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Perceptions of supervisor ethical behavior by psychology interns

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PERCEPTIONS OF SUPERVISOR ETHICAL BEHAVIOR BY PSYCHOLOGY INTERNS

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by

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ABSTRACT

This study examined the ethical behavior of supervisors as perceived by their supervisees. One hundred eleven predoctoral psychology interns completed a web-based survey assessing their perceptions of practicum supervisor lapses in behavior across multiple supervision domains. Participants also answered questions about the impact that perceived ethical lapses of best practices and/or ethical violations had on the supervisory alliance. Survey results indicated that up to three-quarters of participants had perceived at least one ethical lapse of best practices by their previous supervisor. The most frequently reported areas of supervisor non-adherence to ethical standards were: direct observation of clinical work, e.g., live supervision, monitoring of client progress, use of familiar treatments, and use of a supervision contract. The results were consistent with previous studies of ethical practice in supervision (Wall, 2009) and highlight the need for continued study of how ethical guidelines are understood and applied in the practice of clinical supervision. Implications for training in clinical supervision as well as recommendations for future research are discussed.

Introduction and Background

Clinical supervision plays a pivotal role in the professional development of a health service psychologist. It not only facilitates the development of clinical competencies, but also oversees client welfare by evaluating the *entrustability* of the trainee and monitoring the course of evaluation and treatment provided by the supervisee (Falender & Shafranske, 2004; Ten Cate, 2005). Further, the clinical supervisor evaluates the competence of the supervisee and serves as a gatekeeper for the profession. Therefore, supervisors bear particular *ethical* responsibility to clients, supervisees, and the profession as well as to the educational and training institutions with which the supervisee is affiliated. These obligations can only be fulfilled through ethical conduct, professionalism, and the use of best practices by supervisors. Attention to ethical practices in clinical supervision is required, given the centrality of ethics in all professional practice, and particularly in light of client welfare and the training function in clinical supervision, which in part serves to socialize the trainee to ethical practice and professionalism. In addition to didactics, supervisees learn about ethics through the *hidden curriculum* in which ethics are taught through intentional and unintentional supervisor modeling (Falender & Shafranske, 2017). This study investigated psychology interns' perceptions of the ethical behavior of their previous supervisors and offers commentary on the impacts of such perceived conduct on client welfare and on the professional development of the supervisee. We turn now to an overview of clinical supervision.

This section provides a review of the literature on the definition and functions of supervision; the APA guidelines on supervision; supervision in practice; and ethics and professionalism in the practice of supervision.

Definition and Functions of Supervision

The supervision of trainees in psychology is a fundamental aspect of preparation for professional practice (Barnett, 2014; Falender & Shafranske, 2004). Falender and Shafranske (2014b) noted that clinical supervision is now recognized as a core professional competence and that increasingly more attention is being focused on ensuring that supervisors are competent and providing effective supervision. Clinical supervision serves three primary functions: to ensure client welfare; to encourage the professional development of the supervisee; and to protect the general public by serving as a gatekeeper to the profession. Barnett and Molzon (2014) discussed the primary outcomes of supervision as: (a) imparting knowledge, (b) enhancing skills, and (c) preparing supervisees for subsequent training/practice. Falender and Shafranske (2004) defined supervision as:

> a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involves observation, evaluation, feedback, facilitation of supervisee self- assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving. Building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy. Supervision ensures that (it) is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large. (p. 3)

American Psychology Association Guidelines on Supervision

Interest in clinical supervision as a central aspect of clinical training has increased in recent years, particularly with the growth of the competency movement and efforts to clarify factors contributing to effective and ineffective supervision. Clinical supervision is a distinct competency that involves adherence not only to established legal and ethical guidelines but also requires the acquisition of "knowledge, skills, and attitudes/values" (Shafranske & Falender, 2016, p. 182) with regards to a number of domains including diversity and multiculturalism, the

modeling of professionalism, and the establishment and maintenance of a supervisory alliance. The American Psychology Association's newly established *Guidelines for Clinical Supervision in Health Service Psychology* (American Psychological Association [APA], 2015) provides a competency framework with the goal of encouraging the "development of supervisee competence" (p. 33) as well as "ensuring the protection of clients/patients and the public" (p. 33). The Guidelines specifies that the process of supervision must adhere to legal and ethical standards. Specifically, supervisors must "model ethical practice and decision making" (p. 41) and "ensure that supervisees develop the knowledge, skills, and attitudes necessary for ethical and legal adherence" (p. 41). The Guidelines comprise seven domains including supervisor competence; professionalism; diversity; relationships; assessment/evaluation/feedback; problems of professional competence; and ethical/legal/regulatory considerations.

Supervision in Practice

Supervisors are expected to model ethics and professionalism in their positions as role models, trainers, and gatekeepers (Shallcross, Johnson, & Lincoln, 2010). One major role of supervisors is to safeguard the integrity of professional psychology, and by so doing, safeguard society as a whole (Barnett & Molzon, 2014; Thomas, 2010). Gatekeeping in the field of clinical psychology is the process of ensuring that unsuitable individuals do not enter the profession. Barnett and Molzon (2014) highlighted the importance of the gatekeeping responsibility of the supervisor in suggesting that the gatekeeper role should be taken seriously, particularly when remediation efforts fail to ensure trainee competency.

