if not addressed properly (Nelson & Friedlander, 2001).

With a movement towards establishing supervision as a core competency (Falender & Shafranske, 2012; Kaslow et al., 2007), there is an increased concern with the variables and factors that go into creating effective supervisory experiences (Falender & Shafranske, 2004; Vespia, Heckman-Stone, & Delworth, 2002). An understanding of the numerous factors that contribute to both positive and negative supervision experiences can be helpful in establishing a framework towards this goal.

Effective supervision consists of an integration of helpful attitudes and practices that include incorporation of observation, evaluation, feedback, supervisee self-assessment, mutual problem solving, and instruction in the context of the supervisory alliance (Falender & Shafranske, 2004, 2008). Supervisor qualities/traits that contribute to a positive supervision experience include: supervisor supportiveness, skills in providing instruction, skilled

interpretation of clinical interactions, (Kennard, Stewart, & Gluck, 1987), empathy, non-judgmental attitudes, and non-defensive stances (Nelson & Friedlander, 2001). It is found that effective supervisors are those who are willing to self-reflect and examine their own assumptions (Nelson & Friedlander, 2001) while facilitating self-awareness, reflection, and self-efficacy in supervisees (Falender & Shafranske, 2004). Other factors that play into the development of a positive supervisory relationship involve the supervisor's integration of integrity in relationship, ethical values-based practice, appreciation of diversity, and evidence-based practice (Falender & Shafranske, 2004).

Supervision operates with a hierarchical dynamic. A challenge is integrating the hierarchy with the collaborative process that allows for the open communication of ideas. The creation and implementation of a collaborative supervisory atmosphere has been thought to be a contributor to *good* supervision (Selicoff, 2006). An interactive, collaborative development of the supervisory agreement or contract for informed consent is essential to the provision of *good* supervision, as is the clear communication of goals, performance expectations and tasks (Falender & Shafranske, 2004; Falvey, 2002; Sutter, McPherson, & Geeseman, 2002). The supervision contract, most specifically in relation to goal-setting practices, is a critical aspect of supervision as it correlates with a positive supervisory working alliance and to overall supervisee satisfaction with supervision (Lehrman-Waterman & Ladany, 2001). The effective supervisor consistently reviews supervisees' written case notes and audio/video recordings of client sessions, while providing ongoing verbal and written feedback and actively encouraging feedback from the supervisee (Falender & Shafranske, 2004, 2008).

Effective supervision involves the cultivation of a collaborative environment and sense of teamwork (Henderson, Cawyer, & Watkins, 1999). Studies investigating personal

characteristics of effective supervisors highlight that supervisors who are accepting (Hutt, Scott, & King, 1983), flexible, warm, genuine, and understanding (Carifo & Hess, 1987; Martin, Goodyear, & Newton, 1987; Nelson, 1978), approachable and attentive (Henderson et al., 1999), affirming and validating (Wulf & Nelson, 2000), and can make an empathic connection to the challenges that the supervisee must undertake while facilitating a supportive relationship (Nerdrum & Ronnestad, 2002; Worthen & McNeill, 1996), are all qualities essential for provision of effective supervision. Other personal factors found to contribute to effective supervision include supervisors who respect personal integrity, who are authentically interested in the supervisee and the supervision process, support autonomy in the supervisee (Henderson et al., 1999; Hutt et al., 1983), and promote supervisees' strengths (Heppner & Roehlke, 1984).

Among the factors considered critical to the implementation of effective supervision is the development of a strong supervisory working alliance. The supervisory working alliance (SWA) involves a bond or connection, concurrence on goals, and an agreement on tasks (Bordin, 1994). A fundamental aspect of supervisees' experience of good supervision is derived from the supervisory bond, a critical piece in the development of the supervisory alliance (Allen, Szollos, & Williams, 1986; Ellis, 1991; Heppner & Roehlke, 1984; Hutt et al., 1983; Kennard et al., 1987; Ladany & Lehrman-Waterman, 1999; Worthen & McNeill, 1996). From the supervisees' perspective, greater satisfaction with supervision is related to the presence of a supportive relationship and positive feedback (Allen et al., 1986; Efstation, Patton, & Kardash, 1990; Newman, Kopta, McGovern, Howard, & McNeilly, 1988; Selicoff, 2006). Some have posited that supervisors and supervisees who have strong emotional bonds encountered less emotional discord and role ambiguity suggesting that the supervisory dyads with a stronger supervisory working alliances are able to work through and resolve conflicts more easily (Ladany &

Friedlander, 1995). Findings show that students who perceive a strong supervisory working alliance tend to report satisfaction with supervision (Bahrack, 1990; Ladany, Ellis, & Friedlander, 1999; Ladany & Lehrman-Waterman, 1999). The supervisory working alliance has been associated with the supervisee's perception of therapeutic alliance (Patton & Kivlighan, 1997), supervisor style (Chen & Bernstein, 2000; Ladany, Walker, & Melincoff, 2001), increased supervisor self-disclosure (Ladany & Lehrman-Waterman, 1999), discussions of cultural factors in supervision (Gatmon et al., 2001). Unsurprisingly, when the supervisory alliance is perceived as negative, a greater dissatisfaction with the supervision is reported (Ladany et al., 1999). The supervisory alliance has been associated with an increase in well-being and job satisfaction, and a decrease in *burnout*, supporting the premise that the relationship with the supervisor is a critical component in supervision (Livni, Crowe, & Gonsalvez, 2012).

While efforts to identify elements that contribute to high quality supervision has gained momentum (Bernard & Goodyear, 2004; Cafiro & Hess, 1987; Feasy, 2002; Milne & James, 2002; Omand, 2010; Selicoff, 2006; Weeks, 2002; Worthen & McNeill, 1996), there is also interest in examining the nature and impact of negative supervisory events and experiences (Ellis, 2001; Ellis, Siembor, Swords, Morere, & Blanco, 2008; Gray, Ladany, Walker, & Ancis, 2001; Greer, 2002; Nelson & Friedlander, 2001; O'Conner, 2001). The following section discusses the nature of counterproductive experiences.

Counterproductive Experiences in Supervision

Counterproductive experiences (CE) in supervision include events or experiences that supervisees find to be hindering, unhelpful, or harmful in relation to their growth as therapists (Gray, Ladany, Walker, & Ancis, 2001). Ellis (2000, 2001) distinguishes between counterproductive and harmful supervision stressing that counterproductive or *bad* supervision

may occur when supervisor is incapable of meeting the supervisee's needs and is not necessarily harmful or traumatizing nature. The primary difference between counterproductive and harmful supervision is the result on supervisee (Ladany et al., 1999). Harmful supervision may include symptoms of psychological trauma (Orlinsky & Ronnestad, 2005), functional impairment in supervisee's personal and/or professional life; obvious loss of self-esteem, and debilitating general mental or physical health as a result of incident or experience (Nelson & Friedlander, 2001). Counterproductive experiences in supervision can be found to have far-reaching effects and result in a weakened supervisory alliance, an overall negative supervisory experience and potential to negatively impact the supervisee's clients (Ramos-Sanchez et al., 2002).

Supervisees' emotional responses to CEs can include feeling uncomfortable, upset, and unsafe (Gray, Ladany, Walker, & Ancis, 2001). CEs may impact the dynamics that that play out in the supervisory relationship, resulting in the supervisee becoming deferential, hypervigilant, withdrawing from the supervisory process, and less likely to disclose in supervision (Hess et al., 2008; Ladany et al., 1996).

It is posited that the impact of CEs may reach beyond the supervisory relationship, potentially adversely affecting the therapeutic process between the supervisee and their therapy clients (Gray et al., 2001). It is hypothesized that negative effects on the therapeutic process may potentially result in compromised service to the supervisee's clients. Extrapolating from detrimental effects of CES on supervisees, we can make the assumption that the experience of negative supervision may mirror the damaging effects of substandard therapy with clients (Ellis, 2001; Mays & Frank, 1985).

Increased conflict in supervision can lead to ruptures which, when left unaddressed, may result in a weakening of the supervisory alliance (Cheon, Blumer, Shih, Murphy, & Sato, 2009).

Supervisees have reported a supervisor's dismissive attitude to be a contributory factor to a poor supervisory alliance and found that this damaged the supervisory relationship and, further, led to change in the way they approached their supervisors (Gray et al., 2001). Poor supervisory alliances can affect many aspects of supervision including increased work related stress and greater supervisee dissatisfaction with their work (Sternier, 2009). A poor supervisory alliance may decrease the overall effectiveness of supervision (Hutt et al., 1983; Sternier, 2009; Ramos-Sanchez et al., 2002; Sternier, 2009).

Knowledge about the negative effects stemming from counterproductive experiences is required in order to (a) more fully understand the impact of such events on supervision and client welfare; (b) prevent these events from occurring and (c) train supervisors and future supervisors in ways to deal with these issues when, and if, they should arise. In order to study counterproductive events, a valid and reliable means to study the construct must be employed. Presently there are no empirically valid instruments by which to study this phenomenon, thus highlighting the need for the development of a systematic and empirical method to identify CE. This study intends to address this limitation by contributing to the development of a scale to measure counterproductive experiences in clinical supervision. The next section presents the results of a review of the literature pertaining to counterproductive experiences in supervision.

Theoretical and Empirical Scholarship on Counterproductive Experiences in Supervision

An examination of the literature has pointed to specific factors in supervision that have been recognized as CE. These factors include inadequate understanding of performance expectations for supervisee and supervisor/role conflicts, mismatch of supervisor and supervisee theoretical orientations, supervisee and supervisor use of disclosure, supervisor/supervisee styles,

cultural insensitivity, lapses in ethical behaviors, including boundary crossings, sexual violations, multiple relationships (See Appendix A). The following sections summarize these findings.

Inadequate understanding of performance expectations for supervisee and supervisor/role conflicts. Conflicts may arise when supervisors fail to address performance expectations of the supervisee and do not set clear and manageable goals. An understanding of the supervisees' developmental level of training and clinical experience is necessary to appropriately establish these goals (Stoltenberg & McNeill, 1997). Negative supervisory experiences may result from the inability of the supervisor to recognize and meet the specific needs of the supervisee. Supervisees at varying stages in their clinical experience and education need to learn how to confront and resolve specific crises and issues in order to advance to the next level of training. It is thought that at the beginning phase of training the supervisee often has had limited experience and is a period of heightened anxiety, vulnerability, and dependence on the supervisor. This stage later develops into a phase of increased skill, confidence and independence. Supervisors who are unable to address the developmental level of their supervisees and to structure the training experience accordingly may risk straining the supervisory relationship (Bernard & Goodyear, 1998; Stoltenberg & McNeill, 1997; Watkins, 1997, 2010).

Role conflicts. Clinical supervision is inherently hierarchical in that it consists of a more senior member of the profession providing supervision to a more junior member, while constantly evaluating and assessing the level and needs of that individual (Bernard & Goodyear, 1998). Throughout the training period supervisee 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 (Moskowitz & Rupert, 1983; Nellis, Hawkins, Redivo, & Way, 2011; Nelson, Barnes, Evans, & Triggiano, 2008; Nelson & Friedlander, 2001; Olk & Friedlander, 1992). Role conflicts or power struggles can arise when the supervisee is perceived to have greater status because of age, experience, or knowledge (Nelson, et al., 2008). If the supervisor is unaware of his/her own insecurity surrounding this issue it can lead to misuse of authority, causing tension in the relationship. An example of a counterproductive experiences regarding role conflict is seen when the supervisee disagrees with supervisor about implementing a specific technique but carries through with the recommended intervention in an effort to avoid conflict or negative evaluation (Olk & Friedlander, 1992). The relationship between supervisory alliance and role conflict has been examined, demonstrating that a strong supervisory alliance is associated with less supervisee role conflict and ambiguity (Ladany & Friedlander, 1995).

Inappropriate supervisor self-disclosure. Supervisor self-disclosures consist of offering the supervisee personal information about the supervisees' personal life, discussing their experiences in personal therapy or their own clinical work with clients, disclosing about past supervision experiences, and disclosing their personal thoughts and beliefs to the supervisees' clients (Falender & Shafranske, 2004; Ladany & Walker, 2003). Supervisor self-disclosures may ameliorate the supervision experience or, conversely, harm or hinder supervision, depending on the type and frequency of the disclosures. Positive supervisory experiences may flourish when

the supervisor's disclosure of past trial and errors serve to validate the supervisees' own struggles and demonstrate that professional growth can come from mistakes (Knox, Burkard, Edwards, Smith, & Schlosser, 2008; Ladany, & Lehman-Waterman, 1999). Findings also indicate that lack of supervisor self-disclosure can obstruct communication and negatively affect the supervisory relationship (Knox et al., 2008). There are numerous examples of inappropriate self-disclosure on the part of the supervisor including instances of the supervisor making the supervisees aware of conflict within the agency and remarking about other colleagues and staff (Nelson & Friedlander, 2001). Inappropriate, unethical, and harmful supervisor self-disclosure have been characterized as disclosures that are frequent and on-going and are transmitted primarily for the supervisor's own personal needs or gain (Ladany & Walker, 2003).

Supervisor supervision approach and supervisor supervision approach and supervisee learning approach mismatch. Supervisors' approach to the supervision process and their personal style of communication has been found to directly influence the supervisory working alliance (Chen & Bernstein, 2000; Ladany et al., 2001; Sumerel & Borders, 1996). Supervision satisfaction and supervisee self-efficacy can be predicted by supervision style (Fernando & Hulse-Killacky, 2005). Moscovitz and Rupert (1983) found that nearly 40% of all supervisees they surveyed had a major conflict with a supervisor connected to personality issues, supervisory style, or therapeutic techniques and approaches. Supervisees report negative supervision experiences when they perceive their supervisor as being rigid (Allen et al, 1986; Hutt et al., 1983; Kennard et al., 1987; Nelson, 1978), critical (Allen et al., 1986; Hutt et al., 1983; Nelson, 1978), and inattentive (Chung, Baskin & Case, 1998; Shanfield, Matthews, & Heatherly, 1993). Allen et al. (1996) discovered that supervisees' worst experiences in supervision consisted of authoritative or demeaning behavior or attitudes from their supervisors.

This type of supervision may have weakened supervisees' self-efficacy and their readiness to admit mistakes. Nelson and Friedlander (2001) examined supervisory experiences that supervisees perceived to have had disadvantageous effects on their training. Supervisees felt that supervisors they perceived as too busy, remote or uncommitted to the training relations contributed to their negative perception of supervision. An example of a mismatch in styles can be seen when the supervisor prefers to use an authoritarian style and the supervisee seeks a more collaborative supervisory relationship (Allen et al., 1986; Barrett & Barber, 2005).

Supervisor/supervisee theoretical orientation mismatch. Examples of theoretical orientation supervision conflict are seen in a differing of diagnosis, case conceptualization and treatment planning, and other aspects (Hess, Hess, & Hess, 2008). Differences in theoretical perspectives may dictate the styles and approach in which the supervisor communicates, e.g., autonomous, directive, and collaborative (Allen et al., 1986; Hess et al., 2008; Kennard et al., 1987). Interpersonal conflicts can arise when supervisees believe that a different therapeutic technique than that suggested by their supervisors might be more beneficial.

Supervisor/supervisee theoretical mismatching may result in the supervisee feeling discounted or dismissed. Criticism of the supervisee's theoretical orientation can be counterproductive to supervision. In some instances, to avoid clashing with the supervisor or incurring a negative evaluation the supervisee might agree to implement the supervisor's technique even though they are at odds with the supervisor's belief (Olk & Friedlander, 1992). This divergence may cause ruptures or conflict in the supervisory alliance.

Cultural insensitivity. Multicultural competency has been thought of as a critical component in helping supervisees conduct ethical and essential practice with diverse clients (Ancis & Ladany, 2001; Fukuyama, 1994). An important supervisory responsibility includes

focus on the supervisee's sensitivity and insight into diversity issues (Barnett, Erickson, Cornish, Goodyear & Lichtenberg, 2007; Constantine, 2001). Cultural sensitivity as part of multicultural supervision involves the development of cultural awareness, exploration of the cultural dynamics of the supervisory relationship, and discussion of the cultural assumptions of traditional theories (Fong & Lease, 1997; Robinson, Bradley, & Hendricks, 2000).

Certain supervisory behaviors may positively influence the supervisee's development of multicultural competence (Toporek, Ortega-Villalobos, & Pope-Davis, 2004). Research on multicultural supervision suggests that increasing discussion of cultural issues can enhance the supervisory relationship or working alliance (Constantine, 1997), help supervisees perceive their supervisor as more credible, and enhance supervisees' satisfaction with supervision (Inman, 2006; Silvestri, 2003; Tsong, 2005; Yang, 2005). Supervisor qualities and methods of communicating in regards to multiculturalism may play a part in enhancing the overall supervision process and outcome. Supervisees who perceive their supervisors open, accepting, and flexible in regards to discussion and processing of multicultural issues, may feel more comfortable and disclosure more frequently in supervision, (Ancis & Marshall, 2010). This, in turn, may positive affect client outcomes (Ancis & Marshall, 2010).

Racial identity in supervision, or how supervisees think and feel about their own race in conjunction with their supervisor's race, has also been examined (Cook, 1994). Findings show that supervisees who perceived their supervisor to share their own level of racial identity helped strengthen the supervisory working alliance and the supervisee's development of multicultural competence, (Ladany, Brittan-Powell, & Pannu, 1997). Conversely, a lack of concord in terms of priority given to racial issues creates discord may weaken the supervisory alliance (Ladany, et al., 1997). Supervisors who demonstrate deficits in multicultural competency can have negative

effects on the supervisee and by extension, the supervisees' client.

Fukuyama's (1994) investigation into supervisory experiences involved inquiring about critical incidents from ethnic minority supervisees who had completed an internship. Participants described positive critical incidents to include openness and support in supervision, culturally relevant topics discussed in supervision, and opportunities to work with multicultural activities. Negative critical incidents included lack of cultural awareness by supervisors and supervisors who questioned the abilities of the participants. Overall, supervisees' satisfaction with supervision was reported as lower when supervisors did not discuss multicultural issues (Gatmon et al., 2001). When cultural issues are ignored, discounted or treated insensitively by the supervisor (Burkard et al., 2006; Hird, Cavalieri, Dulko, Felice & Ho, 2001) or when the supervisor is viewed as lacking multicultural expertise (Killian, 2001), results can contribute to a negative supervisory experience.

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 at their developmental level and can contribute to creating an atmosphere of frustration and conflict (Barret & Barber, 2005; Chung et al., 1998; Magnuson et al., 2000).

Inadequate attention to ethics, ethical lapses and unethical behavior. Clinical supervision is a crucial environment for practical learning in how ethics are applied and is the foundation by which supervisees understand their legal and ethical responsibilities to clients, the

profession, and the public. In their roles as guide, mentor, and role models, the clinical supervisor must possess a thorough knowledge of the laws and guidelines contained in the APA Code of Ethics in their role as supervisor (Harrar, VandeCreek, & Knapp, 1990). Unethical supervision is encompassed within the framework of harmful or counterproductive supervision (Ellis et al., 2008). Ethical breaches have been found to adversely affect supervisees in a multitude of ways including: negatively impacting the supervisory alliance and relationship (Ladany et al., 1999; Ramos-Sanchez et al., 2002), harming the supervisees' emotional well-being (Gray et al., 2001; Nelson & Friedlander, 2001), creating supervisee self-doubt, self-criticism, and anxiety (Orlinsky & Ronnestad, 2005), and damaging the supervisees' understanding of ethical behavior (Goodyear & Rodolfa, 2012).