In practice, clinical supervision requires the coordination of several overlapping processes: the formation of a strong working alliance; clear identification of training goals,

responsibilities, and expectations; evaluative and gatekeeping responsibilities; and facilitating ongoing professional development (Shafranske & Falender, 2016).

APA Ethics Code

All psychologists (including supervisors) are required to practice according to the APA's (2010) *Ethical Principles of Psychologists and Code of Conduct*. The Ethics Code delineates ethical principles for professional practice, including the practice of supervision. As Nagy (2011) stated, psychologists who join the APA become "duty bound" (p. 52) to comply with the ethical standards. Some ethical principles that apply specifically to supervisors include a respect for the human dignity of both clients and supervisees, maintaining boundaries of competence, avoiding harm or exploitation of supervisees, and the provision of timely, direct feedback to supervisees (APA, 2010).

Cornish (2013) noted that the APA Ethics Code is limited in that it cannot address all potential ethical dilemmas. Thomas (2010) stated that "the ethical standards establish the minimum criteria for acceptable practice that form the basis for determining violations" (p. 18). Ultimately, however, "ethical awareness requires clinicians and supervisors to accept the clinician's humanity in an honest attempt to minimize ethical conflicts and errors in behavior and judgment" (Pakdaman, Shafranske, & Falender, 2014, p. 439). As Papile (2013) concluded in a study of "critical incidents" (p. 123) in supervision, an essential part of supervision is "involving supervisees in ethical decision-making and exploring the challenges surrounding ethical practice" (p. 123).

Ethics and Professionalism in the Practice of Supervision

As Falender and Shafranske (2007) noted, "Supervisors play a crucial role in modeling ethical practice and guiding exploration of the application of ethics and professional standards

throughout the clinical training experience" (pp. 236-237). They also asserted that professionalism necessitates an ongoing orientation to principles of law and ethics throughout an individual's career (Shafranske & Falender, 2016). Thomas (2010) concluded: "A significant component of the development of all psychologists and mental health professionals is learning and internalizing the ethics of their professions" (p. 4). Of particular importance to the practice of effective supervision is the understanding of and adherence to ethical standards of practice. Falender and Shafranske (2007) asserted:

> Professional ethics requires that psychologists perform their professional responsibilities in a competent manner. This involves not only establishing benchmarks of competence during development and at the point of entry into the profession but also necessitates continuous professional development beyond licensure. (p. 238)

Falender and Shafranske (2004) insisted that professional development requires lifelong commitment to legal and ethical issues and that psychologists who act as supervisors have an "ethical responsibility to acquire competence in supervision" (p. 774). Additionally, the authors asserted that specific to ethical practice, a supervisor must have "knowledge of ethics and legal issues specific to supervision" (p. 778) and must "value ethical principles" (p. 778). Supervision consists of ethical, values-based practice across the supervision "triad" (p. 394) of supervisor/supervisee/client (Falender, Shafranske, & Ofek, 2014, p. 394). Addressing ethics in supervision is critical for a number of reasons, particularly since trainees frequently supervise practicum students and because supervisors have a legal liability for ethical breaches on the part of their supervisees (Thomas, 2010).

The following list provides a compilation of ethical best practices as outlined in the literature.

- Directing the process of informed consent
- Discussing limits to confidentiality

- Modeling professionalism and adherence to ethical and legal standards and ensuring supervisee knowledge of these standards
- Delineating multiple roles/responsibilities of the supervisor (e.g., client welfare, gatekeeping, trainee development)
- Addressing boundary issues/multiple relationships
- Maintaining supervisory alliance
- Maintaining competence
- Evaluation and feedback
- Issues related to disclosure
- Maintaining records of supervision
- Describing remediation procedures
- Describing remediation procedures (APA, 2010, 2015; Falender et al., 2014).

Informed consent/supervision contract. The process of informed consent is an essential component of supervision (Thomas, 2010). Informed consent to supervision provides supervisees with information about what to expect over the course of supervision, including potential risks and benefits. The APA Guidelines highlight a major contribution of informed consent in helping to avoid misunderstandings about the structure and functions of supervision (APA, 2015).

Thomas (2010) pointed out that the process of obtaining informed consent also models for supervisees how to do this effectively with their clients. Gottlieb, Robinson, and Younggren (2007) recommend that supervisees "inform themselves" (p. 246) as to the limitations of the APA Ethics Code and that they sign an informed consent document at the initiation of

supervision. Indeed, Thomas (2007) stated that "ethical standards require…that informed consent be obtained in writing" (p. 225).

Another major component of ethical supervision is the development and ongoing adherence to a written supervision contract (Falender & Shafranske, 2014a). A formal supervision contract also serves the purpose of informed consent in that the supervisor and supervisee each agree to the expectations outlined in the document (Shafranske & Falender, 2016). The contract outlines competencies that the supervisee is expected to develop over the course of the training period as well as modes of observation and procedures for evaluation (Gilfoyle, 2008; Shafranske & Falender, 2016). In a recent study conducted by Ellis et al. (2014a), one of the most frequently cited ethical problems reported by supervisees (54% of respondents) was a lack of informed consent to supervision and/or a lack of supervision contract.

Shafranske and Falender (2016) suggested that the supervision contract should encourage "engagement and collaboration" (p. 15) within the supervisory relationship as well as serve as a model for "transparency and professionalism" (p.16). In addition, the contract "establishes a clear professional boundary, sets the tone for the supervisory relationship, and provides a model for supervisees" (Thomas, 2007, p. 222).

Specifically, the contract should include the following components:

- Role and process of supervision
- The primary duty of the supervisor as ensuring the protection of clients
- Roles and expectations of both supervisee and supervisor
- Criteria for evaluation with sample documentation provided
- Procedures to be followed if supervisee does not meet performance criteria
- Expectations of supervisee for supervisory sessions

- Limits of confidentiality in regards to disclosures made by supervisees as well as methods for communicating performance to training program
- Expectations for disclosures related to reactivity and personal factors
- Legal and ethical compliance issues including informed consent, duty to protect and warn, and multiple relationships
- Procedures for problem-solving related to ethical dilemmas (APA, 2015).

Shafranske and Falender (2016) also suggested that supervisors be attuned to both supervisee emotional responsiveness and emotional reactivity and that a supervision contract should include the recognition that personal factors such as these are an essential contributor to supervisee performance and should thus be explicitly addressed in the context of a strong supervisory alliance.

Modeling professionalism and ethical practice. Falender and Shafranske (2007) suggested that, "As a profession, psychology bears a particular responsibility for advancing ethics within its sphere of influence" (p. 236). A supervisor's role in modeling ethical practice throughout the process of clinical supervision is a major factor in the advancement of ethical practice (Falender & Shafranske, 2004). As Johnson and Kaslow (2014) noted, supervisors have an opportunity to create a "culture of ethical practice" (p. 339) by teaching and modeling, both formally and informally, ethics and professionalism in practice . Modeling both ethical practice and professionalism includes a dedication to attributes such as integrity, honesty, deportment, accountability, professional identity, compassion, and respect (Fouad et al., 2009; Glicken & Merenstein, 2007). Effective supervisors consistently model ethical and professional behavior; they also focus on the ongoing development of ethical practice (Barnett, Erickson Cornish, Goodyear, & Lichtenberg, 2007; Gottlieb et al., 2007). According to Falender et al. (2014), an

important *attitude* for an effective supervisor to hold is a respect for ethical principles and the ethics code while an important *skill* for an effective supervisor is "remaining mindful and attuned to ethical and legal aspects of supervision and practice including appropriate boundaries, informed consent, and confidentiality" (p. 395).

Grus and Kaslow (2014) emphasized the important role that supervisors play in that their interactions with supervisees have profound effects on supervisees' professionalism and ethical behavior. Pakdaman et al. (2014) asserted that modeling ethical practice and professionalism in supervision is one of the primary modes by which supervisees develop their own foundation for ethical practice. In particular, Goodyear (2014) highlighted the importance of "unintentional modeling" (p. 89) through indirect cues and behaviors that can impact a supervisee's learning.

Johnson and Kaslow (2014) noted that informal instruction also impacts a trainee's learning. Informal learning can occur in a number of ways, for example, when a trainee observes his or her supervisor interacting with a colleague or client, or through observations of a supervisor's organizational skills, punctuality, or overall demeanor. Glicken and Merenstein (2007) assert that students and trainees are "close observers" (p. 57) of their mentors' behavior, whether intentionally modeled or not. Learning that occurs through this type of informal modeling is known as the "hidden curriculum" (Gabbard, 2012, p. 183; & Castellani, 2010, p. 291), and is fundamental to trainee development.

Supervisor behavior modeled in the environment may run counter to explicit instruction (Johnson & Kaslow, 2014). D'eon, Lear, Turner, and Jones (2007) highlighted that both "poor modeling" (p. 295) and "unresolved ethical dilemmas" (p. 295) serve to undermine the development of professionalism in students. Specifically, the authors draw attention to the anxiety created for supervisees by "exposure to unethical behavior" (p. 295) on the part of their

superiors. It is for this reason that Gabbard (2012) recommended that supervision training incorporate a "hidden curriculum" (p. 183) of ongoing professional development.

While modeling is an essential conduit for trainee learning, it is necessary but not sufficient to teach professionalism; supervisors need clear criteria by which to assess ongoing development of professional competencies (Grus & Kaslow, 2014). Falender and Shafranske (2014a) assert that supervisors are in a position to constantly assess a supervisee's professionalism and compliance with ethical standards. Barnett et al. (2007) suggest that ethical practice in supervision should include the following: assessing training needs; agreement on nature of supervision; maintaining confidentiality; provision of feedback; maintaining appropriate boundaries; being mindful of areas of competence; engaging in self-care; and addressing issues of diversity.

Addressing multiple roles. As Falender and Shafranske (2012) have asserted, it is the supervisor's responsibility to ensure that his/her supervisee is aware of the multiple obligations that comprise the supervisory role. While supervisors serve as gatekeepers to the profession and are expected to take appropriate action if a supervisee's competency is not sufficient, they also are expected to advance a trainee who meets competency expectations (Bodner, 2012; Fouad et al., 2009).

Gottlieb et al. (2007) point out that "supervisory relationships entail power differentials and create unique vulnerabilities for supervisees" (p. 242). For these reasons, supervisees may be more vulnerable because of the power differential. In fact, Pettifor, Sinclair, and Falender (2014) have cited the power differential as often resulting in supervisee reluctance to discuss ethical and cultural issues in supervision.