Ladany et al. (1999) identified areas of supervision that ethical guidelines must be attended to. These include performance evaluation, monitoring of supervisees' activities, confidentiality, ability to work with alternative perspectives, session boundaries and respectful treatment, orientation to professional roles and monitoring of site standards, expertise and competency issues, disclosure to clients (limits of confidentiality), modeling ethical behaviors, responding to ethical concerns, crisis coverage and intervention, multicultural sensitivity towards clients, dual roles, termination and follow-up issues, differentiating supervision from psychotherapy, and sexual issues. Violations in these areas have the potential to damage the working alliance in the supervisory relationship, contribute to conflict, and may have harmful effects on the supervisee, and ultimately on the provision of effective and ethical client care.

Boundary violations, boundary crossings and multiple roles in supervision. Multiple relationships frequently occur between supervisors and supervisees. Supervisors inherently play multiple roles where they may teach, consult, or counsel, all within the supervisory relationship

(Bernard & Goodyear, 2004). These relationships are not unethical per se (APA Ethics Code Standard 3.05[a]) and can often be helpful to the supervisory relationship and benefit the supervisee (Lazarus & Zur, 2002). The development and maintenance of multiple relationships in supervision can be a slippery slope. Pope and Keith-Spiegel (2008) noted, “Nonsexual boundary crossings can enrich psychotherapy, serve the treatment plan, and strengthen the therapist-client working relationship. They can also undermine the therapy, disrupt the therapist-patient alliance, and cause harm to clients” (p. 638).

Ethical breaches in multiple relationships can occur when supervisor loses objectivity or there is a risk of exploiting supervisee (Koocher, Shafranske, & Falender, 2008). Vulnerability and risk of exploitation increase when multiple relationships entail greater role incompatibility (Kitchener, 1988). The Canadian Psychological Association Ethical Guidelines for Supervision in Psychology: Teaching, Research, Practice, and Administration (CPA, 2009), recommends that supervisors should “avoid all forms of exploitation or actions that harm the supervisor or supervisee, and that do not serve the objectives of supervision. These include financial, sexual, gossip, blackmail, false allegations, and coercion in the supervisory and the work relationships” (p.8).

The ethically aware supervisor is cognizant of the boundaries that play a part in the ethical and appropriate provision of supervision. Scholarly examination of boundary issues in supervision has led to differentiation between boundary crossings and violations (Barnett, 2007; Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson 2007; Blevins-Knabe, 1992; Gabbard & Lester, 1995; Gutheil & Gabbard, 1993; Lazarus & Zur, 2002). Boundary violations are thought to be intrinsically unethical and have an elevated probability of causing harm. Examples of boundary violations include sexual relationships between supervisees and

supervisors, failure of the supervisor to maintain confidentiality, and failure to adhere to ethical guidelines regarding evaluation and monitoring of supervisee activities (Ladany et al., 1999). In contrast, boundary crossings are somewhat more ambiguous in definition and may or may not be considered unethical. Boundary crossings and violations are departures from standard supervision practice; however, a boundary crossing may be a pre-meditated exception to the rule based on the supervisor's belief that there would be a low likelihood of causing harm and a great benefit to that person (Thomas, 2010).

Engaging in multiple relationships can be considered inappropriate and ethically unsound when the supervisor asks the supervisee to perform duties and roles outside the description of supervisee. As is the case with dual role relationships between therapist and client, there is an increased chance that educators will lose their objectivity and make student evaluations and other decisions that are not in the best interests of the student (Pope, 1989; Pope, Shover & Levenson, 1980). Furthermore, students well aware of the power and influence of educators may make choices based on their perceptions of what educators want in an effort to mollify them. Audi (1990) posits that "the very invitation to join a professor in a purely social activity may be felt to be hard to refuse, or even coercive" (p. 128).

Examples of inappropriate multiple include supervisors initiating friendships with supervisees and/or socializing with them, confiding in the supervisees, or using the supervisee as a sounding board (Holmes, Rupert, Ross, & Shapera, 1999; Nelson & Friedlander, 2001). Boundary crossings can occur in the assumption of multiple roles when the supervisor treats the supervisee like a client, pathologizes the supervisee, and blurs the line between supervising and therapy, (Kitchener & Harding, 1990; Sherry, 1991). Boundary crossings can also occur when supervisors expose supervisees to internal conflict within the internship, setting the stage for

potential ethical issues (Nelson & Friedlander, 2001).

There is a consensus that multiple or dual relationships of a sexual nature in the supervisory relationship should not be permitted and can be harmful. Sexual boundary violations are considered one of the most critical ethical infringements in the mental health profession. The APA Ethics Code prohibits psychologists from having sexual relationships with “students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority” (APA, 2002, p.10). The power imbalance inherent in the structure of the therapist-patient, teacher-student dyads, and supervisor-supervisee dynamic renders any erotic contact between these dyads unethical and harmful (Celenza, 2007; Thomas, 2010). The clinical supervisor can become a model for abuse of power, demonstrating through his or her actions that it is acceptable to place one's own needs ahead of the needs of a student or a client with whom one is working with (Bartell & Rubin, 1990; Conroe & Schank, 1989). Additionally, the student may be reluctant to raise various issues in supervision for fear that the supervisor will see this as an invitation to initiate a more intimate discussion of the student's personal life (Brodsky, 1980). Thus the student's opportunity to learn is constricted and the client's treatment is affected. Lastly, the clinical supervisor may lose the ability to fairly evaluate the student or the student may believe his or her future career is reliant on her/his acquiescing to the supervisor (Conroe & Schank, 1989).

Examples of sexual violations are observed when the supervisor: initiates conversations or asks questions about supervisee's dating/sexual life, actively pursues a relationship with the supervisee, and makes sexual innuendos and comments, (Glaser & Thorpe, 1986; Koenig & Spano, 2003; Lamb, Catanzaro, & Moorman, 2003; Pope, Keith-Spiegel & Tabachnick, 1986; Zakrewski, 2006). When sexual relationships take place between supervisor and supervisee it is

considered coercive and harmful, ultimately leading to a deleterious effect on the working relationship (Glaser & Thorpe, 1986; Hammel, Olkin, & Taube, 1996; Miller & Larrabee, 1995; Ladany et al., 1999), as well as impacting the entire training group and staff members (Slimp & Burian, 1994). It has also been suggested that dual-role relationships of a sexual nature between educators (supervisors) and students may contribute to the occurrence of therapist-client dual role sexual relationships (Folman, 1991; Kitchener, 1992; Pope, 1989; Pope et al., 1980).

Additional counterproductive experiences. There are additional experiences in supervision thought to be counterproductive that do not readily fall under specific categories. These experiences include supervision that is conducted in an atmosphere where there is insufficient office space or lack of privacy, (Magnuson et al., 2000), instances where the supervisee is not assigned the appropriate number of clients (too few, too many) that was denoted during the application process or the onset of training, inflexibility in scheduling, instances where the supervisor frequently cancels supervision or is often late for supervision, instances where the supervisor uses the supervision session to discuss matters that are not germane to supervision of the supervisee, instances where the supervisor does not address miscommunications, instances of administrative constraints, instances where the supervisor appears unmotivated (Veach, 2001), instances where the supervisor displays lack of respect for the supervisee, instances where supervisor discloses negative opinions about supervisee's peers, colleagues, staff members, or other personnel associated with the clinical site, and instances where the supervisor does not document supervision.

Purpose and Importance of Study

Clinical supervision plays a significant role in the development of the student trainee, welfare of the client, and the protection of the public and the profession (Alonso, 1983; Bernard

& Goodyear, 1998; Falender & Shafranske, 2004; Hess, et al., 2008; Ladany, Friedlander, & Nelson, 2005; Lambert & Ogles, 1997; Loganbill, Hardy, & Delworth, 1983; Watkins, 1997; Worthington, 1987). Without the provision of effective and competent supervision, there is a danger that supervisees will not acquire the skills and knowledge necessary to become clinically competent therapists, and, ultimately will have detrimental effects on client care and outcome. Counterproductive experiences in supervision have been shown to erode the supervisory alliance, contribute to work related stress, and supervisee dissatisfaction with their work. Additionally, ineffective or harmful supervision can potentially jeopardize the welfare of the client (Gray et al., 2002; Ramos-Sanchez, et al., 2002; Sterner, 2009).

There is still a void in the research in the area of counterproductive experiences and how these events and experiences shape the supervisory process, supervisee development, alliance and outcomes. Previous studies have paved the way in the quest for scholarly inquiry into this subject, giving us valuable insight into this phenomenon (Allen et al, 1986; Chung et al., 1998; Ellis, 1991; Ellis et al., 2008; Greer, 2002; Hutt et al., 1983; Kennard et al., 1987; Ladany et al., 1999; Ladany et al., 2001; Moskowitz & Rupert, 1983; Olk & Friedlander, 1992; Ramos-Sanchez et al., 2002). Still, many questions remain unanswered. One important step is the development of an empirically valid and reliable means of identifying counterproductive experiences. This study intends to address this limitation by contributing to the development of a scale to measure counterproductive events in clinical supervision. Specifically, this study through the use of a Q-sort procedure will identify experiences that doctoral clinical psychology students characterize as counterproductive.

Method

The objective of this investigation was to extend our knowledge base regarding the role of counterproductive events and experiences in supervision. In particular, this study sought to broaden our understanding of how these events may impact the supervisory alliance, the overall supervisory process, and client outcomes. Through the development of a valid self-report measure of counterproductive experiences in supervision (CES), future researchers may be able to gain insight into this phenomenon. This section presents an overview of the development of such a scale and the methods and procedures used to achieve this goal.

Scale Development

The primary goal of scale development is to create a valid measure of the underlying property or latent structure of a construct (Clark & Watson, 1995). In order for a construct to be measured the phenomenon must be defined. An operational definition sets the limits for the scale and is designed for researchers to observe and measure a variable. The operational definition used in this study, “counterproductive experiences in supervision”, is defined as: “events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisee’s growth, and contribute to a poor experience of supervision adversely affecting its effectiveness”.

Scale development is constructed using a series of stages. The following stages are compiled from the literature (Clark & Watson, 1995; Cronbach, 1951; DeVellis, 2012). To start, researchers must determine the purpose of the scale. Following this they generate a pool of items that are candidates for eventual inclusion in the scale, deciding format of measurement (i.e., checklist, declarative items, or scales with equally weighted items). The item pool is drawn from items collected based on literature review, theory, and other tests and inventories, and

observations. In formulating the items, there are several factors that are important to consider.

The following outlines these principles:

1. Each item should express only one idea (avoid double-barreled questions that asks respondents to react to two or more parts of the statement).
2. Use statements that are both positive and negative. This reduces response bias of participants and requires them to slow down and read each item rather than responding the same to items written in one direction.
3. Use language that matches the audience's reading level and avoid jargon.
4. Avoid sensitive wording that may bias respondents.
5. Avoid using negatively worded items.

An initial phase involves employing a group of experts who specialize in the subject area to review the items and rate the relevance of each item in relation to what it intends to measure.

Validation measures may be included to evaluate motivations that might sway responses. A small sample that represents the population for which the scale was intended should then be administered the items in order to accrue opinion and feedback on items and format.

Administering the scale to a small representative group before giving the scale to the respondents can help to identify potential problems in wording, format and conceptualization. At this juncture the items are evaluated to determine which will comprise the scale. Finally, the optimal scale length is determined. If the development sample is large enough it may be feasible to halve the sample into two subsamples so that one sample could serve as the primary development sample and the other can be utilized to substantiate the results.

The overarching aim of the research involved completing the four phases of scale development using: licensed clinical supervisors, experts in the field of supervision, and doctoral

students in clinical psychology as subjects. This initial exploratory study focused specifically on doctoral students in clinical psychology and solicited their opinions regarding experiences that constitute counterproductive experiences in supervision.

The development of scale items was identified by a literature search of theoretical and empirical literature. Following the development of the list, a sample of doctoral students was recruited to sort the list of CEs using the Q-sort method. The following sections present the research design, participants, instrumentation, procedures, and data analysis plan.

Research Approach and Design

This study utilized a ranking methodology to obtain information from doctoral students regarding their viewpoints about the impact of counterproductive experiences (CEs) on supervision. A Q-sort methodology, originally conceptualized and developed in the 1950s and 60s (Block, 1961; Stephenson, 1953), was chosen as a means to assess this phenomenon. A Q-sort method, a system of assessing reliability and construct validity of questionnaire items that are being prepared for survey research, was used to develop a preliminary scale of CES. The purpose was to establish an initial set of items with which to measure the construct, *counterproductive experiences in supervision* (CES).

Q-methodology enables the systematic study of subjectivity, people's viewpoints, attitudes, and beliefs. A Q-sort is a forced-rank data collection method in which the participants report the structure of their belief system (Brown, 1980). The Q-sort method is a repetitive process in which the degree of agreement between judges forms the basis of assessing construct validity and improving the reliability of the constructs. The set of items that appear after the participant's rankings are concluded are thought to measure the participant's beliefs about the particular topic that's being evaluated. The ranking of beliefs provides more information than

traditional measures, such as self-report scales, which simply identify the strength of the agreement or disagreement with specific statements or adherence to standards. The benefit of using a Q-sort is predicated on the value of a scale that can establish priority of beliefs. In using a Q-sort as the primary instrument, some of the shortcomings of a questionnaire data are eliminated. Q-sort methodology lessens participant's perceptions of researcher expectations (Shinebourne & Adams, 2007). Another advantage of using the Q-sort method is that it has an ability to isolate and statistically compare opinions and beliefs (Block, 1961). The standardization inherent in the making of the Q-sort encourages examination of responses that are interconnected, rather than being a gradual evaluation of each distinct question and response (Brouwer, 1999). Additionally, the category for each belief is not imposed by the researcher, but instead is drawn out from the participant's responses (van Exel & de Graaf, 2005). This allows for reduction in bias because the participant is not attempting to deduce the researcher's preferred answer. The statistical analysis methods of the Q-sort procedure produces information that can directly be equated to the participant's beliefs and characteristics (van Exel & de Graaf, 2005), and can generate a score capable of comparison to survey and observational scores (McKeown & Thomas, 1988; van Exel & de Graaf, 2005). Another strength of Q-sort methodology is that the instructions for self-administration are uncomplicated, confidentiality can be guaranteed, and the data gathering is standardized.

Participants

The participants who complete the Q-sort are identified as the P-set (van Exel de Graaf, 2005). For the purpose of this study, the P-set consisted of 1st, 2nd, and 3rd year doctoral students enrolled in a doctoral-level clinical psychology program. This study, conducted in collaboration with other research projects under the auspices of the *Clinical Supervision, Training, and*

Professional Development Research Center, at Pepperdine University, shared the united objective of developing a scale designed to measure the construct, *counterproductive experiences in supervision* (CES). The associated studies focused on the opinions of experts in the field of psychology, and directors of training of clinical psychology sites. As representatives of the population for which the scale is being developed, doctoral students in clinical psychology are well positioned to assist in identifying counterproductive experiences and events that occur in supervision. In their roles as *consumers* of supervision, they can directly reflect on their first-hand experiences to sort and rank their opinions about experiences that are considered counterproductive in supervision. In addition to data from doctoral students, the opinions of experts in the field of supervision (published researchers) may help provide insight into this topic based on years of professional experience conducting scholarly research. Further, the data examined from directors of training programs, who supervise trainees and also manage entire training programs, will serve to widen the scope of information concerning the beliefs, opinions, and values about counterproductive experiences in supervision. When examined as a whole, these opinions (opinions of doctoral students, experts, and directors of training) will provide valuable information from the vantage points of multiple perspectives.

A Q-sort does not require scores of participants in order to be effective. The goal of this method is to clarify core opinions of the subject group and reveal a range of viewpoints (Brouwer, 1999; Dziopa & Ahern, 2011). Therefore, only a small sample of doctoral students in clinical psychology was needed to obtain the necessary data. Approximately 89 doctoral students in their 1st-3rd years of training were invited to participate in the study via email recruitment and classroom presentations. Fifteen students (17 %) participated in the study. The 15 doctoral students who chose to participate were given a set of stimuli (the Q-sample), and were asked to

sort these items based on the four viewpoints of the CEs (significant major effect, moderate effect, minimal effect, no effect).

Instrumentation

Demographic questionnaire. This form was developed by the investigator and consisted of questions inquiring about relevant demographic information. The questionnaire asked for the participant's demographic information including theoretical orientation, year in graduate program, and information describing the last clinical practicum where the participant was supervised (i.e., VA, clinic, hospital setting, community based internship sites, child v. adult populations, etc.). This section contained both closed and open-ended questions with a supplementary section for the participant to provide any additional information pertaining to responses coded "other". In the second phase of recruitment (Phase II), the majority of the participants did not return the demographic questionnaires with the completed protocols. While the demographic questionnaires are not considered critical to the initial stages of development of the CES scale, the information obtained from this form could have proved useful in contributing to future research (See Appendix B).

Q-sample. In Q-sort terminology, the research instrument is the set of opinion statements, about a topic called a Q-sample.

Identifying a concourse. The concourse refers to the field of all possible opinions about a particular topic. It includes the pool of material used for identifying the statements or questions that will comprise the Q set for participants to sort during data collection. From the concourse, the researcher selects a representative sample of statements called the Q-set and puts each item on a card. The participants, collectively called the P-set, sort the cards in a process called the Q sort (Brouwer, 1999). For the purpose of this study, the concourse has been circumscribed as

counterproductive experiences in supervision. A thorough examination of the theoretical and empirical literature was reviewed to identify experiences that are considered to be counterproductive in clinical supervision.

Developing a Q-set. The Q-set consists of a sample of statements about a topic. The items that comprise the Q-sort are known as the Q-set (van Exel & de Graaf, 2005). The Q-statement is the question that is being asked. The Q-statement must be clearly defined and must ask only one question. Q-sorts are generally composed of between 40-80 items (Brown, 1980; Watts & Stenner, 2005). Q-sorts with fewer than 40 items are not broad enough to allow participants to draw different opinions. Greater than 80 items in a Q-set is thought to be too broad and becomes challenging for participants to narrow down beliefs.

For the purpose of this study, the Q-set contained 50 items to represent each question being asked (See Appendix C). The two types of Q-sets are naturalistic and ready-made (McKeown & Thomas, 1988). Naturalistic Q-sets are derived from the concept of interest and include items developed from interviews, observations, and review of literature. Ready-made Q-set items are taken from a secondary source because they usually are culled from pre-existing rating scales or questionnaires (McKeown & Thomas, 1988). This study developed a naturalistic Q-set drawn from the review of literature regarding counterproductive, negative, or harmful experiences in supervision.