Boundary issues/multiple relationships. Gottlieb et al. (2007) note that: "Supervisors are ethically and legally required to act in the best interest of their supervisees" (p. 244). The APA (2010) Ethics Code explicitly states that supervisors are to avoid harm and/or exploitation of supervisees. The risk of harm to supervisees increases when multiple relationships create ethical dilemmas and lead to boundary crossings and/or boundary violations.

Multiple relationships have long been considered challenging with regards to ethical conduct (Minnes, 1987). Gottlieb et al. (2007) discuss ethical issues related to multiple relationships in supervision. Thomas (2010) discusses several areas related to multiple relationships in supervision that could lead to ethical dilemmas:

- Boundaries
- Exploitation and abuse of power
- Psychotherapy with supervisees
- Sexual harassment and sexual exploitation
- Sexual contact with supervisees
- Impaired objectivity and judgment
- Unforeseen or unavoidable multiple relationships

One major type of ethical conflict that occurs in supervision has to do with boundary crossings and boundary violations. Thomas (2010) asserted that "whether a particular action on the part of a supervisor or consultant constitutes a boundary crossing, boundary violation, helpful intervention, or just a neutral, inconsequential interaction depends on many factors" (p. 107). A boundary crossing is generally not deemed unethical according the ethical codes and standards; however, a boundary crossing may still have a negative impact on the supervisory alliance. For example, a boundary crossing may consist of a supervisor initiating personal contact with a

supervisee outside of the workplace or disclosing an inappropriate amount or type of personal information, such that the disclosure causes the supervisee distress. There are often many more neutral types of boundary crossings, such as in gift-giving or informal exchanges. A determination of what constitutes *inappropriate* contact or disclosure is highly subjective and generally delineated on a case-by-case basis. As Gottlieb et al. (2007) note, "harming supervisees is unethical and potentially illegal; if it were reasonable to anticipate that [a] proposed relationship would be harmful, pursuing it would be unacceptable" (p. 245).

A boundary violation represents an occurrence that *does* breach ethical standards as outlined in professional practice guidelines and has the potential to harm supervisees and/or a supervisee's clients. Examples include the development of a sexual relationship between supervisee and supervisor or a supervisor's failure to adequately monitor supervisee ethical practice with clients or maintain confidentiality within the supervisor/supervisee dyad (Ladany, Ellis, & Friedlander, 1999). A boundary violation may also occur when a supervisor utilizes diagnostic language to clinically assess a supervisee's competency or personal attributes (Shafranske & Falender, 2016). Ultimately, it is the supervisor who is responsible for determining whether or not to initiate a secondary role with a supervisee, keeping in mind that engaging in a secondary role may be unethical if it is incompatible with the supervisory relationship (Thomas, 2010).

Multiple relationships are examples of boundary crossings that are not clearly unethical can still pose problems in terms of boundary management and can sometimes develop into a boundary crossing or boundary violation (Gottlieb et al., 2007). For example, Budz (2014) surveyed 69 doctoral supervisees and found that the *blurring* of professional boundaries was a consequence of interacting with supervisors via social media. Hardy (2011) surveyed 84

supervisees regarding perceived ethical issues in supervision and found that 33% cited a boundary violation occurring over the course of supervision, with 27% of reported boundary violations described as sexual in nature. Results of the study indicated that many supervisees experienced some confusion about what classifies as ethical behavior in supervision and what to do if a boundary violation occurs.

Another recent study found that even when supervisees experience *positive boundary crossings* such as supervisor self-disclosure or ride sharing, such interactions nonetheless often led to role confusion on the part of the supervisee (Kozlowski, Pruitt, DeWalt, & Knox, 2014). The authors recommended that supervisors consult or use an ethical decision-making model to determine how a boundary crossing could potentially impact a supervisee. Indeed, role conflict has been cited in previous literature as a contributor to negative events in supervision (Ladany, Friedlander, & Nelson, 2005).

Maintaining competence. Maintaining competence is an essential aspect of ethical practice in supervision (Johnson, Barnett, Elman, Forrest, & Kaslow, 2013). Falender and Shafranske (2007) specify that:

> Efforts to articulate and to apply the construct of competence are salient to the profession and particularly to supervision, because supervised clinical training provides the context for competence to be developed as well as for foundational attitudes and practices, which encompass professionalism, to be instilled. (p. 232)

Supervisors are required to obtain training to ensure they are able to demonstrate adequate knowledge, skills, and attitudes to supervise trainees (Newman, 2013; Watkins, 2012). Supervisees, for their part, are expected to develop competence that comprises their ability to apply knowledge, skills, and attitudes/values necessary to adequately engage in clinical work with clients (Shafranske & Falender, 2016).

Barnett and Molzon (2014) suggest that two types of competence are necessary for the ethical practice of supervision: (a) in the clinical area being supervised and (b) in the practice of supervision. Importantly, when a supervisor identifies an issue related to professional competence, that supervisor has an ethical responsibility to communicate the concern with the supervisee and collaboratively develop a plan to address the issue (APA, 2010). Falender and Shafranske (2007) assert that both self-assessment and self-reflection are crucial in the development of competence and for ethical practice.

Supervisors respect the human dignity of both clients and supervisees; in fact, diversity competence is considered an "ethical imperative" (p. 182) in clinical practice (APA, 2010; Bernard & Goodyear, 2014; Falender, Shafranske, & Falicov, 2014). Indeed, Falender, Shafranske, and Falicov (2014) note that multicultural and diversity competence is an ethical necessity in both clinical care and in supervision. Falender and Shafranske (2007) also conceptualize diversity and multicultural competence as an ethical standard that should be an ongoing focus of self-assessment for both supervisor and supervisee. Specifically, cultural issues such as religious coping and spirituality should be considered in the context of client care and also in the context of demonstrating respect for the worldview of the supervisee (Falender et al., 2014).

As Barnett and Molzon (2014) suggest, "It is important that supervisees develop a sophisticated approach to addressing ethical challenges and dilemmas that involves the application of a process of ethical decision making rather than looking for the 'right answer'" (p. 1056). Indeed, Falender and Shafranske (2007) note that "ethical competence is often narrowly construed, placing emphasis on behavioral outcomes related to correct or incorrect decisions, rather than directing attention to the underlying processes and values involved in

ethical decision-making" (p. 236). As Handelsman, Gottlieb, and Knapp (2005) note, "Becoming an ethical professional is more complex than simply following a set of rules or doing what one sees one's mentors do" (p. 59).

Evaluation and feedback. Other important components of ethical supervision are assessment, evaluation, and feedback (Falender & Shafranske, 2004). The APA (2010) Ethics Code states that a supervisee should be provided with direct feedback in a timely manner. This involves the ability and willingness on the part of the supervisor to provide clear and constructive feedback, ideally based on direct observation of trainee performance rather than trainee self-report. Supervisors should provide both *formative feedback*, i.e., feedback aimed at monitoring the ongoing progress of supervisee performance, and *summative evaluations* aimed at assessing levels of competency and progression in training (Shafranske & Falender, 2016). Feedback linked to direct observation of trainee performance enhances accuracy and effectiveness (APA, 2015).

Supervisors are required to monitor their supervisees' performance, which may also include monitoring outcome measures with regards to client clinical outcome (Shafranske & Falender, 2016). The supervision guidelines recommend that supervisors encourage supervisee self-assessment in the process of evaluation and also that supervisors elicit feedback from their supervisees on the process and experience of supervision (APA, 2015).

As Goodyear (2014) succinctly states: "feedback is indispensable to supervisee learning" (p. 87). Recent studies indicate that supervisors provide direct feedback relatively infrequently (Ellis et al., 2014a). This is problematic in that a failure to provide adequate feedback has been associated with a lack of communication to supervisees regarding their development of ongoing competencies and has also been linked to gatekeeping inadequacies (Thomas, 2010).

Failure to provide consistent feedback has also been linked to a higher risk of ethical complaints (Falvey & Cohen, 2004). Ladany et al. (1999) found that the most common ethical complaint from supervisees was related to inadequate feedback while Hoffman, Hill, Holmes, and Freitas (2005) found that negative feedback provided indirectly to supervisees is associated with poor training outcomes.

Ladany, Mori, and Mehr (2013) interviewed 128 supervisees about effective and ineffective supervisor characteristics and found that supervisees valued "positive and challenging" feedback as well as supervisor self-disclosure for the benefit of the supervisee (p. 41). Additionally, a study by Ellis et al. (2014b) found that 39% of supervisees reported that their supervisors did not review their sessions with clients. Some supervisees also indicated that their supervisors provided "no evaluative feedback" (p. 458).

According to the APA (2015) Guidelines, it is recommended that supervisors be mindful of the following when providing feedback to supervisees: the power differential; cultural considerations; the developmental level of the supervisee; any potential negative impacts on the supervisee; and the amount of feedback a supervisee receives at a given time.

Research on Ethics in Supervision

Supervisory alliance. Research has demonstrated that the quality of the supervisory alliance affects supervisee satisfaction (Ladany et al., 1999), supervisee self-disclosure regarding personal reactivity (Falender & Shafranske, 2004; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999), the quality of evaluative practice (Lehrman-Waterman & Ladany, 2001), and client care (Nelson & Friedlander, 2001). Recent research into working alliance suggests that a strong supervisory relationship affects supervisee disclosure, the development of cultural competence, ratings of self-efficacy, and ratings of satisfaction (Bernard & Goodyear, 2014;

Falender et al., 2014). Thomas (2010) asserts that in some cases, supervisor self-disclosure may be an "ethically appropriate" (p. 135) and "effective" intervention (p. 135).

For the trainee, an ethical breach may lead to a loss of trust and a corresponding decrease in disclosure needed for continued client care. A weak supervisory alliance and a reluctance on the part of the supervisee to disclose in supervision can have a negative impact on a trainee's professional development as well as on client care (Ofek, 2013). Mehr, Ladany, and Caskie (2010) found in a study of 204 supervisees that approximately 84% withheld information from a supervisor. The researchers also found that the perception of a strong working alliance on the part of a supervisee is related to higher levels of supervisee disclosure during supervision (Mehr et al., 2010, 2015). Additionally, an ethical breach may preclude opportunities for ongoing training and skills development on the part of the trainee. Gottlieb et al. (2007) assert that a loss of trust in the supervisor/supervisee dyad can have significant, long-term impact on a trainee's professional development. Ellis et al. (2014a) noted that a lack of warmth and empathy often leads supervisees to perceive supervision as either inadequate or harmful. In addition, Ladany et al. (2013) found that the supervisory relationship was a critical component of effective supervision. As Watkins (2012) asserts, "the supervision relationship, individualization, developmental differentiation, and self-reflection (for supervisee and supervisor) appear to be crucial cornerstones…to [the] supervision process" (p. 193)

The APA (2015) Guidelines identify a strong working alliance in the context of the supervisory relationship as an essential component to effective supervision. Bernard and Goodyear (2014) assert that both supervisory relationship and supervisory working alliance are important to ensure effective clinical supervision while Ladany (2014) suggests that one major contributor to ineffective supervision is the failure to consider issues of alliance as essential to

the supervisory process. In addition, Pakdaman et al. (2014) assert that it is an ethical imperative for supervisors to prioritize the working alliance.