Specifying the P-set. In this study, the target population consisted of 1st, 2nd, and 3rd year doctoral students from an APA clinical psychology doctoral program. These subjects were given instructions known as “conditions of instructions” for the Q-sorting process. There is some debate over the appropriate size of the P-set, with some theorists holding to the conviction that the number of participants in a Q-sort should be significantly smaller than the number of Q-set

items, and others supporting the premise that additional participants lend strength to factor interpretation (Brouwer, 1999). This study, in accord with views of the minimalist theorists, hoped to be able to yield data from groups of at least 4 or 5 individuals for defining each individual viewpoint. In initial stages of recruitment (Phase I), only 1 student elected to participate, rendering the study invalid. After a second recruitment phase (Phase II), the final number of participants in this study, the P-set, consisted of 15 doctoral students.

Procedure for administration of the Q-sort. To administer the Q-sort, the investigator gives participants a deck of cards with each card containing one of the specific topic items drawn from the research. The participant is asked to appraise each item and rank it based on their conviction about the item's adherence to a particular attitude, belief, or principle. Generally, Q-sorts have a pre-established distribution so that participants have demarcated locations as to where the items can be placed, within limits. The placement of items is called Q-sorting (Brown, 1980). The items that are included are provided as objects of opinion only, with no right answer being imposed upon the participants (Brown, 1993).

Research Procedure

This section will cover the domains of subject recruitment, human subject protection, instructions, and data collection. The chosen research methodology, Q-sorting by self-administration, was selected as the preferred means of obtaining the opinions of doctoral students. The self-administration Q-method is a valuable assessment tool used to efficiently measure subjective attitudes, opinion and beliefs of individuals. Q-methodology studies have traditionally relied on face-to-face administration to lead participants correctly through the steps involved in the Q-sorting process. The cost and time commitments of one-on-supervision limit Q-methodology's potential applicability to geographically scattered samples (Reber, Kaufman,

& Cropp, 2000). The self-administered Q-sort is cost effective and that requires less effort to administer when compared to Q-sorts administered in-person (Dziopa & Ahern, 2011).

Recruitment

Prior to recruiting participants, the researcher contacted Dr. DeMayo, Associate Dean of the Graduate School of Education and Psychology at Pepperdine University, to request permission to recruit students (See Appendix D). Once approval was received, the researcher applied for permission from the Institutional Review Board (hereafter referred to as IRB) of the Graduate and Professional Schools at Pepperdine University. After receiving approval from the IRB, an initial recruitment phase (Phase I), was conducted. In the initial phase of the study, recruitment criteria limited the participants to 2nd and 3rd year doctoral students, based on the belief that students who had experienced at least a year of clinical training and supervision in a doctoral program would have a greater breadth of experience to draw upon when asked to rank their beliefs about counterproductive experiences in supervision. In this first phase, packets containing the relevant study materials were provided in four different locations affiliated with the Pepperdine University clinical psychology doctoral program. This was done, in part, to make the Q-sort study accessible to students who may spend the majority of their time in these different campus locations. These sites included: the Encino Community Counseling Clinic, the West Los Angeles Community Counseling Clinic, the Jerry Butler/Mental Health Clinic, and the West Los Angeles Pepperdine Psy.D. student lounge.

Prior to embarking on recruitment, the researcher contacted the Directors of the Community Counseling Centers at Pepperdine University to ask permission to leave the packets at their clinical sites for student pick-up (See Appendix E). Of the four Pepperdine Counseling Clinics, permission to leave packets was granted at three of the locations (described above). The

next part of the recruitment phase involved contacting current students in their 2nd and 3rd year of the doctoral program via email and printed announcements. The recruitment e-mail consisted of two parts: (a) a Letter from the Clinical Supervision, Training, and Professional Research Center (See Appendix F), and, (b), a Letter of Introduction which provided a description of the study, a request for participation, and instructions describing the different locations where the study material could be retrieved (See Appendix G). Cheryl Saunders, the Psy.D. Program Administrator at Pepperdine University, forwarded this email to all 2nd and 3rd year students. Additionally, a printed announcement containing the same information was placed in the mailboxes of these students. The study packets contained the following information: one copy of the recruitment letter describing the study and the benefits and risks involved, procedural instructions for submitting the completed material, the stack of Q-sort cards with instructions, and one empty manila envelope for participants to place the completed forms. The outside of the manila envelope displayed a label with the names: Nina Grayson, Principal Investigator, and Dr. Edward Shafranske, Dissertation Advisor. Participants were instructed to place the envelope containing the completed data into an inter-campus mail envelope with the participant's name and Cheryl Saunder's name on the outside. The instructions included in the packets clearly informed the participants that the inner envelopes and the accompanying material would not contain any identifying information, thereby ensuring that the participants will remain anonymous. Students were instructed to mail the completed study packets via inter-campus mail to the mailbox of Cheryl Saunders, Psy.D. Program Administrator. After receiving the packets, Ms. Saunders removed the outer inter-campus envelope containing the participant's names on the outside. At this point the researcher retrieved the inner envelopes containing the completed study material from Ms. Saunders.

Due to a lack of response from participants in this initial phase, an alternative method of recruitment was necessary to gather data and complete the study. To this end, a second stage of recruitment was established with the goal of obtaining an adequate number of participants to create a valid P-set. In Phase II, an application describing modifications to the study and requesting permission to proceed was sent to the IRB. The modifications included extending participant criteria to include 1st, 2nd, and 3rd year students with the aim of reaching a broader population. Additionally, procedures related to submission of completed materials were simplified. Finally, the use of an incentive in the form of a Starbucks gift card was included in the study packets. After receiving a second approval from the IRB, the researcher emailed a request to all Psy.D. practicum instructors. This email provided an overview and description of the study and requested permission to give a 5-6 minute presentation to doctoral students in their practicum classes (See Appendix H). Once permission was obtained, the researcher gave a brief presentation in several of the 1st, 2nd, and 3rd year practicum classes. The presentation consisted of a description of the study, the benefits and risks involved, instructions explaining where students could pick up the study packets, as well as procedures for returning the completed protocols (See Appendix I). Following the presentation a short interval was allotted for question and answers.

Students were informed that the study packets were available in the Psy.D. Student Lounge located at the West Los Angeles campus of Pepperdine University. The packets contained the following information: one copy of the recruitment letter describing the study and the risks and benefits involved, the stack of Q-sort cards with instructions, and one empty envelope for participants to place the completed forms. The outside of the envelope displayed a label with the names: Nina Grayson, Principal Investigator, and Dr. Edward Shafranske,

Dissertation Advisor. Students were instructed to place the completed packets in the mailbox of Cheryl Saunders, Psy.D. program administrator. The researcher then retrieved the submitted data from Ms. Saunders. A follow-up e-mail was sent to students two weeks after the presentations (See Appendix J).

Instructions. The conditions of instructions specific to this study involved provided written instructions with the following information: “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 you have specifically experienced yourself. Imagine that the following experience occurred in supervision. Please sort each card in stacks in order of severity of counterproductive impact on the process of supervision between a licensed clinical supervisor and trainee. You can put as many cards in each category as you wish.” The categories are listed as:

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

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

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

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

The participant was asked to read all the cards and make a preliminary sorting into three piles that represented the items the participant feels most strongly about being problematic, the items the participant feels are less problematic, and the items that the participant considers to be

neutral. The doctoral students were also given a plain card without words or markings, giving them the option, if applicable, of communicating further ways of defining CE that were not included. This action has the ability to increase the content validity of the scale. The recruited doctoral students were given four envelopes marked as “ 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 a stack. (See Appendix K).

Protection of human subjects. Prior to Phase I and Phase II of recruitment, an application for Claim of Exemption was submitted to the Institutional Review Board (IRB) of Pepperdine University for approval. This ensured that the study was conducted in accord with the Belmont Report, U.S. Code of Regulations, DHHS (CFR) Title 45 Part 46, entitled Protection of Human Subjects, and Parts 160 and 164, entitled *Standards for Privacy of Individually Identifiable Health Information* and the California Protection of Human Subjects in Medical Experimentation Act. This research study involved asking opinions regarding counterproductive experiences in clinical supervision from an adult population that is not a protected group. This study neither asked for information that could directly identify the participant nor were identifiers used that linked the participant’s identity to his/her data; the study presented no more than a minimal risk to the participants and disclosure of the data outside the study did not place the participants at risk of criminal/civil liability or damage to their financial standing, employability, or reputation; and no deception was used. This study was judged to be exempt based on 45 CFR 46.101(b)(2).

In all phases of the recruitment process, participants were informed of the study’s purpose and intent, potential benefits and risks, and participation procedures via in person classroom presentation, participant recruitment email, and announcements placed in the potential

participants' mailboxes. Potential participants were informed that they could contact the investigator or the faculty advisor should they have any questions. Participants were informed that the data would be obtained anonymously ensuring that identities would not be revealed. Furthermore, they were told that their participation was voluntary and that they could withdraw from the study at any time. Participants were offered a copy of the study's abstract upon completion. The study and recruitment for the study was 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.

With respect to the benefits of participation, in Phase I of recruitment, doctoral students were informed that while there was no direct benefit from participation in the study, they could take satisfaction in the knowledge that the contents under investigation (CE) are considered essential in the advancement of doctoral students' understanding of supervision and the supervisory process, and that by sharing their expertise and experience they were contributing to the field of supervision in psychology. In the second recruitment phase (Phase II), participants were informed that participation in the study included the benefit a Starbucks's gift card. Further, participants were told that if they chose to withdraw from the study, at any point, they would be permitted to keep the Starbucks' card.

With regards to risks involved, this study presented no more than minimal risk to the human subjects in light of the following (a) The risk of possible fatigue was minimal due to the short nature of the test procedure (approximately 15 minutes); (b) no personally identifiable data was collected. The parameters of the study did not require participants to reflect directly on their own experiences of counterproductive experiences in supervision, however, participants were informed that if the subject matter evoked any negative or distressful emotions, the participant/s

could speak with the clinical or academic training director, faculty member, or his/her personal therapist (if in treatment). Additionally, the participant/s were offered to contact the dissertation advisor, Dr. Edward Shafranske, to help manage any possible negative consequences as a result of participation in the study.

Consent for participation. A request for waiver of documentation of informed consent was submitted to the IRB since the research does not present more than minimal risk, as defined by the Protection of Human Subjects Federal Regulation (2009). Participation in this study provided implicit consent and implied that participants fully understood the nature and potential risks and benefits of the study. A waiver/exemption of documentation of consent was requested and approved by the Pepperdine IRB for Phase I and II of this study (See Appendix L)

Data Collection and Analysis

Doctoral students enrolled in their 1st, 2nd, and 3rd year of a clinical psychology program were approached to participate in the study through a recruitment presentation, and by email invitation. The doctoral students were instructed to retrieve the study packets in the Psy.D. Student Lounge located at the West Los Angeles campus. The packet contents contained: the recruitment letter which outlined the study and described the risks and benefits associated with participation, the Q-sort stack of 50 cards, instructions for completing the Q-sort, and procedures for submitting the completed packets. The stack of cards each contained an item from the Q-sample with instructions on how to sort each card. The participants were instructed to place the completed Q-sort materials in a large empty envelope with the names of the principal investigator, Nina Grayson, and Dr. Edward Shafranske, dissertation advisor, labeled on the outside. These packets were submitted to the mailbox of Cheryl Saunders, Psy.D. Program

Administrator. The researcher was notified when the packets arrived at which time they were collected for data analysis.

Upon receipt of the materials, the next step involved performing raw frequency counts and obtaining a percentage for each item. First, the researcher reviewed each card within each Q-sort stack category, and assigned a number (or score) based on the participant's ranking (0=no effect; 1=minimal effect; 2=moderate effect; 3=significant major effect). The data was entered into an excel spreadsheet. It is important to note that although the data possesses qualities that are categorical or nominal, for the purposes of this study the data is being treated as ordinal. Ordinal variables possess all of the qualities of nominal variables, except ordinal variables are clearly ordered. For instance, the participants were asked to sort cards into different four categories--no effect, minimal effect, moderate effect and significant major effect-- using an ordinal level of measurement. While there is an order to the four response choices, there is no way to prove an equal distance between the choices. An equal distance between the choices would be considered an interval variable, which possesses all of the qualities of nominal (and ordinal) variables, though they also contain evenly spaced values between the intervals. The results will contribute to the formulation of initial set of CE 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 CE 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.

Results

This section presents the results of the Q-sort completed by 15 participants. Participants were asked to sort each experience based on how counterproductive they believed each experience to be. The categories were *no effect*, *minimal effect*, *moderate effect*, and *significant*

major effect on the 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). A percentage was determined for each CE, in an effort to show the relative strength of the whole item. Table 1 presents the CEs in nine domains and the percentage of respondents who ranked each CE across four categories.

Counterproductive Experiences in Supervision

An analysis of the data showed that each category contained CEs that the participants believe has the potential to significantly impact supervision. The results of the sorted CEs from each domain are outlined below based on the order of the categories with the greatest overall effect on supervision to the least significant effect on the supervisory alliance and process of supervision. Table 2 presents the top quartile of experiences that were opined by participants to have the most counterproductive impact on supervision.

Cultural insensitivity. Among the nine domains, counterproductive events or experiences related to cultural insensitivity were thought to have the most significant major effect on the process of supervision. Out of fifteen doctoral students, all but one found that the CE, *supervisor assumes cultural/racial stereotypes when discussing clients*, had significant major effect on the supervisory process, while the remaining participant believed this CE to have a moderate effect ($ModE= 1$; $SigE= 14$). The CE, *supervisor does not consider the impact of the client's cultural identities*, was largely considered to have a significant major effect on supervision, and a minimal effect at the very least ($MinE=1$; $ModE=3$; $SigE= 11$). Similarly, the CE, *supervisor does not encourage the use of culturally appropriate interventions*, found that 10 doctoral students believe it to have a significant impact on the process of supervision, 4 believe it

has minimal to moderate impact, and I thought that it had no effect on supervision ($NoE=1$; $MinE=1$; $ModE=3$; $SigE=10$).

Inadequate understanding of performance expectations for the supervisee and supervisor/role conflicts. In general, the respondents opined that when a *supervisor has changing performance expectations of the supervisee* it would likely have a moderate to significant effect on supervision and strain the supervisory alliance ($ModE=3$; $SigE=12$). Similarly, doctoral students indicated that the CE, *supervisor fails to clearly communicate performance expectations to the supervisee*, will have a moderate to significant impact on supervision ($ModE=6$; $SigE=8$). When the *supervisor's performance expectations are developmentally inappropriate, i.e., too high or too low in light of the supervisee's experience and competence*, doctoral students believe this will have a minimal to significant effect of the supervisory process ($MinE=2$; $ModE=7$; $SigE=6$).

Failure to address needs of the supervisee. In general, the 15 doctoral students who participated in this study believe that the experiences in this category have a significant impact on the process of supervision. The CEs, *supervisor does not consider the developmental needs of the trainee* ($ModE=8$; $SigE=7$), and *supervisor is unresponsive to supervisee's verbalized training/supervision needs* ($ModE=7$; $SigE=8$), indicate that participants find these counterproductive events to have moderate to significant effects on the process of supervision. A more varied perspective was seen regarding the CE, *supervisor appears to be distracted in supervision*, ($NoE=2$; $MinE=5$; $ModE=4$; $SigE=4$), with participant's responses ranging from no effect to significant effect on the supervisory alliance. The event in this category that was found to have the greatest impact was, *supervisor is unresponsive to supervisee's disclosures about*

personal difficulties affecting their professional performance, (NoE=1; MinE=2; ModE=2; SigE=10).

Supervisor supervision approach and supervisee learning approach mismatch.

Counterproductive experiences related to the supervisor's approach and the supervisee's learning approach showed that participants' opinions varied and ranged from minimal effect to significant effect on the supervisory alliance and the process of supervision. The two CEs which doctoral students primarily rated as having a significant major impact on the process of supervision involved instances where the supervisor made critical statements without offering productive advice and when the supervisor did not acknowledge or address strains or ruptures in the supervisory relationship. Strikingly, for the CE, *Supervisor often makes critical judgments of supervisee without providing constructive feedback*, 14 out of 15 doctoral students found this CE to have a significant major effect on the supervision process and 1 student believed it to have a moderate effect (*ModE=1; SigE=14*). Examination of the CE, *supervisor does not address strains or conflicts between the supervisor and supervisee*, shows most respondents believed this to have a moderate to significant impact on supervision (*MinE=1, ModE=5; SigE=9*). For other CEs in this category, there was a more varied response, for example, the CE, *supervisor and supervisee do not agree about the steps to achieve the supervisory goal*, respondents believed that it had a minimal to significant impact on the supervisory alliance (*MinE=3, ModE=7; SigE=5*). Similarly, the CE, *supervisor is often insensitive when giving feedback*, found participants believed it had a minimal to significant result on the process of supervision (*MinE=2; ModE=6; SigE=7*).

Additional counterproductive experiences. All of the doctoral students ranked the CE, *supervisor does not demonstrate respect for the supervisee*, as having a significant major effect

on the process of supervision (*SigE=15*). The CE, *supervisor does not demonstrate empathy for the supervisee*, was largely deemed as having a significant major effect on supervision with 11 out of 15 doctoral students indicating this belief, while the remainder of responses endorsed this CE as having no effect to moderately impacting the process of supervision (*NoE=1; MinE=2; ModE= 1; SigE=11*). There was variability within this category of CEs, with students endorsing that the remainder of the items yielded no effect to significant major effect on the process of supervision. For example, one participant believed that the CE, *the supervisor is frequently late for supervision*, had no effect on the process of supervision or supervisory alliance, while the remainder of the responses ranged from minimal to significant in this CE's effect on supervision (*NoE=1; MinE=5; ModE=7; SigE=2*). In a similar fashion, participants ranked the CE, *supervisor demonstrates inflexibility in scheduling*, with variable responses, ranging from having no effect to significant effect on supervision (*NoE= 2; MinE= 6; ModE=4; SigE= 3*).

Inadequate attention to ethics, ethical lapses, and unethical behavior. Results from the Q-sorts showed that, for the most part, this category yielded variability within responses, with endorsements ranging from no effect to significant effect on the process of supervision. Examples of this range in responses are seen in the CEs, *supervisor does not consistently sign off on charts/progress notes of supervisee*, (*NoE=4; MinE=8, ModE=2; SigE=1*), *supervisor does not consistently observe or view audio/videotapes or provide live supervision of supervisee*, (*NoE= 3; MinE=8; ModE=3; SigE=1*), and *supervisor provides minimal feedback on mid-year evaluation* (*NoE=1; MinE=6; ModE=6; SigE=2*). Notably, the CE, *supervisor is unavailable to discuss clinical emergencies outside of regularly scheduled supervision*, was found by doctoral students to have a moderate to significant effect on the process of supervision (*ModE=4; SigE=11*). Further, 10 out of 15 doctoral students believe that there could be significantly

detrimental effects on the process of supervision in the instance of a *supervisor directing the supervisee not to file a child abuse report when the supervisee reports clear instances of neglect and abuse*, while the remainder of students believe that this CE could have at least a minimal to moderate effect on supervision ($MinE=3$; $ModE=2$; $SigE=10$).

Boundary crossings/violations. Most of the doctoral students reported that a supervisor expressing attraction to the supervisee could cause a significant (negative) effect on the process of supervision ($SigE=12$). Conversely, a supervisor inquiring about a supervisee's personal life was, for the most part, not endorsed as being particularly adverse or impactful to the process of supervision ($MinE=10$; $ModE=3$; $SigE=2$). The CE, *supervisor discusses other supervisees' performance in supervision* was found by 8 doctoral students to be unfavorable to enhancing the supervisory process, while the remainder of participants rated this CE as having no effect to moderate effect ($NoE=3$; $MinE=3$; $ModE=1$; $SigE=8$). Doctoral students were variable in their responses to the CEs *supervisor makes jokes with sexual innuendos* ($NoE=2$; $MinE=3$; $ModE=5$; $SigE=5$) and *supervisor asks supervisee to edit a journal article the supervisor has written for publication*, ($NoE=4$; $MinE=5$, $ModE=4$; $SigE=2$). The CE, *supervisor attempts to help the supervisee to resolve a personal conflict*, indicates that doctoral students did not find this counterproductive event to have a significantly major (negative) impact on the process of supervision, with 6 out of 15 students endorsing that they believe this CE has no effect ($NoE=6$; $MinE=4$; $ModE=4$; $SigE=1$).

Supervisor/supervisee theoretical orientation mismatch. Based on the result of the Q-sort, the 15 participants had varying beliefs regarding the impact of CEs in this category on the process of supervision. For the most part, the events and experiences in this category were thought to have at least minimal effect on supervision. The two CEs found to have the most

moderate to significant impact on supervision, were *supervisor criticizes supervisee's primary theoretical orientation*, ($MinE=2$; $ModE=8$; $SigE=5$), and, *supervisor lacks the knowledge of the psychotherapy procedures that the supervisee has been taught in graduate school* ($NoE=1$; $MinE=3$; $ModE=8$; $SigE=3$).

Inappropriate supervisor self-disclosure. The 15 participants in the study generally ranked the CEs in this category over 4 of the 4 viewpoints, indicating variability in opinions and beliefs in this area. An example is seen in the CE, *supervisor discloses negative opinions about the supervisee's clients*, where students' beliefs on this topic range from no effect to significant effect on the supervisory process ($NoE=6$; $MinE=4$, $ModE=4$; $SigE=1$). Correspondingly, the CE, *supervisor disclosing negative opinions about the profession*, showed a range of opinion from no effect to significantly impacting supervision ($NoE=6$; $MinE=5$; $ModE=1$; $SigE=3$). Notably, out of 50 CEs ranked in this Q-sort method, the only CE that was not ranked by any participant as having a significant impact was in this category. The CE, *supervisor discloses negative opinions about colleagues, staff, or the training site*, was the only CE to not have any value noted on the significant major effect category ($NoE=3$, $MinE=7$; $ModE=5$).

Counterproductive experiences provided by participants. The following CEs were written by participants on a blank card that was provided in the study packets:

- “Supervisor displays lack of concern for clients, focusing only on filling in time slots.” ($SigE=3$)
- “Supervisor belittles supervisee in front of others” ($SigE=3$)
- “Supervisor demonstrates “favorites” in supervision groups.” ($SigE=3$)
- “Supervisor display disrespectful behavior towards other supervisees.” ($SigE=3$)

- “Supervisor becomes offended when supervisee doesn’t engage in personal conversations.” (*SigE=3*)
- “Supervisor is absent from supervision for an extended period of time for personal reasons.” (*SigE=3*)
- “Supervisor provides negative feedback to supervisee since the supervisee doesn’t acknowledge or laugh at supervisor’s micro-aggressions.” (*ModE=2*)
- “Supervisor makes assumption regarding a supervisee’s attitude towards a theoretical orientation.” (*MinE=1*)

Discussion

The outcomes of this study indicate that all of 50 CEs were deemed by doctoral students to have some adverse impact on the process of supervision. Certain counterproductive experiences were found to have more likelihood than other experiences to negatively impact the supervisory process. Moreover, analysis of participant’s responses reveals a significant level of variability in the distribution of responses in each of the CE categories.

Examination of the data showed that certain counterproductive experiences were opined as having greatest potential for negatively impacting the supervisory process. Notably, all 15 doctoral students believed that the item, *Supervisor does not show respect for the supervisee*, would have a significant major effect on the supervisory process. A fundamental aspect of effective supervision is the establishment of the supervisory alliance, which is built on an emotional bond and characterized by trust, respect, and caring. The full consensus on this item supports the findings of earlier research which found that when supervisors were dismissive of the supervisee’s thoughts and feelings, the supervisee perceived a more negative supervisory relationship (Gray et al., 2001). Almost all respondents reported that the item, *Supervisor does*

not demonstrate empathy for the supervisee, would have a significant major impact on supervision, reflecting previous research which found empathy, warmth, trust and positive regard to be essential characteristics for effective supervisors (Muse-Burke, Ladany, & Deck, 2001; Stoltenberg, McNeil, & Delworth, 1998; Worthen & McNeil, 1996). Almost all participants reported that the item, *Supervisor often makes critical judgments of supervisee without providing constructive feedback*, would have a major significant effect on supervision. This almost unanimous belief is consistent with research highlighting that non-constructive or critical feedback may have a detrimental impact on supervisee development, the supervision process, and supervision outcome (Allen et al., 1986; Daniels & Larson, 2001; Ladany, Hill, Corbett, & Nutt, 1996; Wulf & Nelson, 2000). Another notably impactful CE, *Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations/role conflict*, is related to an inadequate understanding of performance expectations for the supervisee and supervisor and role ambiguity in supervisory relationships. This strong belief among participants is reflective of the well-researched concept that inconsistent expectations of the supervisee can contribute to negative experiences in supervision (Olk & Friedlander, 1992; Ramos-Sanchez, et al., 2002).

Among the nine domains, counterproductive events or experiences related to cultural insensitivity were thought to have the most significant major effect on the process of supervision. Three items in this domain, (e.g., *Supervisor assumes cultural/racial stereotypes when discussing clients*, *Supervisor does not encourage the use of culturally appropriate interventions*, and, *Supervisor does not consider the impact of the client's cultural identities*), were found by most of the respondents to have a significant major impact on the supervisory process, reinforcing the findings from previous studies which found that supervisees' satisfaction with

supervision was reported as lower when supervisors did not discuss cultural issues (Gatmon et al., 2001), or when supervisors ignored, discounted or treated cultural issues insensitively (Burkard et al., 2006; Hird et al., 2001), and used negative cultural stereotyping of clients or supervisee (Singh & Chun, 2010; Toporek et al., 2004). Indeed, the supervisor's lack of culturally diverse experiences and limited multicultural training was found to greatly diminish the effectiveness of the supervisory process (Killian, 2001). Research on multicultural supervision suggests that increasing discussion of cultural issues can enhance the supervisory relationship or working alliance (Constantine, 1997), help supervisees perceive their supervisor as more credible, and enhance supervisees' satisfaction with supervision (Inman, 2006; Silvestri, 2003; Tsong, 2005; Yang, 2005).

In the domain concerning legal/ethical lapses, it was not surprising to find at least two CEs which the majority of respondents believed to have moderate to significant major effect on the process of supervision (e.g., *Supervisor is unavailable to discuss clinical emergencies outside the regularly scheduled supervision*, and, *Supervisor directs the supervisee to not file a child abuse report when the supervisee reports clear instances of neglect and abuse*). Research conducted by Ladany et al. (1999), found that when a supervisor fails to follow the ethical guidelines for monitoring supervisee's conduct, including crisis coverage and intervention, the results could harm the supervisory relationship, and more critically, pose a direct threat to client care.

It is interesting to note that when looking across many of the domains, there appears to be a scatter, or a significant degree of variability in the distribution of responses. This may be accounted for by intra scale variability, or inter-relationships between the items which may result in less robust findings. An example of this can be seen in the domain examining boundary crossing/violations. One item, *Supervisor expresses attraction to supervisee*, was almost

unanimously regarded as being significantly impactful to the supervisory process. This is not surprising given the majority of research conducted in the area of sexual/boundary violations indicates that when sexual relationships take place between supervisor and supervisee it is considered to be coercive and harmful in nature, ultimately having a deleterious impact on the working relationship (Glaser & Thorpe, 1986; Hammel et al., 1996; Lamb et al., 2003; Miller & Larrabee, 1995; Ladany et al., 1999), as well as adversely affecting the entire training group and staff members (Sлимп & Burian, 1994). It thought-provoking that, although this particular CE was regarded by doctoral students to have a significant impact on the supervisory process, the other CEs in this domain were found to have variability in their responses. It can be conjectured that items considered to be highly personal in nature (e.g., *Supervisor expresses attraction to supervisee*), would be viewed as having a greater impact than an item that might be considered less egregious and more of a professional error (e.g., *Supervisor asks supervisee to edit a journal article the supervisor has written for publication*).

Limitations

One possible limitation of this study includes a lack of representativeness in the sample of doctoral students who participated. Although Q-methodology was not designed for large, randomized participant samples (Watts & Stenner, 2005), it would strengthen the findings if the viewpoints, attitudes, and opinions were culled from a more diverse group of doctoral students. The 15 participants largely consisted of Caucasian females enrolled in a doctoral program in clinical psychology program in Los Angeles. The study participants, by and large, have been exposed to the same training and core curriculum; some have had specialized coursework in supervision. While we likely accounted for a small range of opinions that exist between doctoral

students, there may have been greater diversity and variability in the perspectives of doctoral students in other training programs throughout the United States.

Another potential limitation could be attributed to the challenge of recruiting students to participate in research that requires a non-traditional method for obtaining information. Q-methodology, a research approach for studying subjectivity, may not be as familiar to potential study participants as a more ubiquitous form of research instrumentation such as survey methodology. Further, Q-sorts have traditionally been conducted with personal interviews, through which the investigator can assure that the subject followed the correct steps and constructed an accurate representation of personal feelings as reflected in the Q-sort (McKeown & Thomas, 1988). This study used a self-administered method to obtain information, thereby making it difficult to ensure the subject's proper performance of the task and potentially compromising study conclusions by introducing unmeasured methodological variability (Reber et al., 2000). Moreover, it is possible that in the initial phase of recruitment for this study the logistical obstacles associated with obtaining and submitting the study packets appeared daunting for potential subjects. For future research in this area, the utilization of a computer-based Q-sort method could provide a solution to the challenges described. Computer-based systems using the Internet can ensure accurate performance of the Q-sort, administer studies to subjects anywhere, off-set the financial burdens associated with paper-based administration, and collect results without delay (Reber et al., 2000).

This study aimed to recruit at least eight doctoral students in an attempt to gather distinct viewpoints regarding CEs in supervision, and was successful in recruiting fifteen participants. Although this study concentrated specifically on doctoral students, when examined in concert

with the results from experts in the field of supervision and directors of clinical training, this study will offer a more complex view of CEs in supervision.

Implications for Clinical Training

This study succeeded in completing the first four steps of scale development for the CES. The development of such a scale is necessary to better understand the phenomenon of counterproductive experiences and the effect of these events and experiences on features and outcomes of supervision, such as alliance, efficacy of supervision, treatment outcomes, and supervisees' development of clinical competence. In an era of competency-focused practices in the fields of psychology and supervision, the CES can support the facilitation of implementing supervisory guidelines in an effort to develop learning stratagems and evaluation procedures that meet criterion-referenced competence standards (Falender & Shafranske, 2007). Examples of this include the implementation of the CES in psychotherapy training sites for the aim of training incoming groups of supervisors. The final scale, when completed, could be utilized in supervision training coursework of graduate students in psychology, as well integrated into the specific continuing education courses in supervision provided for licensed supervisors.

Recommendations for Future Research

This study completed the first four steps necessary for scale development using the population of doctoral students. The results obtained from the study should be used in concert with the results gathered from the sampled population of directors of clinical training and experts in the field of supervision in order to compare the perspectives of each population and assist with item selection and discrimination. It will be helpful to conduct an analysis of the combined results in order to identify areas of overlap and agreement, and, conversely, areas where the groups diverge. A re-assessment of the current items should be conducted with the intention of

eliminating items that are found to be inappropriate, redundant, or poorly worded. This study investigated the opinions, beliefs, and viewpoints of doctoral students regarding the effects of counterproductive experiences on supervision. Our research did not examine the frequency of such events occurring, speaking to the need to investigate this further. Finally, the scale needs to be optimized. At this point the investigator will have a pool of items that demonstrates reliability (DeVellis, 2012).

It is recommended that further inquiry be done into the nature, frequency, and occurrence of specific CEs rated by doctoral students to have the most impactful overall effect on the process of supervision. For example, the CEs in the domain of cultural sensitivity were strongly emphasized as having a significant impact on supervision; one of the most significant factors for learning and integrating multicultural competencies into practice is having supervision experiences that uphold and increase cultural expertise (Pope-Davis & Coleman, 1997; Sue & Sue, 2008). Results from this study highlight that cultural sensitivity is an area of supervision that warrants further exploration and scientific inquiry.

Finally, it will be useful to explore the counterproductive experiences that the doctoral students noted on blank cards. Most participants who chose to use the blank cards, shared statement/s that had significant overlap with ideas already captured in the Q-set; it would be helpful to have more detailed descriptions with examples. These opinions could potentially be included as items in a replication of this study; a replication that could be administered through a computer-based Q-sort, which might eliminate some of the potential logistical and financial issues associated with the administration of a paper-based Q-sort study.

Conclusion

The purpose of this study was to contribute to the understanding of counterproductive events in supervision by completing the initial steps in the development of a scale of counterproductive experiences/events (CEs). Fifteen doctoral students completed a Q-sort of 50 CEs that were gathered from theoretical and empirical literature in supervision practices. While some variability existed among participants, CEs from all domains of counterproductive experiences were opined to have a moderate to significant major effect on supervision. The present study has contributed to the field of supervision by highlighting critical events that may adversely impact the process and quality of supervision. By investigating the opinions, beliefs, and viewpoints about CEs from the perspective of supervisees, we were able to gain insight into areas that were deemed to be problematic by this population. As the more *junior* or inexperienced member of the supervisory dyad, supervisees are placed in a challenging position. Supervisees are expected to collaborate on many aspects of the supervision process yet paradoxically, the hierarchical nature of the supervisory relationship demands that supervisees be evaluated and scrutinized, inherently placing them in a vulnerable position. Through deepening our understanding into what supervisees consider counterproductive in supervision, we can work towards lessening these negative experiences, while helping to build more cohesive and effective supervisory relationships. We hope that the research explicated in this study will contribute to the ongoing development of competency-focused supervision training and will pave the way for a more rigorous implementation of guidelines and standards by which psychologists conduct clinical supervision, an essential element in the safeguarding of client care and the development well-trained and competent future psychologists.

References

- Allen, G. J., Szollos, S. J., & Williams, B. E. (1986). Doctoral students' comparative evaluations of best and worst psychotherapy supervision. *Professional Psychology: Research and Practice, 17*, 91-99. doi:10.1037/0735-7028.17.2.91
- Alonso, A. (1983). A development theory of psychodynamic supervision. *The Clinical Supervisor, 1*, 23-26. doi:10.1300/J001v01n03_04
- Ancis, J., & Ladany, N. (2001). Multicultural supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, & practice* (3rd ed., pp. 63-90). Philadelphia, PA: Brunner-Routledge.
- Ancis, J. R., & Marshall, D. S. (2010). Using a multicultural framework to assess supervisees' perceptions of culturally competent supervision. *Journal of Counseling & Development, 88*(3), 277-284. doi:10.1002/j.1556-6678.2010.tb00023.x
- American Psychological Association (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073. doi:10.1037/0003-066X.57.12.1060
- Audi, R. (1990). The ethics of graduate teaching. In S. M. Cahn (Ed.), *Morality, Responsibility and the University: Studies in Academic Ethics*, (pp. 119-133). Philadelphia, PA: Temple University Press. Retrieved from http://www.temple.edu/tempres/titles/670_reg.html
- Bahrlick, A. S. (1990). *Role induction for counselor trainees: Effects on the supervisory working alliance* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (No. 9014392)
- Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 7*(3), 317-331. doi:10.1080/10503300500268524
- Barnett, (2007). In search of the effective supervisor. *Professional Psychology: Research and Practice, 38*(3), 268-275. Retrieved from <http://psycnet.apa.org/psycinfo>
- Barnett, J. E., Erickson Cornish, J.A., Goodyear, R.K., & Lichtenberg, J.W. (2007). Commentaries on the ethical and effective practice of clinical supervision. *Professional Psychology: Research and Practice, 38*(3), 268-275. doi:10.1037/0735-7028.38.3.268
- Barnett, J. E., Lazarus, A. A., Vasquez, M. J. T., Moorehead-Slaughter, O., & Johnson, W. B. (2007). Boundary issues and multiple relationships: Fantasy and reality. *Professional Psychology: Research and Practice, 38*, 4, 401-410. doi:10.1037/0735-7028.38.4.401
- Barrett, M., & Barber, J. (2005). A developmental approach to the supervision of therapists in

- training. *Journal of Contemporary Psychotherapy*, 35, 169–183. doi:10.1007/s10879-005-2698-8
- Bartell, P., & Rubin, L. (1990). Dangerous liaisons: Sexual intimacies in supervision. *Professional Psychology: Research and Practice*, 21, 442-450. doi:10.1037/0735-7028.21.6.442
- Behnke, S. (2005). The supervisor as gatekeeper: Reflections on ethical standards. *Monitor on Psychology*, 36, 90. Retrieved from <http://www.apa.org/monitor/may05/ethics.aspx>
- Bernard, J. M. (1979). Supervisory training: A discrimination model. *Counselor Education and Supervision*, 19, 60–68. doi:10.1002/j.1556-6978.1979.tb00906.x
- Bernard, (2006). Tracing the development of clinical supervision. *The Clinical Supervisor*, 24(1), 3-21. doi:10.1300/J001v24n01_02
- Bernard, J. M., & Goodyear, R. K. (1998). *Fundamentals of clinical supervision* (2nd ed.). Boston: Allyn & Bacon.
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). Boston, MA: Allyn & Bacon.
- Blevins-Knabe, B. (1992). The ethics of dual relationships in higher education. *Ethics & Behavior*, 2(3), 151-163. doi:10.1207/s15327019eb0203_2
- Block, J. (1961). *The q-sort method in personality assessment and psychiatric research*. Palo Alto, CA: Consulting Psychologists Press. doi:10.1037/13141-000
- Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 13-37). New York, NY: Wiley & Sons, Inc.
- Brear, P., Dorrian, J., & Luscri, G. (2008). Preparing our future counselling professionals: Gatekeeping and the implications for research. *Counselling & Psychotherapy Research*, 8(2), 93-101. doi:10.1080/14733140802007855
- Brodsky, A. M. (1980). Sex role issues in the supervision of therapy. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research, and practice* (pp. 509-522). New York, NY: Wiley & Sons, Inc.
- Brouwer, M. (1999). Q is accounting for tastes. *Journal of Advertising Research*. 39(2), 35-39.
- Brown, S.R. (1980). *Political subjectivity: Applications of Q methodology in political science*. New Haven, CT: Yale University Press.