Inadequate supervision. There is evidence that inadequate supervision during training can result in negative outcomes in clinical work (Barnett, 2014). Fouad et al. (2009) suggest that ethical and legal competence requires supervisors to be well versed in professional, ethical, and legal standards and must be able to address ongoing ethical issues in supervision. Despite this ethical imperative, ethical breaches are not uncommon. Research shows that about half of supervisees have perceived an ethical lapse of best practices and/or an ethical violation on the part of their supervisor (Ladany et al., 1999; Wall, 2009). Ethical lapses of best practices most frequently included issues related to performance evaluation, confidentiality, and in supervisors' flexibility in utilizing a range of theoretical orientations.

A recent study conducted by Ellis et al. (2014a) that surveyed the experiences of supervisees distinguished *inadequate* from *harmful* supervision. In the study, inadequate supervision was defined as occurring when:

> the supervisor is unable, or unwilling, to meet the criteria for minimally adequate supervision, to enhance the professional functioning of the supervisee, to monitor the quality of the professional services offered to the supervisee's clients, or to serve as a gatekeeper to the profession. (p. 439)

The study defined harmful supervision as "supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee" (p. 440). Results of the study indicated that 93% of supervisees were receiving "inadequate" (p. 434) supervision and 36% were receiving "harmful" (p. 434) supervision. In addition, over half of supervisees reported having received inadequate supervision at some point in their training. A complementary study by Crall (2011) noted that the perceived frequency of ethical breaches by supervisors was around 33%.

There is evidence that even advanced supervisees may not be fully aware of the ethical obligations of the supervisor (Cikanek, Veach, & Braun, 2004). Pettifor et al. (2014) state:

> The factors of supervisor privilege and supervisee lack of power result in supervisees generally feeling less empowered, and especially less empowered to discuss ethics, cultural dimensions, or their intersection with supervision, especially without an articulated collaborative process (p. 204).

Importantly, Thomas (2010) notes that: "Particularly in supervision, novice clinicians may not understand what is appropriate behavior for supervisors" (p. 107).

Ladany et al. (1999) conducted the first major study linking supervisor behavior to ethical standards and supervisee perceptions. The researchers found that a supervisor's adherence to standards of ethical practice affected both the process and the outcome of clinical supervision and that there was a negative impact on the quality of client care resulting from perceived lapses of ethical best practices on the part of the supervisor. As part of the study, the researchers identified several practice areas of supervision that require adherence to ethical principles.

- Performance evaluation and monitoring of supervisee activities
- Confidentiality issues in supervision
- 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
- Modeling ethical behavior and responding to ethical concerns
- Crisis coverage and intervention
- Dual roles
- Differentiating supervision from psychotherapy and counseling

- Sexual issues
- Multicultural sensitivity toward clients
- Multicultural sensitivity toward supervisees
- Client termination and follow up issues (Ladany et al., 1999)

Specifically, over half of all supervisees surveyed as part of the study had perceived at least one ethical breach over the course of their clinical training. Results also indicated that less perceived adherence to ethical guidelines was associated with a weaker working alliance and less supervisee satisfaction. Supervisees reported that overall, perceived ethical lapses of best practices had a mild to moderate negative impact on client care. The most frequently perceived ethical lapses fell into the categories of issues with evaluation, confidentiality, and ability of the supervisor to adopt alternative theoretical perspectives. Notably, 33% of supervisees reported that perceived ethical lapses had to do with problems with evaluation such as inadequate feedback or failure to review taped sessions (Ladany et al., 1999).

Wall (2009) expanded the study conducted by Ladany et al. (1999) by surveying 180 supervisees about their perceptions of supervisor unethical behavior and the impact that the experience had on the supervisory relationship, client care, and supervisee emotional well being. Wall adapted instrumentation used by Ladany et al. to create the *Ethical Practices in Supervision Scale*, a revised scale meant to streamline data collection and incorporate new research on supervision as a distinct competency. Results indicated that 23% of supervisees perceived at least one ethical lapse on the part of their supervisor and 26% had questioned the ethical judgment of their supervisor at least once. The most frequently cited areas of perceived supervisor non-adherence were in direct observation of clinical work, supervision contracts, confidentiality, and supervising in a treatment modality in which the supervisor is untrained.

Among those who reported perceived ethical lapses of best practices, approximately 66% indicated that their supervisor did not directly observe their clinical work, instead relying on supervisee report and/or progress notes. Additionally, 42% indicated that a supervisory contract was not utilized on at least once occasion. Supervisees also indicated that 38% of supervisors allowed their supervisees to conduct treatment in a modality in which the supervisor was not trained (Wall, 2009).