- Brown, S. R. (1993). A primer on Q methodology. *Operant Subjectivity, 16*,(3/4), 91-138. Retrieved from <http://qmethod.org/articles/vanExel.pdf>
- Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D. A., Kozlowski, J. M., Hess, S. A., & Knox, S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. *Journal of Counseling Psychology, 53*, 288-301.
- Burke, W., Goodyear, R. K., & Guzzard, C. (1998). A multiple-case study of weakening and repairs in supervisory alliances. *American Journal of Psychotherapy, 52*, 450- 462.
- Canadian Psychological Association. (2009). *Ethical Guidelines for Supervision in Psychology: Teaching, Research, Practice, and Administration*. Ottawa, Ontario: Author.
- Carifio, M. S., & Hess, A. K. (1987). Who is the ideal supervisor? *Professional Psychology: Research and Practice, 18*, 244-250. doi:10.1037/0735-7028.18.3.244
- Celenza, A. (2007). *Sexual boundary violations: Therapeutic, supervisory, and academic contexts*. Lanham, MD: Jason Aronson.
- Chen, E. C., & Bernstein, B. L. (2000). Relations of complementarity and supervisory issues to supervisory working alliance: A comparative analysis of two cases. *Journal of Counseling Psychology, 47*, 485-497. doi:10.1037/0022-0167.47.4.485
- Cheon, H., Blumer, M. L. C., Shih, A., Murphy, M. J., & Sato, M. (2009). The influence of supervisor and supervisee matching, role conflict, and supervisory relationship on supervisee satisfaction. *Contemporary Family Therapy, 31*, 52–67. doi:10.1007/s10591-008-9078-y
- Chung, Y. B., Baskin, M. L., & Case, A. B. (1998). Positive and negative supervisory experiences reported by counseling trainees. *Psychological Reports, 82*, 752. doi: 10.2466/pr0.1998.82.3.762
- Clark, L., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment, 7*(3), 309-319. doi:10.1037/1040-3590.7.3.309
- Cobia, D. C., & Boes, S. R. (2000). Professional disclosure statements and formal plans for supervision: Two strategies for minimizing the risk of ethical conflicts in post-master's supervision. *Journal of Counseling & Development, 78*(3), 293-296. doi:10.1002/j.1556-6676.2000.tb01910.x
- Conroe, R., & Schank, J. (1989). Sexual intimacy in clinical supervision: Unmasking the silence. In G. R. Schoener, J. H. Milgrom, J. C. Gonsiorek, E. T. Luepker and R. M. Conroe (Eds.) *Psychotherapists' Sexual Involvement with Clients: Intervention and Prevention*, (pp. 245-262). Minneapolis, MN: Walk-In Counseling Center. Retrieved from <http://psychnet.apa.org/journals>

- Constantine, M. G. (1997). Facilitating multicultural competency in counseling supervision: Operationalizing a practical framework. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education, and training, and supervision* (pp. 310-324). Newbury Park, CA: Sage. doi:0.4135/9781452232072.n14
- Constantine, M. G. (2001). Multiculturally-focused counseling supervision: Its relationship to trainees' multicultural counseling self-efficacy. *The Clinical Supervisor, 20*(1), 87
doi.org/10.1300/J001v20n01_07
- Cook, D. A. (1994). Racial identity in supervision. *Counselor Education and Supervision, 34*, 132-139. doi:10.1002/j.1556-6978.1994.tb00320.x
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*, 297-334. Retrieved from
http://psych.colorado.edu/~carey/Courses/PSYC5112/Readings/alpha_Cronbach.pdf
- Crook-Lyon, R., Heppler, A., Leavitt, L., & Fisher, L. (2008). Supervisory training experiences and overall development in pre-doctoral interns. *The Clinical Supervisor, 27*(2), 268-284. doi.org/10.1080/07325220802490877
- Daniels, J. A., Larson, L. M. (2001). The impact of performance feedback on counseling self-efficacy and counselor anxiety. *Counselor Education and Supervision, 41*(2), 120-130. doi.org/10.1002/j.1556-6978.2001.tb01276.x
- DeVellis, R. F. (2012). *Scale development: Theory and applications*, Third Edition. Thousand Oaks, CA: Sage Publications.
- Duff, C. T. & Shahin, J. (2010) Conflict in clinical supervision: Antecedents, impact, amelioration, and prevention. *The Alberta Counselor, 31*, 3-8.
- Dye, H. A., & Borders, L. D. (1990). Counseling supervisors: Standards for preparation and practice. *Journal of Counseling and Development, 69*, 27-32. doi:10.1002/j.1556-6676.1990.tb01449.x
- Dziopa, F., & Ahern, K. (2011). A systematic literature review of the applications of Q-technique and its methodology. *Methodology: European Journal of Research Methods for the Behavioral and Social Sciences, 7*(2), 39-55. doi:10.1027/1614-2241/a00021
- Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology, 37*(3), 322-329. doi:10.1037/0022-0167.37.3.322

- Ellis, M. V. (1991). Critical incidents in clinical supervision and in supervisor supervision: Assessing supervisory issues. *Journal of Counseling Psychology, 38*, 342-349. doi:0.1037/0022-0167.38.3.342
- Ellis, M. V. (2001). Harmful supervision: A cause for alarm: Comment on Gray et al. (2001) and Nelson and Friedlander (2001). *Journal of Counseling Psychology, 48*(4), 401-406. doi:10.1037/0022-0167.48.4.401
- Ellis, M. V. (2000). Bridging the Science and Practice of Clinical Supervision: Some Discoveries, Some Misconceptions, *The Clinical Supervisor, 29*(1), 95-116. doi.org/10.1080/07325221003741910
- Ellis, M. V., Siembor, M. J., Swords, B. A., Morere, L., & Blanco, S. (2008, June). *Prevalence and characteristics of harmful and inadequate supervision*. Paper presented at the 4th Annual International Disciplinary Conference on Clinical Supervision, Buffalo, NY.
- Ellis, M. V., Berger, L., Hanus, A. E., Ayala, E. E., Swords, B., & Siembor, M. (2014). Inadequate and harmful clinical supervision: Testing a revised framework and assessing occurrence. *The Counseling Psychologist 42*, 434-472. doi:10.1177/0011000013508656
- Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association. doi:10.1037/10806-000
- Falender, C. A., & Shafranske, E. P. (2008). Best practices of supervision. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (pp. 3-15). Washington, DC: American Psychological Association. doi:10.1037/11792-001
- Falender, C. A., & Shafranske, E. P. (2012). The importance of competency-based clinical supervision and training in the twenty-first century: Why bother? *Journal of Contemporary Psychotherapy, 42*(3) 129-137. doi:10.1007/s10879-011-9198-9
- Falvey, J. E. (2002). *Managing clinical supervision: Ethical practice and legal risk management*. Pacific Grove, CA: Brooks/Cole.
- Feasy, D. (2002). *Good practice in supervision with psychotherapists and counselors: The relational approach*. Philadelphia, PA: Whurr Publishers.
- Fernando, D. M., & Hulse-Killacky, D. (2005). The relationships of supervisory styles to satisfaction with supervision and the perceived self-efficacy of master's-level counseling students. *Counselor Education and Supervision, 44*(4), 293-304. doi:0.1002/j.1556-6978.2005.tb01757.x

- Folman, R. Z. (1991). Therapist-patient sex: Attraction and boundary problems. *Psychotherapy: Theory, Research, Practice, Training*, 28, 168-173. doi:10.1037/h0092234
- Fong, M. L., & Lease, S. H. (1997). Cross-cultural supervision: Issues for the White supervisor. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 387-405). Thousand Oaks, CA: Sage. doi:10.4135/9781452232072.n17
- Forrest, L., Elman, N., Gizara, S., & Vacha-Haase, T. (1999). Trainee impairment: A review of identification, remediation, dismissal, and legal issues. *Counseling Psychologist*, 27, 627-686. doi:10.1177/0011000099275001
- Fukuyama, M. A. (1994). Critical incidents in multicultural counseling supervision: A phenomenological approach to supervision research. *Counselor Education and Supervision*, 34, 142-151. doi:10.1002/j.1556-6978.1994.tb00321.x
- Gabbard, G. O. & Lester, E. (1995). *Boundaries and Boundary Violations in Psychoanalysis*. New York, NY: Basic Books.
- Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., Rodolfa, E. (2001). Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter? *Journal of Multicultural Counseling and Development*, 29, 102-113. doi:10.1002/j.2161-1912.2001.tb00508.x
- Glaser, R. D., & Thorpe, J. S. (1986). Unethical intimacy: A survey of sexual contact and advances between psychology educators and female graduate students. *American Psychologist*, 41, 43-51. doi:0.1037/0003-066X.41.1.43
- Goodyear, R. K., & Rodolfa, E. (2012). Negotiating the complex ethical terrain of clinical supervision. In S. J. Knapp, M. C. Gottlieb, M. M. Handelsman, & L. D. VandeCreek (Eds.), *APA handbook of ethics in psychology, Vol 2: Practice, teaching, and research*, (Vol. 2, pp. 261–276). Washington, D.C.: American Psychological Association.
- Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. *Journal of Counseling Psychology*, 48, 371-383. doi:10.1037/0022-0167.48.4.371
- Greer, J. A. (2002). Where to turn for help: Responses to inadequate clinical supervision. *Clinical Supervisor*, 21, 135-143. doi:10.1300/J001v21n01_11
- Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry* 150, 188-196. Retrieved from <http://ajp.psychiatryonline.org/article.aspx?articleID=169248>

- Hammel, G. A., Olkin, R., & Taube, D. O. (1996). Student–educator sex in clinical and counseling psychology doctoral training. *Professional Psychology: Research and Practice, 27*(1), 93-97. doi:10.1037/0735-7028.27.1.93
- Harrar, W. R., VandeCreek, L., & Knapp, S. (1990). Ethical and legal aspects of clinical supervision. *Professional Psychology: Research and Practice, 21*(1), 37-41. doi:10.1037/0735-7028.21.1.37
- Henderson, C. E., Cawyer, C., & Watkins, C. (1999). A comparison of student and supervisor perceptions of effective practicum supervision. *The Clinical Supervisor, 18*(1), 47-74. doi:10.1300/J001v18n01_04
- Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. *Journal of Counseling Psychology, 31*, 76-90. doi:10.1037/0022-0167.31.1.76
- Hess, A. K., Hess, K. D., & Hess, T. H. (2008). *Psychotherapy supervision: Theory, research, and practice* (2nd ed.). Hoboken, NJ US: John Wiley & Sons Inc. Retrieved from <http://psycnet.apa.org/psycinfo/2008-12978-001>
- Hess, S., Knox, S., Schultz, J. M., Hill, C. E., & Sloan, L. (2008). Predoctoral Interns' Nondisclosure in Supervision. *Psychotherapy Research, 18*, 4, 400-411. doi:10.1080/10503300701697505
- Hird, J. S., Cavalieri, C. E., Dulko, J. P., Felice, A. A. D., & Ho, T. A. (2001). Visions and realities: Supervisees perspectives of multicultural supervision. *Journal of Multicultural Counseling and Development, 29*, 114-130. doi:10.1002/j.2161-1912.2001.tb00509.x
- Holmes, D. L., Rupert, P. A., Ross, S. A., & Shapera, W. E. (1999). Student perceptions of dual relationships between faculty and students. *Ethics and Behavior 9*(2), 79 – 107. doi:10.1207/s15327019eb0902_1
- Hutt, C. H., Scott, J., & King, M. (1983). A phenomenological study of supervisees' positive and negative experiences in supervision. *Psychotherapy: Theory, Research, and Practice, 20*, 118- 123. doi:10.1037/h0088471
- Inman, A. G. (2006). Supervisor multicultural competence and its relation to supervisory process and outcome. *Journal of Marriage and Family Therapy, 32*(1), 73- 85. doi:10.1111/j.1752- 0606.2006.tb01589.x
- Kaslow, N. J., Falender, C. A., & Grus, C. L. (2012). Valuing and practicing competency-based supervision: A transformational leadership perspective. *Training and Education in Professional Psychology, 6*(1), 47-54. doi: 10.1037/a0026704

- Kaslow, N. J., Rubin, N. J., Bebeau, M. J. Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S. M., & Smith, I.L. (2007). Guiding principles and recommendations for the assessment of competence. *American Psychological Association, 38*(5), 441-451.
- Kennard, B. D., Stewart, M. S., & Gluck, M. R. (1987). The supervision relationship: Variables contributing to positive versus negative experiences. *Professional Psychology: Research and Practice, 18*(2), 172-175. doi:10.1037/0735-7028.18.2.172
- Killian, K. D. (2001). Differences making a difference: Cross-cultural interactions in supervisory relationships. *Journal of Feminist Family Therapy, 12*, 61-103. doi:10.1300/J086v12n02_03
- Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling and Development, 6*, 217-221. doi:10.1002/j.1556-6676.1988.tb02586.x
- Kitchener, K. S. (1992). Psychologist as teacher and mentor: Affirming ethical values throughout the curriculum. *Professional Psychology: Research and Practice, 23*, 190-195. doi:10.1037/0735-7028.23.3.190
- Kitchener, K. S., & Harding, S. S. (1990). Dual role relationships. In B. Herlihy & L. Golden. *AACD Ethical Standards Casebook* (4th ed.). Alexandria, VA: American Association for Counseling and Development.
- Knox, S., Burkard, A. W., Edwards, L. A., Smith, J. J., & Schlosser, L. Z. (2008). Supervisors' reports of the effects of supervisor self-disclosure on supervisees.' *Psychotherapy Research, 18*(5), 543-559. doi:10.1080/10503300801982781
- Knox, S., Edwards, L. M., Hess, S. A., & Hill, C. E. (2011). Supervisor self-disclosure: Supervisees' experiences and perspectives. *Psychotherapy, 48*, 4, 336-341. doi:10.1037/a0022067
- Koenig, T. L., & Spano, R. N. (2003). Sex, supervision, and boundary violations: Pressing challenges and possible solutions. *The Clinical Supervisor, 22*, 1-19. Retrieved from <http://psycnet.apa.org>
- Koocher, G. P., Shafrankse, E. P., & Falender, C. A. (2008). Addressing Ethical and Legal Issues in Clinical Supervision. In C.A. Falender and E.P. Shafrankse (Eds), *Casebook for Clinical Supervision: A Competency-Based Approach* (pp. 159-180). Washington, DC: APA Books. doi:10.1037/11792-008
- Ladany, N., Brittan-Powell, C. S., & Pannu, R. (1997). The influence of supervisory racial identity interaction and racial matching on the supervisory working alliance and supervisee multicultural competence. *Counselor Education & Supervision,*

36(4), 284-304. doi:10.1002/j.1556-6978.1997.tb00396.x

- Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development, 77*, 447-455. doi:10.1002/j.1556-6676.1999.tb02472.x
- Ladany, N., & Friedlander, M. L. (1995). The relationship between the supervisory working alliance and trainees' experience of role conflict and role ambiguity. *Counselor Education and Supervision, 34*, 220-231. doi:10.1002/j.1556-6978.1995.tb00244.x
- Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Counseling and Psychotherapy Research: Linking Research with Practice*. Washington, DC: American Psychological Press.
- Ladany, N., Hill, C. E., Corbett, M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*, 10-24. doi:10.1037/0022-0167.43.1.10
- Ladany, N., & Lehrman-Waterman, D. (1999). The content and frequency of super-a TriparTiTe Vision of superVision: Supervisor self-disclosures and their relationship to supervisor style and the supervisory working alliance. *Counselor Education and Supervision, 38*, 143-160. doi:10.1002/j.1556-6978.1999.tb00567.x
- Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist, 27*, 443-475. doi:10.1177/0011000099273008
- Ladany, N., & Walker, J. A. (2003). Supervision self-disclosure: Balancing the uncontrollable narcissist with the indomitable altruist. *Journal of Clinical Psychology, 59*, 5, 611-621. doi:10.1002/jclp.10164
- Ladany, N., Walker, J. A., & Melincoff, D. S. (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure. *Counselor Education and Supervision, 40*, 263-275. doi:0.1002/j.1556-6978.2001.tb01259.x
- Lamb, D. H., Catanzaro, S. J., & Moorman, A. S. (2003). Psychologists reflect on their sexual relationships with clients, supervisees, and students: Implications for professional practice. *Professional Psychology: Research and Practice, 294*, 498-503.
- Lambert, M. J., & Ogles, B. M. (1997). The effectiveness of psychotherapy supervision. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 421-446). New York, NY: Wiley.
- Lazarus, A. A., & Zur, O. (2002). *Dual relationships in psychotherapy*. New York, NY: Springer.

- Lehrman-Waterman, D., & Ladany, N. (2001). Development and validation of the Evaluation Process Within Supervision Inventory. *Journal of Counseling Psychology, 48*, 168-177. doi:10.1037/0022-0167.48.2.168
- Livni, D., Crowe, T. P., & Gonsalvez, C. J. (2012). Effects of supervision modality and intensity on alliance and outcomes for the supervisee. *Rehabilitation Psychology, 57*(2), 178-186. doi:10.1037/a0027452
- Loganbill, C., Hardy, E., & Delworth, U. (1983). Supervision: A conceptual model. *Counseling Psychologist, 10*(1), 3-42.
- Magnuson, S., Wilcoxon, S. A., & Norem, K. (2000). A profile of lousy supervision: Experienced counselors' perspectives. *Counselor Education and Supervision, 39*, 190-202. doi:10.1002/j.1556-6978.2000.tb01231.x
- Martin, J. S., Goodyear, R. K., & Newton, F. B. (1987). Clinical supervision: An intensive case study. *Professional Psychology: Research and Practice, 18*, 225-235. doi:10.1037/0735-7028.18.3.225
- Mays, D. T., & Frank, C. M. (1985). *Negative outcome in psychotherapy and what to do about it*. New York, NY: Springer.
- McKeown, B., & Thomas, D. (1988). *Q Methodology*. Newbury Park, CA: Sage.
- Miller, G. M., & Larrabee, M. J. (1995). Sexual intimacy in counselor education and supervision: A national survey. *Counselor Education and Supervision, 34*, 332-343. doi:10.1002/j.1556-6978.1995.tb00199.x
- Milne, G. M. (2007). An empirical definition of clinical supervision. *British Journal of Clinical Psychology, 46*, 437-447. doi:10.1348/014466507X197415
- Milne, G. M., & James, I. A. (2002). The observed impact of training on competence in clinical supervision. *British Journal of Clinical Psychology, 41*, 55-72. doi:10.1348/014466502163796
- Moskowitz, S. A., & Rupert, P. A. (1983). Conflict resolution within the supervisory relationship. *Professional Psychology: Research and Practice, 14*(5), 632-641. doi:10.1037/0735-7028.14.5.632
- Muse-Burke, J. L., Ladany, N., & Deck, M. D. (2001). The supervisory relationship. In L.J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (pp.28-62). Philadelphia, PA: Brunner- Routledge.