In addition, results indicated that perceived ethical lapses of best practices negatively impacted the supervisory alliance, trust in the supervisor, willingness to disclose information in supervision, emotional well being, and motivation to be in the field. A reported 76% of supervisees stated that the perceived ethical lapse negatively impacted their trust in the supervisor and 73% indicated that the breach negatively impacted working alliance. Additionally, 54% said they were less willing to disclose in supervision, 34% reported a negative impact on emotional well being, and 22% reported a negative impact on client care and/or motivation to remain in the field (Wall, 2009).

Overall, results indicated that the majority of participants perceived their clinical supervisors to be adhering to ethical standards, but that many participants observed that their supervisors were not adherent to all ethical standards. These results were consistent with findings by Ladany et al. (1999). In a more recent study, Ladany (2014) noted that "generally…it seems that many supervisors do not attend as scrupulously to the ethical imperatives of supervision as they do when it comes to psychotherapy per se" (p. 1,097).

A call to research. Trainees under clinical supervision learn about ethics primarily through observation of their supervisors. As discussed previously, the hidden curriculum is a powerful force in the ethical preparation of new clinical trainees (Gabbard, 2012; Hafferty &

Castellani, 2010). Trainees are highly impacted by the ethics they learn in the context of observation and clinical practice; trainees who witness unethical behavior by their supervisors may be more likely to engage in similar behavior in their own clinical work. In this way, ethical practice through modeling in supervision has the potential to have a global impact on the quality of clinical practice more broadly. Additionally, trainee perceptions of unethical conduct by supervisors can strain the supervisory alliance. As previously discussed, a poor working alliance has a local impact on the clinical work performed by trainees under supervision. Although clinical supervision represents a fundamental aspect of training in terms of accountability and gatekeeping, improving competence and professional development, and protecting and serving clients, there is recent evidence to suggest that supervisees are still experiencing harmful and/or unethical supervision (Ellis et al., 2014a).

Results from the Wall (2009) study indicate that perceived ethical violations, when they occur, negatively impact the supervisory alliance, trust in the supervisor, willingness to disclose information in supervision, supervisee emotional well-being, and motivation to be in the field. These findings are important for a number of reasons. First, as discussed previously, the quality of the supervisory alliance and a supervisee's trust in his or her supervisor is essential for adequate supervision. This is especially important when considering the potential negative impact of non-disclosure on both trainee development and client care. Second, emotional well-being and motivation to remain in the field are fundamental for the perpetuation of the field of psychology itself. Importantly, Johnson and Kaslow (2014) note that unethical practice by supervisors can negatively impact a trainee's professional development and lead to competence issues in future practice. It is important to consider that the supervisees receiving training today will be the supervisors imparting knowledge tomorrow.

Gottlieb et al. (2007) explain that "a fundamental problem in ethical decision making [is when] ethical dilemmas arise, they are often less about what objectively occurred and far more about how they were perceived" (p. 242). While the literature on ethics in supervision has expanded in recent years, there remains a need to further understand the perceptions of supervisees regarding the ethical behavior of their supervisors, particularly in the context of supervision as a distinct clinical competency.

Purpose of this Study

The purpose of this study was to advance understanding of the ethical behavior of supervisors as perceived by their supervisees. This study, building on the work of Wall (2009) and others, aimed to further examine supervisor ethical conduct, perspectives of interns as per ethical behavior in supervision, and obtain a global assessment of the effects of ethical breaches on the supervisory alliance and client care. Thus, this investigation intends to expand the research base with regard to the ethical practice of supervision.

Method

Research Approach and Design

This study investigated trainees' perceptions of supervisory ethical behavior. The survey aimed to expand on the prior work of Wall (2009) by utilizing a targeted survey available to psychology interns on the Internet. The study utilized Wall's original instrumentation with the addition of new questions to reflect current developments in the field of supervision. Several researchers have argued in favor of study replication; for example, Makel (2014) insisted that replication studies serve the field by clarifying hypotheses and verifying results. Other researchers have pointed to the need to expand the definition of replication beyond statistical significance to broader, more flexible replication goals (Anderson & Maxwell, 2016). The purpose of the current study was to gain an understanding of how interns' perceptions of their supervisors' ethical behavior have changed since Wall's 2009 study. This was accomplished by retaining a portion of Wall's original instrument and adding additional questions to reflect new developments in the field of supervision.

There are some disadvantages to using surveys administered via the Internet. For example, Ward and Pond (2015) point out that "careless responding" (p. 554) by participants of Internet-administered surveys can skew study results and negatively impact the validity of a study. Other potential drawbacks include unanticipated technical difficulties (Fricker & Schonlau, 2002) and an inability to verify if respondents meet inclusion criteria (e.g., status as a current pre-doctoral intern). In addition, the APA prohibits the use of Internet surveying on its listservs. This represents a barrier to obtaining a potentially larger sample.

Despite the drawbacks, the current study utilized a targeted survey administered via the Internet in order to increase the potential respondent pool via forwarding, streamline the data

collection process, and limit cost. As a method for data collection, surveys administered via the Internet have the advantage of wide dissemination and simplification of return procedures (as compared to a traditional pen-and-paper survey instrument that would require postage). As such, they are cost-effective and provide for relatively straightforward administration of self-report measures (Hoonakker & Carayon, 2009; Uhlig et al., 2014). Self-report measures are the most commonly-used instrument in supervision studies (e.g., Ellis, 2014b, Ladany et al., 1999). In addition, surveys administered via the Internet have the added advantage of increasing the potential respondent pool through a snowballing procedure. For example, interns who receive the survey may elect to forward it to other interns who they believe may be interested in participation.