- Nellis, A. C., Hawkins, K. L., Redivo, M., & Way, S. (2011). *Productive conflict in supervision*. Paper presented at the 2011 ACES Conference, Nashville Tennessee.
- Nelson, G. L. (1978). Psychotherapy supervision from the trainee's point of view: A survey of preferences. *Professional Psychology: Research and Practice, 9*, 539-550. doi:10.1037/0735-7028.9.4.539
- Nelson, M. L., Barnes, K. L., Evans, A. L., & Triggiano, P. J. (2008). Working with conflict in clinical supervision: Wise supervisors' perspectives. *Journal of Counseling Psychology, 55*(2), 172-184. doi:10.1037/0022-0167.55.2.172
- Nelson, M. L., & Friedlander, M. L. (2001). A close look at conflictual supervisory relationships: The trainee's perspective. *Journal of Counseling Psychology, 48*(4), 384-395. doi:10.1037/0022-0167.48.4.384
- Nerdrum, P., & Ronnestad, M. H. (2002). The trainees' perspective. A qualitative study of learning empathic communication in Norway. *The Counseling Psychologist, 30*, 609-629. doi:10.1177/00100002030004007
- Newman, A. S. (1981). Ethical issues in the supervision of psychotherapy. *Professional Psychology, 12*, 690-695. doi:10.1037/0735-7028.12.6.690
- Newman, F. L., Kopta, S. M., McGovern, M. P., Howard, K. I., & McNeilly, C. L. (1988). Evaluating the conceptualizations and treatment plans of interns and supervisors during a psychology internship. *Journal of Consulting and Clinical Psychology, 56*(5), 659-665. doi:10.1037/0022-006X.56.5.659
- O'Conner, P. B. (2001). Reasons for less than ideal psychotherapy supervision. *Clinical Supervisor, 19*, 1173-183. Retrieved from http://www.researchgate.net/journal/0732-5223_The_Clinical_Supervisor
- Olk, M. E., & Friedlander, M. L. (1992). Trainees' experiences of role conflict and role ambiguity in supervisory relationships. *Journal of Counseling Psychology, 39*(3), 389-397. doi:10.1037/0022-0167.39.3.389
- Omand, L. (2010). What makes for good supervision and whose responsibility is it anyway? *Psychodynamic Practice 16*(4), 377-392. Retrieved from <http://www.tandfonline.com/toc/rpc019/16/U5U4EigwLww>
- Orlinsky, D. E., & Rønnestad M. H. (2005). Research implications: Ongoing and future studies, In D. E. Orlinsky & Michael Helge Rønnestad (Eds.), *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: American Psychological Association (APA).
- Patton, M. J., & Kivlighan, D. M. (1997). Relevance of the supervisory alliance to the counseling alliance and to treatment adherence in counselor training. *Journal of Counseling Psychology, 44*, 108-115. doi:10.1037/0022-0167.44.1.108

- Pelling, N. Barletta, J. & Armstrong, P. (2009). *The practice of clinical supervision*. Bowen Hills, Qld: Australian Academic Press.
- Pope, K. S. (1989). Sexual intimacies between psychologists and their students and supervisees: Research, standards, and professional liability. *Independent Practitioner*, 3, 33-41. Retrieved from <http://psycnet.apa.org/psycinfo/1992-36881-001>
- Pope-Davis, D. B., & Coleman, H. L. (1997). *Multicultural counseling competencies: Assessment, education and training, and supervision*. CA: Sage. doi:10.4135/9781452232072
- Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology*, 64, 638-652. doi:10.1002/jclp.20477
- Pope, K. S., Keith-Spiegel, P., & Tabachnick, B. G. (1986). Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system. *American Psychologist*, 41, 147-158. Retrieved from <http://www.kspope.com/sexiss/research5.php>
- Pope, K. S., Shover, L. R., & Levenson, H. (1980). Sexual behavior between clinical supervisors and trainees: Implications for professional standards. *Professional Psychology*, 11, 157-162. Doi:10.1037/0735-7035-7028.11.1.157
- Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist*, 41(11), 993-1006. doi:10.1037/0003-066X.41.2.147
- Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in Psychotherapy and Counseling: A practical guide for psychologists* (2nd ed.). San Francisco, CA: Jossey-Bass. doi:10.1037/0735-7028.11.1.157
- Protection of Human Subjects Federal Regulation, 46 C. F. R. §102 (2009).
- Ramos-Sanchez, L., Esnil, E., Goodwin, A., Riggs, S., Touster, L. O., Wright, L. K., Ratansiripong, P., & Rodolfa, E. (2002). Negative Supervisory events: Effects on Supervisor and supervisory alliance. *Professional Psychology: Research and Practice*, 13, 197-202. doi:10.1037/0735-7028.33.2.197
- Reber, B. H., Kaufman, S. E., & Cropp, F. (2000). Assessing Q-assessor: A validation study of computer-based Q-sorts versus paper sorts. *Operant Subjectivity*, 23(4), 192-209. Retrieved from <http://operantsubjectivity.org/>
- Rodolfa, E., Hall, T., Holms, V. Davena, A., Komatz, D., Antunez, M., & Hall, A. (1994). The management of sexual feelings in therapy. *Professional Psychology: Research and Practice*, 25, 168-172. doi:10.1037/0735-7028.25.2.168

- Robinson, B., Bradley, L. J., & Hendricks, C. B. (2000). Multicultural counselling supervision: A four-step model toward competency. *International Journal for the Advancement of Counseling, 22*, 131-141. doi:10.1023/A:1005567609258
- Selicoff, H. (2006). Looking for good supervision: A fit between collaborative and hierarchical methods. *Journal of Systemic Therapies, 25*(1), 37-51. doi:10.1521/jsyt.2006.25.1.37
- Shanfield, S. B., Matthews K. L., & Heatherly, V. (1993). What do excellent psychotherapists do? *American Journal of Psychiatry, 150*, 1081-1084. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330630/>
- Sherry, P. (1991). Ethical issues in the conduct of supervision. *The Counseling Psychologist, 19*, 566-584. doi:10.1177/0011000091194006
- Shineborne, P., & Adams, M. (2007). Therapists' understandings and experiences working with clients and problems of addiction: A pilot study using Q methodology. *Counseling and Psychotherapy Research, 7*(4), 211-219. doi:10.1080/14733140701726159
- Silvestri, T. J. (2003). The temporal effect of supervisor focus, the supervisor working alliance, and the graduate training environment upon supervisee multicultural competence (Doctoral dissertation, Lehigh University, 2003). *Dissertation Abstracts International, 63*, 6108.
- Singh, A., & Chun, K. Y. S. (2010). "From the margins to the center": Moving towards a resilience-based model of supervision for queer people of color supervisors. *Training and Education in Professional Psychology, 4*(1), 36-46. doi:10.1037/a0017373
- Slimp, P. A., & Burian, B. K. (1994). Multiple role relationships during internship: Consequences and recommendations. *Professional Psychology: Research and Practice, 2*(5), 39-45. doi:10.1037/0735-7028.25.1.39
- Sterner, W. R. (2009). Influence of the supervisory working alliance in supervisee work satisfaction and work-related stress. *Journal of Mental Health Counseling, 31*(3), 249-263. Retrieved from <http://mftcourses.net/documents/sterner%202009.pdf>
- Stephenson, W. (1953). *The study of behavior: Q-technique and its methodology*. Chicago, IL: University of Chicago Press. Retrieved from <http://qmethod.org/articles/vanExel.pdf>
- Stoltenberg, C. D., & McNeill, B. W. (1997). Clinical supervision from a developmental perspective: Research and practice. In C. E. Watkins, Jr. (Ed.), *Handbook of Psychotherapy Supervision* (pp. 184-202). New York, NY: Wiley.

- Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco, CA: Jossey-Bass.
- Sue, D. W., & Sue, S. (2008). *Counseling the culturally diverse: Theory and practice*. Hoboken, NJ: Wiley. Retrieved from <http://psycnet.apa.org/journals>
- Sumerel, M. B., & Borders, L. D. (1996). Addressing personal issues in supervision: Impact of counselor's experience level on various aspects of the supervisory relationship. *Counselor Education and Supervision, 35*, 268-286. Retrieved from <http://academicguides.waldenu.edu/mpsyr8232>
- Sutter, E., McPherson, R. H., & Geeseman, R. (2002). Contracting for supervision. *Professional Psychology: Research And Practice, 33*, 495-498. doi:10.1037/0735-7028.33.5.495
- Thomas, J. (2010). *The Ethics of Supervision and Consultation*. Washington, DC: APA
Retrieved from <http://janettthomas.com/books/>
- Toporek, R. L., Ortega-Villalobos, L., & Pope-Davis, D. B. (2004). Critical incidents in multicultural supervision: Exploring supervisees' and supervisors experiences. *Journal of Multicultural Counseling and Development, 32*, 66-83. doi:0.1002/j.2161-1912.2004.tb00362.x
- Tsong, Y. V. (2005). 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. *Dissertation Abstracts International Section A, 65*, 3291. Retrieved from <http://search.proquest.com.lib.pepperdine.edu/pqdtft/docview/305123657/fulltextPDF/2DE8A43925BB4EEEPQ/6?accountid=13159>
- van Exel J, & de Graaf, G. (2005). Using Q methodology in administrative ethics. *Public Integrity, 11*(1), 53-68.
- Vargas, L. A. (1989, August). *Training psychologists to be culturally responsive: Issues in supervision*. Paper presented at the annual convention of the American Psychological Association, New Orleans, LA. Retrieved from <http://onlinelibrary.wiley.com/>
- Veach, P. (2001). Conflict and counterproductivity in supervision-when relationships are less than ideal. Comment on Nelson and Friedlander and Grey et al. *Journal of Counseling Psychology, 48*, 396-400. doi:10.1037/0022-0167.48.4.396
- Vespia, K. M., Heckman-Stone, C., & Delworth, U. (2002). Describing and facilitating effective supervision behavior in counseling trainees. *Psychotherapy: Theory, Research, Practice, Training, 39*, 56-65. doi:10.1037/0033-3204.39.1.56

- Watkins, C. E. (1994). The ineffective psychotherapy supervisor: Some reflections about bad behaviors, poor process, and offensive outcomes. *The Clinical Supervisor, 16*, 163-180. doi:10.1300/J001v16n01_09
- Watkins C. E., (2010). Psychoanalytic constructs in psychotherapy supervision. *American Journal of Psychotherapy, 64*(4), 393-416. Retrieved from <http://www.ajp.org/>
- Watts, S., & Stenner, P. (2005). Doing Q methodology: Theory, method, and interpretation. *Qualitative Research in Psychology, 2*(1), 67-91. doi:10.1191/1478088705qp022oa
- Weaks, D. (2002). Unlocking the secrets of 'good supervision': A phenomenological exploration of experienced counselors' perceptions of good supervision. *Counseling and Psychotherapy Research, 2*, 33-39. Retrieved from <http://psycnet.apa.org/psycinfo/>
- Worthen, V., & McNeill, B. W. (1996). A phenomenological investigation of "good" supervision events. *Journal of Counseling Psychology, 43*(1), 25-34.
- Worthington, E. L. Jr. (1987). Changes in supervision as counselors and supervisors gain experience. *Professional Psychology: Research and Practice, 18*, 189-208. doi:10.1037/0735-7028.18.3.189
- Wulf, J. & Nelson, M. L. (2000). Experienced psychologists' recollections of internship supervision and its contributions to their development. *The Clinical Supervisor, 19*(2), 123-145. Retrieved from http://www.tandfonline.com/doi/abs/10.1300/J001v19n02_07#preview
- Yang, P. (2005). The effects of supervisor cultural responsiveness and ethnic group similarity on Asian American supervisees' perceptions of supervisor credibility and multicultural competence. *Dissertation Abstracts International, 65*, 6681. Retrieved from <http://www.worldcat.org/title/dissertation-abstracts-international>
- Zakrewski, R. F. (2006). A national survey of American psychological association student affiliates' involvement and ethical training in psychology educator-student sexual relationships. *Professional Psychology: Research and Practice, 37*(6), 724-730. doi:10.1037/0735-7028.37.6.724

Table 1

<i>Counterproductive Experiences in Supervision</i>	<i>NoE=0 (%)</i>	<i>MinE=1 (%)</i>	<i>ModE=2 (%)</i>	<i>SigE=3 (%)</i>
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%)	2 (13%)	7 (46%)	5 (33%)
Supervisor fails to clearly communicate performance expectations to the supervisee.	0 (0%)	0 (0%)	6 (40%)	8 (53%)
Supervisor's performance expectations are developmentally inappropriate, i.e., too high or too low in light of the supervisee's experience and competence.	0 (0%)	2 (13%)	7 (46%)	6 (40%)
Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations.	0 (0%)	0 (0%)	3 (20%)	12 (80%)
Inappropriate Supervisor Self-Disclosure.				
Supervisor often discloses information about his/her personal life.	5 (33%)	5 (33%)	4 (26%)	1 (6%)
Supervisor discloses negative opinions about the supervisee's clients.	6 (40%)	4 (26%)	4 (26%)	1 (6%)
Supervisor discloses negative opinions about the profession.	6 (40%)	5 (33%)	1 (6%)	3 (20%)
Supervisor discloses personal disillusionment about his/her career as a psychologist.	5 (33%)	3 (20%)	2 (13%)	5 (33%)
Supervisor discloses negative opinions about colleagues, staff, or the training site.	3 (20%)	7 (46%)	5 (33%)	0 (0%)
Supervisor Supervision Approach and Supervisee Learning Approach Mismatch				
Supervisee and supervisor do not agree about the steps to achieve the supervisory goals.	0 (0%)	3 (20%)	7 (46%)	5 (33%)

(Continued)

<i>Counterproductive Experiences in Supervision</i>	<i>NoE= 0 (%)</i>	<i>MinE=1 (%)</i>	<i>ModE=2 (%)</i>	<i>SigE=3 (%)</i>
Supervisor is inflexible in his/her approach to supervision.	0 (0%)	5 (33%)	6 (40%)	4 (26%)
Supervisor often makes critical judgments of supervisee without providing constructive feedback.	0 (0%)	0 (0%)	1 (6%)	14 (93%)
Supervisor is often insensitive when giving feedback.	0 (0%)	2 (13%)	6 (40%)	7 (46%)
Supervisor does not address strains or conflicts between supervisee and supervisor.	0 (0%)	1 (6%)	5 (33%)	9 (60%)
Supervisor does not appropriately structure the supervision session.	1 (6%)	10 (66%)	3 (20%)	1 (6%)
Supervisor/Supervisee Theoretical Orientation Mismatch				
Supervisor and supervisee often differ in their conceptualization of cases.	5 (33%)	5 (33%)	4 (26%)	1 (6%)
Supervisor and supervisee often differ in which therapeutic approach is best suited to achieve the treatment goals.	4 (26%)	7 (46%)	3 (20%)	1 (6%)
Supervisor lacks knowledge of the psychotherapy procedures that the supervisee has been taught in graduate school.	1 (6%)	3 (20%)	8 (53%)	3 (20%)
Supervisor has limited knowledge about supervisee's theoretical orientation.	3 (20%)	3 (20%)	7 (46%)	2 (13%)
Supervisor criticizes supervisee's primary theoretical orientation	0 (0%)	2 (13%)	8 (53%)	5 (33%)
Cultural Insensitivity				
Supervisor does not consider the impact of the client's cultural identities.	0 (0%)	1 (6%)	3 (20%)	11 (73%)
Supervisor does not consider the impact of his/her own and supervisee's cultural identities.	0 (0%)	2 (13%)	5 (33%)	8 (53%)
Supervisor does not encourage the use of culturally appropriate interventions.	1 (6%)	1 (6%)	3 (20%)	10 (66%)

(continued)

<i>Counterproductive Experiences in Supervision</i>	<i>NoE=0 (%)</i>	<i>MinE=1 (%)</i>	<i>ModE=2 (%)</i>	<i>SigE=3 (%)</i>
Supervisor assumes cultural/racial stereotypes when discussing clients. Failure to Address Needs of the Supervisee	0 (0%)	0 (0%)	1 (6%)	14 (93%)
Supervisor does not consider the developmental needs of the trainee.	0 (0%)	0 (0%)	8 (53%)	7 (46%)
Supervisor is unresponsive to supervisee's verbalized training/supervision needs.	0 (0%)	0 (0%)	7 (46%)	8 (53%)
Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting their professional performance.	1 (6%)	2 (13%)	2 (13%)	10 (66%)
Supervisor appears distracted in supervision. Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior	2 (13%)	5 (33%)	4 (26%)	4 (26%)
Supervisor provides minimal feedback on the midyear evaluation.	1 (6%)	6 (40%)	6 (40%)	2 (13%)
Supervisor directs the supervisee not to file a child abuse report when the supervisee reports clear instances of neglect and abuse.	0 (0%)	3 (20%)	2 (13%)	10 (66%)
Supervisor speaks about clients in a recognizable way, e.g., using their names in public areas.	1 (6%)	1 (6%)	7 (46%)	6 (40%)
Supervisor does not consistently observe or review audio/videotapes or provide live supervision of supervisee.	3 (20%)	8 (53%)	3 (20%)	1 (6%)
Supervisor does not consistently sign off on charts/progress notes of supervisee.	4 (26%)	8 (53%)	2 (13%)	1 (6%)
Supervisor is unavailable to discuss clinical emergencies outside of regularly scheduled supervision.	0 (0%)	0 (0%)	4 (26%)	11 (73%)
Supervisor sometimes ignores agency policies.	4 (26%)	4 (26%)	5 (33%)	2 (13%)

(continued)

<i>Counterproductive Experiences in Supervision</i>	<i>NoE=0 (%)</i>	<i>MinE=1 (%)</i>	<i>ModE=2 (%)</i>	<i>SigE=3 (%)</i>
Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained.	2 (13%)	4 (26%)	4 (26%)	5 (33%)
Boundary Crossings/Violations				
Supervisor invites supervisee to attend a personal event outside of supervision.	6 (40%)	5 (33%)	2 (13%)	2 (13%)
Supervisor asks supervisee to edit a journal article the supervisor has written for publication.	4 (26%)	5 (33%)	4 (26%)	2 (13%)
Supervisor discusses other supervisees' performance in supervision.	3 (20%)	3 (20%)	1 (6%)	8 (53%)
Supervisor inquires about the supervisee's personal life (e.g., Are you dating anyone?)	0 (0%)	10 (66%)	3 (20%)	2 (13%)
Supervisor attempts to help the supervisee to resolve a personal conflict.	6 (40%)	4 (26%)	4 (26%)	1 (6%)
Supervisor makes jokes/comments with sexual innuendos.	2 (13%)	3 (20%)	5 (33%)	5 (33%)
Supervisor expresses attraction to supervisee.	0 (0%)	2 (13%)	1 (6%)	12 (80%)
Additional Counterproductive Experiences				
Inadequate environment/office space is provided for supervision.	3 (20%)	8 (53%)	2 (13%)	2 (13%)
Supervisee's professional responsibilities (e.g., nature of workload, time) were not accurately represented during the application process.	1 (6%)	3 (20%)	6 (40%)	5 (33%)
Supervisor demonstrates inflexibility in scheduling.	2 (13%)	6 (40%)	4 (26%)	3 (20%)
Supervisor is frequently late for supervision.	1 (6%)	5 (33%)	7 (46%)	2 (13%)
Supervisor does not provide guidance about professional development as a psychologist.	1 (6%)	5 (33%)	6 (40%)	3 (20%)

(continued)

<i>Counterproductive Experiences in Supervision</i>	<i>NoE=0 (%)</i>	<i>MinE=1 (%)</i>	<i>ModE=2 (%)</i>	<i>SigE=3 (%)</i>
Supervisor does not demonstrate empathy for the supervisee.	1 (6%)	2 (13%)	1 (6%)	11 (73%)
Supervisor does not demonstrate respect for the supervisee.	0 (0%)	0 (0%)	0 (0%)	15 (100%)

Note. %= Percentile of Participants

Table 2

Top Quartile of Most Perceived Counterproductive Experiences in Supervision

Supervisor does not demonstrate respect for supervisee

Supervisor often makes critical judgments of supervisee without providing constructive feedback

Supervisor assumes cultural or racial stereotypes when discussing clients

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

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

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

Supervisor expresses attraction to supervisee

Supervisor fails to clearly communicate performance expectations to the supervisee

Supervisor does not address strains or conflicts between supervisee and supervisor

Supervisor is unresponsive to supervisees' verbalized training/supervision needs

Supervisor does not encourage the use of culturally appropriate interventions

Supervisor does not consider the developmental needs of the trainee

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

Supervisor does not demonstrate empathy for the supervisee

APPENDIX A

Counterproductive Experiences in Supervision Identified in the Literature

Counterproductive Experiences in Supervision Identified in the Literature

Authors	Year	Study	Results
Allen, Szollos, & Williams	1986	Doctoral students' comparative evaluations of best and worst psychotherapy supervision	Trainee's worst experiences in supervision included authoritative and/or demeaning supervision.
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.
Cobia & Boes	2000	Professional disclosure statements and formal plans for supervision: Two strategies for minimizing the risk of ethical conflicts in post-master's supervision	Ethical conflicts related to issues of informed consent, due process, competence, confidentiality, and dual relationships in supervision are discussed. Two strategies proposed as to minimize potential for ethical conflict in post-master's supervision: use of professional disclosure statements by supervisors that fully disclose all potential risks, benefits, and expectations of entering into supervision and development of formal plans for supervision. Goals for this contract are based on a review of supervisee preparation and experience, as well as ongoing assessment of skills and development

			<p>as a counselor. Collaborating on contract for supervision can increase accountability felt by supervisees for the progress of supervision and also serve as framework for effective and appropriate review and feedback.</p>
Crook- Lyon, Heppler, Leavitt, & Fisher	2008	Supervisory training experiences and overall development in pre-doctoral interns	<p>Study examined pre-doctoral interns' perceptions of extent and quality of supervision training provided in graduate programs & pre-doctoral internship sites. N= 233 pre-doctoral interns. Results: 72% of interns reported having supervised at least 1 trainee during graduate training, only 39% had completed a graduate course on supervision. Principal finding: lack of supervision training reported by clinical psychology interns. Majority interns surveyed (61%) had not completed a formal graduate course in supervision, 11% of participants reported no exposure to any kind of supervision training during graduate school or internship. Results: most interns (72%) supervised at least 1 trainee prior to</p>

			or during internship. Typical intern in sample had not completed a graduate course in supervision but chose to (or was expected to) provide supervision to at least one trainee during graduate career; total #of supervision training activities and # of hours found to predict interns' psychotherapy supervision dev. level scores.
Ellis	1991	Critical incidents in clinical supervision and in supervisor supervision: Assessing supervisory issues	Naturalistic study based on work of previous studies (Loganbill, Hardy, and Delworth's, 1982) and (Sansbury, 1982). Doctoral students and supervisors. Critical incidents obtained after each counselor-supervision session & each supervisor-supervision session; rated on 10 supervisory issues. Results offered limited support for Sansbury's hierarchy of supervisory issues. Significant differences between counselors & supervisors & between counselor supervision & supervisor supervision. Pattern of supervisory issues was overall more similar than dissimilar.
Ellis	2001	Harmful supervision: A cause for alarm:	Bad supervision does not cause psychological harm to supervisees or

		Comment on Gray et al. (2001) and Nelson and Friedlander (2001)	clients, but harmful supervision can cause damage on a short and/or long term basis.
Ellis, Siembor, Swords, Morere, & Blanco	2008	Prevalence and Characteristics of Harmful and Inadequate Clinical Supervision	Outlines initial theoretical rationale for what constitutes inadequate and harmful supervision. Suggests strategies to prevent inadequate and harmful supervision. Offered more refined definitions of harmful and inadequate supervision.
Gray, Ladany, Walker & Ancis	2002	Psychotherapy trainees' experiences of counterproductive events in supervision	Interviewed 13 trainees who attributed CE to supervisor's dismissive attitude about thoughts and feelings; Most did not believe supervisor was aware of CE, all respondents believed that CE weakened supervisory relationship & changed how they approached supervisors; trainees reported CE negatively affected work with clients, trainees did not feel they could disclose their perceptions of CE to their supervisors.
Greer	2002	Where to turn to for help: Responses to inadequate clinical supervision.	Calls for a specific outlining of the mutual rights for supervisors and supervisees including a "bill of rights" for supervisees; supervision contract necessary to emphasize legal/ethical responsibilities to supervisors.
Jacobs	1991	Violations of the	Supervisors who do not

		supervisory relationship: An ethical and educational blindspot	address conflicts or ruptures considered an abuse of power; conflict between supervisor and supervisee may have negative effects on clients.
Hutt, Scott, & King	1983	A phenomenological study of supervisees' positive and negative experiences in supervision.	Investigated supervision process from supervisee's viewpoint. Found that facilitative relationship is a necessary-but not sufficient- condition for positive supervision; effective supervision integrates both task and person-oriented behavior. "negative supervision" has impact on supervisee's training.
Kennard, Stewart, & Gluck	1987	The supervision relationship: Variables contributing to positive versus negative experiences	68 trainee-supervisee pairs used self-report measures to report a negative experience with supervisors that were instructional, interpretive, and unsupportive.
Ladany, Hill, Corbett, & Nutt.	1996	Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors.	90 % of supervisees surveyed experienced negative reaction to a supervisor which they did not disclose. Reasons for non-disclosure included: deference to supervisor's authority, strategic self-presentation, fear of "political suicide". Trainees reported greater dissatisfaction with supervision when

			not disclosing because of poor supervisory alliance, fear of professional harm, and perceived supervisee incompetence. Supervisees reported greater satisfaction with supervision when they did disclose negative reactions towards supervisors.
Ladany, Lehrman-Waterman, Molinaro, & Wolgast.	1999	Psychotherapy supervisor ethical practices: Adherence to the guidelines, the supervisory working alliance, and supervisee satisfaction.	N=151 (primarily) counseling trainees. Most frequent violations related to evaluations and confidentiality. Violations were most frequently discussed with someone other than supervisor.
Larrabee & Miller	1993	Sexual intimacy in counselor education and supervision: A national survey.	Nation-wide survey of randomly selected females, examined effect of sexual intimacy in graduate education. Discusses implications for counselor educators and supervisors.
Magnuson, Wilcoxon, & Norem	2000	A profile of lousy supervision: Experienced counselors' perspectives.	Interviews examined supervisory approaches and behaviors that impede growth of supervisees. "Lousy" supervisors described as unbalanced, developmentally inappropriate, intolerant of differences, poor model of professional/personal attributes, untrained, professionally apathetic.

Moskowitz & Rupert	1983		Survey study examined frequency, type, and outcome of trainee's experiences of conflict in supervision. Almost 40% of trainees experienced major conflict w/supervisor related to personality issues, supervision style, or therapeutic techniques or approaches.
Muratori	2001	Examining supervisor impairment from the counselor trainee's perspective.	Impaired supervisors may misuse power, producing feelings of negativity about the profession for the supervisee; Ethical misconduct negatively affects supervisory alliance; decision-making tree can aid supervisee when difficult issues arise. Impaired supervisors may experience more severe sx of impairment due to failure to heed warning signs of gradual deterioration of emotional functioning. Trainees may be forced to take action against impaired supervisor if quality of supervision is being compromised or if trainee believes that he/she is in harm's way.
O'Connor	2001	Reasons for less than ideal psychotherapy supervision	Contrasted ideal supervision as described in theoretical & empirical literature with forms of supervision that are

			<p>“less than ideal”; focus on circumstances that permit inadequate supervision to go unheeded; discussed regulatory, organizational, and psychological factors; inadequate supervision contrasted with more blatant forms of professional misconduct. Suggests phenomenon persists because of absence of precise official guidelines for identifying and correcting the problem.</p>
Nelson & Friedlander	2002	<p>Negative supervisory events: Effects on supervisory satisfaction and supervisory alliance</p>	<p>(N= 13 counseling supervisees). Supervisee developmental level, supervisory working alliance, trainee attachment style, and negative supervisory events were examined to determine their relationship with one another. Findings: Destructive impact of negative supervisory events on supervision/supervisee development. Impact varies depending upon a supervisee's developmental level or the strength of the supervisor--supervisee alliance. Supervisors should more supportive of supervisees in early developmental stages.</p>
Nelson et al.	2008	Working with	Supervisor fails to

		conflict in clinical supervision: Wise supervisors' perspectives	clearly identify supervisee goals and expectations; Supervisors indicated that failure to communicate expectations early in training could lead to difficulties in relations with supervisees.
Ramos, Sanchez, Esnil, Goodwin, Riggs, Touster, Wright, Ratanasiripong, & Rodolfa	1999	Core problems in clinical supervision: Factors related to outcomes	N=146 APPIC interns. Negative supervision events can hinder development of sup. alliance and has overall detrimental effect on training of interns.
Unger	1999	What is effective supervision? A national survey and introduction of a model	Quantitative, survey examined aspects of supervision that promoted successful supervisory experiences
Veach	2001	Conflict and counterproductivity in supervision-when relationships are less than ideal. Comment on Nelson & Friedlander and Grey et al.	Cases in Nelson & Friedlander (2001) study may not represent all counterproductive events and conflicts. Larger samples needed. Research on immediate versus long-term impact of CE recommended.
Watkins	1997	The ineffective psychotherapy supervisor: Some reflections about bad behavior, poor process, and offensive outcomes	Defines bad, poor, ineffective supervisor behaviors. Use of theory to reflect on ineffective supervision.
Worthen & McNeill	1996	Phenomenological investigation of "good" supervision events.	Study examined experiences in supervision thought to have positive ramifications in supervision.

APPENDIX A- References

- Allen, G. J., Szollos, S. J. & Williams, B. E. (1986). Doctoral students' comparative evaluations of best and worst psychotherapy supervision. *Professional Psychology: Research and Practice, 17*, 91-99. doi:10.1037/0735-7028.17.2.91
- Chung, Y. B., Baskin, M. L., & Case, A. B. (1998). Positive and negative supervisory experiences reported by counseling trainees. *Psychological Reports, 82*, 752. doi:10.2466/pr0.1998.82.3.762
- Cobia, D. C., & Boes, S. R. (2000). Professional disclosure statements and formal plans for supervision: Two strategies for minimizing the risk of ethical conflicts in post-master's supervision. *Journal of Counseling and Development, 78*, 293-296. doi:10.1002/j.1556-6676.2000.tb01910.x
- Crook-Lyon, R., Heppler, A., Leavitt, L., & Fisher, L. (2008). Supervisory training experiences and overall development in pre-doctoral interns. *The Clinical Supervisor. doi:10.1080/07325220802490877*
- Ellis, M. V. (1991). Critical incidents in clinical supervision and in supervisor Supervision. Assessing supervisory issues. *Journal of Counseling Psychology, 38*, 342-349. doi:10.1037/0022-0167.38.3.342
- Ellis, M. V. (2001). Harmful supervision: A cause for alarm: Comment on Gray et al. (2001) and Nelson and Friedlander (2001). *Journal of Counseling Psychology, 48*, 4, 401-406. doi:10.1037/0022-0167.48.4.401
- Ellis, M. V., Siembor, M. J., Swords, B. A., Morere, L., & Blanco, S. (2008, June). *Prevalence and characteristics of harmful and inadequate supervision*. Paper presented the 4th Annual International Disciplinary Conference on Clinical Supervision, Buffalo, NY. doi:10.1037/0022-0167.48.4.401
- Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. *Journal of Counseling Psychology, 48*, 371-383. doi:10.1037/0022-0167.48.4.371
- Greer, J. A. (2002). Where to turn to for help: Responses to inadequate clinical supervision. *Clinical Supervisor, 21*, 135-143. doi:10.1300/J001v21n01_11
- Hutt, C. H., Scott, J., & King, M. (1983). A phenomenological study of supervisees' positive and negative experiences in supervision. *Psychotherapy: Theory, Research, and Practice, 20*, 118- 123. doi:10.1037/h0088471
- Jacobs, K. (1991). Violations of the supervisory relationship: An ethical and educational blindspot. *Social Work, 36*, 130-135. doi: 10.1093/sw/36.2.130

- Kennard, B. D., Stewart, S. M., & Gluck M. R. (1987). The supervisory relationship: Variables contributing to the positive versus negative experiences. *Professional Psychology: Research and Practice, 16*, 172-175. doi:10.1037/0735-7028.16.2.172
- Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*(1). doi:10.1037/0022-0167.43.1.10
- Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist, 27*, 443-474. doi:10.1177/0011000099273008
- Magnuson, S., Wilcoxon, S. A., & Norem, K. (2000). A profile of lousy supervision: Experienced counselors' perspectives. *Counselor Education and Supervision, 39*, 189-202. doi:10.1002/j.1556-6978.2000.tb01231.x
- Moskowitz, S. A., & Rupert, E. A. (1983). Conflict resolution within the supervisor relationship. *Professional Psychology: Research and Practice, 14*, 632-641. doi:10.1037/0735-7028.14.5.632
- Muratori, M. C. (2001). Examining supervisor impairment from the counselor trainee's perspective. *Counselor Education and Supervision, 41*, 1. doi:10.1002/j.1556-6978.2001.tb01267.x
- Nelson, M. L., & Friedlander, M. L. (2001). A close look at conflictual supervisory relationships: The trainee's perspective. *Journal of Counseling Psychology, 48*, 384-395. doi:10.1037/0022-0167.48.4.384
- O'Conner, P. B. (2001). Reasons for less than ideal psychotherapy supervision. *Clinical Supervisor, 19*, 1173-183. doi: 10.1300/J001v19n02_10
- Ramos-Sanchez, L., Esnil, E., Goodwin, A., Riggs, S., Touster, L. O., Wright, L. K., Ratansiripong, P., Rodolfa, E. (2002). Negative supervisory events: Effects on Supervisor and supervisory alliance. *Professional Psychology: Research and Practice, 13*, 197-202. doi:10.1037/0735-7028.33.2.197
- Unger, D. (1999). Core problems in clinical supervision: Factors related to outcomes. In M.L. Friedlander (Chair), *Psychotherapy supervision: For better or for worse*. Symposium conducted at the 107th Annual Convention of the American Psychological Association, Boston, MA. Retrieved from <http://psycnet.apa.org/journals>
- Watkins, C. E. (1997). The ineffective psychotherapy supervisor: Some reflections about bad behaviors, poor process, and offensive outcomes. *The Clinical Supervisor 16*, 163-180. doi:10.1300/J001v16n01_09

Worthen, V. & McNeill, B. W. (1996). A phenomenological investigation of “good” supervision events. *Journal of Counseling Psychology, 43*, 25-3.

APPENDIX B

Demographics Questionnaire

Demographics Questionnaire

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

1. How would you best describe your *current* practicum site (e.g., veterans affairs hospital or medical center, community counseling center, university counseling center, consortium, private general hospital, state/county/other public hospital, correctional facility, psychiatric hospital, private outpatient clinical, school district, Armed Forces medical center, child/adolescent psychiatric or pediatrics, private psychiatric hospital, other)?

2. How would you best describe your previous practicum site (*if relevant*) (e.g., veterans affairs hospital or medical center, community counseling center, university counseling center, consortium, private general hospital, state/county/other public hospital, correctional facility, psychiatric hospital, private outpatient clinical, school district, Armed Forces medical center, child/adolescent psychiatric or pediatrics, private psychiatric hospital, other)?

3. Which of the following best describes your primary theoretical orientation?
 - a. Cognitive-Behavioral
 - b. Existential/Humanistic
 - c. Family Systems
 - d. Psychodynamic
 - e. Other _____

4. How many separate clinical practicums or externship experiences (specific year long training rotations) have you had to date in your doctoral program.

APPENDIX C

Counterproductive Experiences in Supervision: Theoretical and Empirical Findings
50 Items

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 their personal life.

Supervisor discloses negative opinions about the supervisee's clients.

Supervisor discloses negative opinions about the profession.

Supervisor discloses personal disillusionment about their career as a psychologist.

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

Supervisor Supervision Approach and Supervisee Learning Approach Mismatch

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

Supervisor is inflexible in his or her approach to supervision.

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

Supervisor is often insensitive when giving feedback.

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

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

Supervisor/Supervisee Theoretical Orientation Mismatch

Supervisor and supervisee often differ in their conceptualization of cases

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

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

Supervisor has limited knowledge about supervisee's theoretical orientation.

Supervisor criticizes supervisee's primary theoretical orientation.

Cultural Insensitivity

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

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

Supervisor does not encourage the use of culturally appropriate interventions.

Supervisor assumes cultural/racial stereotypes when discussing clients.

Failure to Address Needs of the Supervisee

Supervisor does not consider the developmental needs of the trainee.

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

Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting their professional performance.

Supervisor appears to be distracted in supervision.

Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior

Supervisor provides minimal feedback on the midyear evaluation.

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

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

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

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

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

Supervisor sometimes ignores agency policies.

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

Boundary Crossings/Violations

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

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

Supervisor discusses other supervisees' performance in supervision.

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

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

Supervisory makes jokes/comments with sexual innuendos.

Supervisor expresses attraction to supervisee.

Additional Counterproductive 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 D

Letter to Dr. DeMayo: Permission to Recruit Doctoral Students

Robert DeMayo, Ph.D.
Associate Dean and Professor of Psychology
Graduate School of Education and Psychology
Pepperdine University

Letter to Dr. DeMayo: Permission to Recruit Doctoral Students

Dear Nina,

You have my permission to distribute the email announcement to Pepperdine Psy.D. students. Good luck with this important study.

Robert A. deMayo, Ph.D., ABPP
Associate Dean and Professor of Psychology
Graduate School of Education and Psychology
Pepperdine University

Telephone: [REDACTED]; Fax: [REDACTED]

Email: [REDACTED]

From: Nina Grayson [REDACTED] **Sent:** Monday, July 15, 2013 7:25 PM **To:** deMayo, Robert **Cc:** Shafranske, Edward **Subject:** Seeking Permission to Recruit Students

Dear Dr. DeMayo,

I hope this e-mail finds you well. I'm writing to ask your permission to recruit students as part of a comprehensive research project sponsored by the Clinical Supervision, Training and Professional Development Center directed by Dr. Edward Shafranske.

My study involves asking students in the Psy.D. Program at Pepperdine University to rate experiences they feel to be counterproductive to supervision. They will not be asked to disclose actual experiences that they have experienced in supervision, rather they will be asked to provide opinions about hypothetical experiences and events (which have been drawn from the supervision literature). Students will be asked to sort these experiences according to their likely impact on supervision using a Q-sort procedure. With your permission I would like to ask Pepperdine students who are currently seeing clients at the Pepperdine University Community Clinics, including the clinic at the Union Rescue Mission, to participate in this study.

My intention is to recruit the potential participants by sending an email announcement to Pepperdine Psy.D. students that describes the study and asks for their participation. The email will also contain information describing where participants may retrieve the Q-sort packets. The packets will contain the following information: one copy of the recruitment letter describing the study and the benefits and risks involved, one demographic questionnaire, the stack of Q-sort cards with instructions, and one empty manila envelope in which participants may place the completed forms. This envelope will have my name, Nina Grayson, Principal Investigator, and Dr. Edward Shafranske's name on the outside. This envelope may then be placed in an inter-campus mail envelope with the participant's name and Cheryl Saunder's name on the outside.

The packet will be mailed via inter-campus mail to the mailbox of Cheryl Saunders, Psy.D., Program Administrator. Ms. Saunders will receive the packets and remove the outer inter-campus envelope containing the participant's names on the outside. I will then retrieve the inner envelopes with the submitted data from Ms. Saunders. These envelopes and the accompanying material will not contain any identifying information, thereby ensuring that the participants will remain anonymous. Please let me know if I have your permission to approach students by e-mailing me at: [REDACTED].

If you have any questions or concerns please do not hesitate to call me at ([REDACTED]) or by e-mail or to contact Dr. Shafranske [REDACTED] or ([REDACTED]). Thank you for considering this request.

Sincerely,

Nina Grayson, M.A.

APPENDIX E

Phase I Recruitment: Letter to Clinic Directors/Permission to Leave Packets

Phase I Recruitment: Letter to Clinic Directors/Permission to Leave Packets

[Name]
Clinic Director
[Pepperdine Clinic Name]
[Pepperdine Clinic Address]

Dear Dr. [Name]:

I am a student in the Doctor of Psychology Program at Pepperdine University. For my clinical dissertation project, I have chosen to study counterproductive experiences that occur in the supervision between a clinical supervisor and a trainee. Counterproductive experiences are defined as events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. My study contributes to a comprehensive research project sponsored by the Clinical Supervision, Training and Professional Development Center directed by Dr. Edward Shafranske which is developing a measure of counterproductive experiences in supervision (CES).

My study involves asking students in the Psy.D. Program at Pepperdine University to rate experiences they feel to be counterproductive to supervision. They will not be asked to disclose actual experiences that they have experienced in supervision, rather they will be asked to provide opinions about hypothetical experiences and events (which have been drawn from the supervision literature). Students will be asked to sort these experiences according to their likely impact on supervision using a Q-sort procedure. With your permission I would like to ask Pepperdine students who are currently seeing clients at the Pepperdine University Community Clinics, including the clinic at the Union Rescue Mission, to participate in this study. Your only involvement as Clinic Director would be to allow a box containing the research packets to be placed in the workroom of the clinic.

I will recruit the potential participants by sending an email announcement to Pepperdine Psy.D. students that describes the study and asks for their participation. The email will also contain information describing where participants may retrieve the Q-sort packets. The packets will contain the following information: one copy of the recruitment letter describing the study and the benefits and risks involved, one demographic questionnaire, the stack of Q-sort cards with instructions, and one empty manila envelope in which participants may place the completed forms. This envelope will have my name, Nina Grayson, Principal Investigator, and Dr. Edward Shafranske's name on the outside. This envelope may then be placed in an inter-campus mail envelope with the participant's name and Cheryl Saunderson's name on the outside. The packet will be mailed via inter-campus mail to the mailbox of Cheryl Saunders, Psy.D., Program Administrator. Ms. Saunders will receive the packets and remove the outer inter-campus

envelope containing the participant's names on the outside. I will then retrieve the inner envelopes with the submitted data from Ms. Saunders. These envelopes and the accompanying material will not contain any identifying information, thereby ensuring that the participants will remain anonymous.

The nature of the study is time sensitive and it would be extremely helpful to be able to place the packets in the Pepperdine Clinics. This study intends to contribute to the empirical study of clinical supervision and your assistance by allowing me to leave the packets at your clinical sites is much appreciated.

Please let me know if I have your permission to place a box containing the research packets in your clinic workroom by e-mailing me at: [REDACTED]

If you have any questions or concerns please do not hesitate to contact me via email, call me at [REDACTED], or contact Dr. Shafranske at [REDACTED] or [REDACTED].

Thank you, again, for considering this request.

Sincerely,

Nina Grayson, M.A.

APPENDIX F

Phase I Recruitment: Center Letter

Phase I Recruitment: Center Letter

CLINICAL SUPERVISION, TRAINING AND PROFESSIONAL DEVELOPMENT RESEARCH CENTER

GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY
PEPPERDINE UNIVERSITY

Dear Psy.D. Student:

Based on your experience as a doctoral student in clinical psychology, you are invited to participate in a research project being conducted by Nina Grayson, M.A., under the supervision of Dr. Edward Shafranske, and developed in the *Clinical Supervision, Training and Professional Development Research Center*. The Center is dedicated to advance knowledge through applied research and publication. One of the aims of the Center is to contribute to the development 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 at (██████████) or at ██████████.

Sincerely,

Edward P. Shafranske, Ph.D., ABPP

Carol A. Falender, Ph.D.

APPENDIX G

Phase I Recruitment: Letter to Doctoral Students

Phase I Recruitment: Letter to Doctoral Students

Dear Student:

I am a student in the Doctor of Psychology Program at Pepperdine University. For my clinical dissertation project, I have chosen to study counterproductive experiences that occur in the supervision between a clinical supervisor and a trainee. You have been selected for participation in this study as part of a sample of current psychology doctoral students. I would greatly appreciate your assistance in taking part in this study and contributing to the field of clinical supervision.

Counterproductive experiences are defined as events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. 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 essential to further the knowledge base about counterproductive experiences in supervision as well as to provide a research tool for future use in investigating the relationship between counterproductive experiences and features and outcomes of supervision.

Packets containing the material for the study will be left at three different Pepperdine Clinical Sites: Pepperdine Clinic at the West LA campus, Pepperdine Clinic at the Encino campus, and the Pepperdine clinic at the Union Rescue Mission. The packets will contain the following information: one copy of the recruitment letter describing the study and the benefits and risks involved, one demographic questionnaire, the stack of Q-sort cards with instructions, and one empty manila envelope in which participants may place the completed forms. This envelope will have my name, Nina Grayson, Principal Investigator, and my dissertation advisor's name, Dr. Edward Shafranske, on the outside. This envelope may then be placed in an inter-campus mail envelope with the participant's name and Cheryl Saunder's name on the outside. The packet should be mailed via inter-campus mail to the mailbox of Cheryl Saunders, Psy.D., Program Administrator. Ms. Saunders will receive the packets and remove the outer inter-campus envelope containing the participant's names on the outside. I will then retrieve the inner envelopes with the submitted data from Ms. Saunders. These envelopes and the accompanying material will not contain any identifying information, thereby ensuring that your identities will remain anonymous.

I ask that you complete the demographics questionnaire, follow the procedures for the Q-sort ranking, deliver the packet, in its entirety, via inter-campus mail to the mailbox of Cheryl Saunders, Psy.D., Program Administrator. The time to complete the Q-sort will be approximately 15 minutes.

With the knowledge that advancement to professional status can be an arduous task, requiring doctoral students to fulfill a multitude of responsibilities and obligations, I would like to extend my sincere appreciation for taking the time to consider being a participant in this endeavor.

While there is no direct benefit for you to participate in this study, satisfaction may be derived from the knowledge that your participation will contribute to the field and the literature and 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.

This research does not require you to provide identifying information in the demographic questionnaire, nor does the research require you to sign a consent form. This ensures that the identities of all participants will remain anonymous. If you so desire, you will be provided with documentation linking you to the research. Participation in the study is voluntary and you may withdraw your participation at any point during the study. Additionally, you are not obligated to answer every question and your class standing and grades will not be affected by refusal to participate or by withdrawing from the study.

If you would like an abstract of the study results, you may request to obtain a copy by sending me an email, which is: [REDACTED]. You do not need to participate in this study to receive a copy of the abstract. You may contact me via my email address or Dr. Edward Shafranske, Dissertation Advisor, at: [REDACTED] or ([REDACTED]), if you have questions or comments regarding this study. If you have questions about your rights as a research participant, you may contact Dr. Doug Leigh, Chairperson of the Graduate and Professional Schools IRB, Pepperdine University, at [REDACTED].

This study intends to contribute to the empirical study of clinical supervision and your assistance by forwarding the recruitment section of this e-mail is particularly welcomed. Thank you, again, for your assistance with this research project.

Sincerely,

Nina Grayson, M.A.
Doctoral Student

[REDACTED]

APPENDIX H

Phase II Recruitment: Letter to Practicum Instructors

Phase II Recruitment: Letter to Practicum Instructors

Dear Drs. Aviera, Falender, Harrell, Himelstein, Keatinge, Rowe and Shafranske:

I am a student in the Doctor of Psychology Program at Pepperdine University and I am initiating a second phase of recruitment for my dissertation research, which examines counterproductive experiences in clinical supervision. I am contacting you to ask for your support of this recruitment effort by allowing me to give a 3-4 minute presentation on the research project and to recruit participants at the beginning or end of your class (PSY 773, PSY 776 or PSY 716) on [date]. It was advised that it would be best to ask you to leave the room during the presentation to limit the possibility of any undue influence that you as a faculty member might have on the recruitment process. Therefore, your only involvement would be to allow me to enter your classroom either at the beginning or at the end of class to present the study and invite students to participate. I describe the study below.

For my clinical dissertation project, I have chosen to study counterproductive experiences that occur in the supervision between a clinical supervisor and a trainee. Counterproductive experiences are defined as events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. 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 essential to further the knowledge base about the relationship between counterproductive experiences and features and outcomes of supervision. My study contributes to a comprehensive research project sponsored by the Clinical Supervision, Training and Professional Development Center directed by Dr. Edward Shafranske which is developing a measure of counterproductive experiences in supervision (CES).

The study involves asking students to indicate the impact of experiences they believe to be counterproductive to supervision. They will not be asked to disclose actual experiences that they have experienced in supervision, rather they will be asked to provide opinions about hypothetical experiences and events (which have been drawn from the supervision literature). Students will be asked to sort these experiences according to their likely impact on supervision using a Q-sort procedure. Participants will receive the benefits of a Starbucks gift card of \$ 5 and knowledge that they have contributed to the research in the field of clinical supervision as well as assisted in a fellow student's dissertation research. Participation in this research poses no greater than minimal risk of harm to the participant; possible risks include boredom or emotional discomfort in reflecting on counterproductive experiences in supervision. Please let me know if I have your permission to present to your practicum students by e-mailing me at [REDACTED]. If you have any questions or concerns please do not hesitate to call me at [REDACTED] or to contact Dr. Shafranske at [REDACTED] or [REDACTED].

Thank you, again, for considering this request.

Sincerely,
Nina Grayson, M.A

APPENDIX I

Phase II Recruitment: Presentation/Letter to Doctoral Students

Phase II Recruitment: Presentation/Letter to Doctoral Students

Dear Students:

I am a doctoral candidate in the Doctor of Psychology Program at Pepperdine University. For my clinical dissertation project, I have chosen to study counterproductive experiences that occur in the supervision between a clinical supervisor and a trainee. You have been selected for participation in this study as part of a sample of current psychology doctoral students. I would greatly appreciate your assistance in taking part in this study and contributing to the field of clinical supervision.

Counterproductive experiences are defined as events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisee's growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. 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 essential to further the knowledge base about counterproductive experiences in supervision as well as to provide a research tool for future use in investigating the relationship between counterproductive experiences and features and outcomes of supervision.

Packets containing the material for the study will be left at the Psy.D. student lounge on a table with clearly marked envelopes or packets. The envelopes will be marked "CES Study" on the outside. The packets will contain the following information: one copy of the recruitment letter describing the study and the benefits and risks involved, one demographic questionnaire, the stack of Q-sort cards with instructions, one gift card for Starbucks, and one empty envelope in which you may place the completed forms. This envelope will be labeled, "CES Completed Study", along with the names, Nina Grayson, Principal Investigator, and Dr. Edward Shafranske, Dissertation Advisor, written on the outside. This envelope may then be placed in Cheryl Saunder's mailbox. I will then retrieve the packets with the submitted data from Cheryl. These envelopes and the accompanying material will not contain any identifying information, thereby ensuring that your identities will remain anonymous. I ask that you complete the demographics questionnaire and follow the procedures for the Q sort ranking. The time to complete the Q-sort will be approximately 15 minutes.

I would like to extend my sincere appreciation for taking the time to consider being a participant in this endeavor. Satisfaction may be derived from the knowledge that in sharing your expertise on supervision you will be contributing to the field and adding to the body of literature. An additional benefit from participation in this study is a gift card for Starbucks. If at any time you choose to withdraw from the study, you may still keep the gift card. 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.

Participation in the study is voluntary and you may withdraw your participation at any point during the study. Additionally, you are not obligated to answer every question and your class standing and grades will not be affected by refusal to participate or by withdrawing from the study. If you so desire, you will be provided with documentation linking you to the research. If you would like an abstract of the study results, you may request a copy by sending me an email: ninakate@mac.com. You do not need to participate in this study to receive a copy of the abstract. You may contact me via my email address: [REDACTED] or contact Dr. Edward Shafranske, Dissertation Advisor, at: [REDACTED] if you have questions or comments regarding this study.

I appreciate your consideration of this request to participate in this research project. This study intends to contribute to the empirical study of clinical supervision and your participation is welcomed. Thank you, again, for your assistance with this research project.

Yours Truly,

Nina Grayson, M.A.
Doctoral Candidate in Clinical Psychology

[REDACTED]

APPENDIX J

Phase II Recruitment: Follow- up Letter to Doctoral Students

Phase II Recruitment: Follow- up Letter to Doctoral Students

Dear Doctoral Students:

I would like to extend my sincere appreciation to those of you who have participated in the research project entitled, “CES Study”, conducted by Nina Grayson, M.A., under the supervision of Dr. Edward Shafranske, and developed in the *Clinical Supervision, Training and Professional Development Research Center*. **This is a friendly reminder that the study packets are still available in the Psy.D. student lounge for 1st, 2nd, and 3rd year students who interested in participating in the study and have not already done so.**

The following portion provides a brief overview of the study, including the benefits and risks involved, and procedures for participation.

For my clinical dissertation project, I have chosen to study counterproductive experiences that occur in the supervision between a clinical supervisor and a trainee. You have been selected for participation in this study as part of a sample of current psychology doctoral students. I would greatly appreciate your assistance in taking part in this study and contributing to the field of clinical supervision.

Counterproductive experiences are defined as events or experiences that occur in clinical supervision that strain the supervisory alliance, hinder supervisee’s growth, and contribute to a poor experience of supervision adversely affecting its effectiveness. 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 essential to further the knowledge base about counterproductive experiences in supervision as well as to provide a research tool for future use in investigating the relationship between counterproductive experiences and features and outcomes of supervision.

Packets containing the material for the study will be left at the Psy.D. student lounge on a table with clearly marked envelopes or packets. The envelopes will be marked “CES Study” on the outside. The packets will contain the following information: one copy of the recruitment letter describing the study and the benefits and risks involved, one demographic questionnaire, the stack of Q-sort cards with instructions, one gift card for Starbucks, and one empty envelope in which you may place the completed forms. This envelope will have the name of the study, “CES Study”, along with the names, C/O Cheryl Saunders, Nina Grayson, Principal Investigator, and Dr. Edward Shafranske, Dissertation Advisor, written on the outside. This envelope may then be placed in Cheryl Saunder’s mailbox. I will then retrieve the packets with the submitted data from Cheryl. These envelopes and the accompanying material will not contain any identifying information, thereby ensuring that your identities will remain anonymous. I ask that you complete the demographics questionnaire and follow the procedures for the Q sort ranking. The time to complete the Q-sort will be approximately 15 minutes.

Participation in the study is voluntary and you may withdraw your participation at any point during the study. Additionally, you are not obligated to answer every question and your class standing and grades will not be affected by refusal to participate or by withdrawing from the study. If you so desire, you will be provided with documentation linking you to the research. If you would like an abstract of the study results, you may request a copy by sending me an email: [REDACTED]. You do not need to participate in this study to receive a copy of the abstract. If you have any questions or comments regarding this study please do not hesitate to contact me at [REDACTED] or Dr. Edward Shafranske at: [REDACTED].

I would like to extend my sincere appreciation for taking the time to consider being a participant in this endeavor. Satisfaction may be derived from the knowledge that in sharing your expertise on supervision you will be contributing to the field and adding to the body of literature. An additional benefit from participation in this study is a gift card for Starbucks. If at any time you choose to withdraw from the study, you may still keep the gift card. 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.

I appreciate your consideration of this request to participate in this research project. This study intends to contribute to the empirical study of clinical supervision and your participation is welcomed. Thank you, again, for your assistance with this research project.

Yours Truly,

Nina Grayson, M.A.
Doctoral Candidate in Clinical Psychology

APPENDIX K

Administration Instructions for Q-sort

Administration Instructions for Q-sort

You have received cards, each with a statement of counterproductive events 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/envelope as you wish.

Step 1. Prior to placing the cards in the envelopes, please read all the cards and make a preliminary sorting into three piles:

- 1) What you believe are most problematic CE
- 2) Items you believe are less problematic/not problematic
- 3) Items you feel neutral about

Step 2. Rank each of these cards and place them in any of the following categories/envelopes: 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 3. You have been provided with a blank card. If applicable, please include in writing, a phenomenon of CE that was not included. If you choose to include a CE that was not captured in the cards you were provided with, please rank this card by placing it in one of the four categories/envelopes, as noted above.

Step 4. Seal each envelope and place the sealed envelopes in the large manila envelope you were provided with. The outside of the envelope will be labeled with the title of the study “CES Study”, and the names of the Principal Investigator, Nina Grayson, and the Dissertation Advisor, Dr. Edward Shafranske.

Step 5. Deliver the packet, in its entirety, to the mailbox of Cheryl Saunders, Psy.D., Program Administrator.

APPENDIX L

IRB Exemption Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

November 19, 2013

Nina Grayson

Protocol #: P0513D13-AM1

Project Title: Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Clinical Psychology Doctoral Students

Dear Ms. Grayson:

Thank you for submitting your application, *Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Clinical Psychology Doctoral Students*, 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, Dr. 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 informed consent 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 Kevin Collins, Manager of the

6100 Center Drive, Los Angeles, California 90045 ■ 310-568-5600