Participants

Potential participants were identified through the Association of Psychology Postdoctoral and Internship Centers (APPIC, 2017) directory of registered internship sites. Participants recruited for the study were interns in APPIC-affiliated predoctoral internships in clinical, school, counseling, and combined programs. An email was sent to 758 internship training directors of APPIC sites with an introductory description of the study and with a request to forward the self-report measures to their current interns. According to APPIC, 3,197 students matched for the 2016-2017 internship training year. A total of 111 current interns participated in the study. It is impossible to determine the exact number of trainees invited to participate in the study since (a) there are different numbers of interns at each training site, (b) training directors who received the survey invitation may not have forwarded it to their interns, and (c) interns who received the study may have forwarded it to other interns. Recent research utilizing a survey design has drawn between 100 and 200 participants on average (Kirk, 2014; Powers, 2015).

General characteristics of participants. Demographic information for the 111 study participants are presented in Table A1 (See Appendix A). Demographic characteristics of supervisors as reported by study participants are displayed in Table A2 (See Appendix A). The participants in this study included 111 psychology pre-doctoral interns. The sample consisted of 98 (88.3%) women, 12 (10.8%) men, and one respondent (.9%) who answered *Other*. The sample was 88 (79.3%) White (non-Hispanic), six (5.4%) Asian/Pacific Islander, eight (7.2%) Hispanic/Latino, seven (6.3%) African American/Black, one (.9%) American Indian/Alaskan Native, two (1.8%) Biracial, and five (4.5%) who marked Other as their racial/ethnic identification. Of the study participants, 91 (82%) were enrolled in clinical psychology doctoral programs, 13 (11.7%) were enrolled in counseling doctoral programs, five (4.5%) were in school psychology programs, and two (1.8%) marked Other for type of doctoral program. Study participants were in the process of earning either a Psy.D. (52.3%) or a Ph.D. (46.8%) degree. Participants reported a range of practicum experiences prior to internship with a range of 1 to 5 or more. The majority (47, 42.7%) of respondents had completed three yearlong practicum rotations prior to beginning internship training. Thirty-three of the participants (30%) had completed four practicum rotations and 21 (19.1%) had completed 5 or more yearlong rotations. The majority of study participants (22.9%) reported that they had trained at a community mental health center prior to their internship year. The next most common practicum site prior to internship was Other (19.3%). Of the 111 participants, 93.6% indicated that their primary supervisor was a licensed psychologist, 3.7% had a licensed professional in another discipline, and 2.8% were primarily supervised by an unlicensed psychologist.

Instrumentation

The survey instrument used in this study was the Ethical Practices in Supervision Scale – Revised (EPSS-R), which was adapted from Wall's 2009 Ethical Practices in Supervision Scale (EPSS). Five new questions were added to the EPSS for the purposes of this study to reflect new developments in the field. The questions were intended to reflect an emphasis on the following areas of ethical best practice in supervision: monitoring of client progress, provision of feedback, explicit discussion of multiple roles and responsibilities, and a focus on the supervisory relationship.

The EPSS-R utilizes a revised Likert scale meant to streamline data collection and incorporate new research on supervision as a distinct competency. The current study utilized three distinct instruments: a Demographics Questionnaire updated to reflect current APPIC standards; the EPSS-R; and the Working Alliance Inventory-Supervision (Bond Scale; see Appendices B, C, and D).

Demographics questionnaire. A demographics questionnaire was utilized to collect a variety of data on both participants and their prior supervisors, including age, gender identity, sexual orientation, race/ethnicity, site data, and theoretical orientation. The questionnaire was modeled after the instrument used by Wall (2009) and modified for the current study to reflect 2015 APPIC demographic information collected from pre-doctoral applicants (see Appendix B for demographics instrument).

Ethical practices in supervision scale - revised. The original EPSS constructed by Wall for her 2009 study included 28 questions regarding supervisees' perceptions of the ethical behavior of their supervisors. Questions were rated on a Likert scale from 1 = *strongly disagree*

to 5 = *strongly agree*. Questions comprised the following 10 domains of supervisor ethical practice:

- Monitors supervisee performance and professional activities (3)
- Observes supervisee performance and professional activities (3)
- Practices multicultural sensitivity toward clients and supervisees (2)
- Maintains appropriate boundaries and carefully monitors dual roles (3)
- Discusses the process of evaluation, provides regular feedback about supervisee performance and competence, and documents strengths and areas for improvement (3)
- Supervises only therapist-client relationships in which supervisor is competent (3)
- Models professional principles, values, and ethics (2)
- Legal issues (3)
- Ensures adequate disclosure to client (3)
- Identifies parameters of supervision (3; Wall, 2009).

In addition, the Wall (2009) study included a final question in which participants were asked to identify ways in which a perceived unethical breach impacted a number of areas including: the supervisory alliance; trust in the supervisor; willingness to disclose information; motivation to remain in the field; quality of client care; and emotional impact.

Five new questions were added to the EPSS for the purposes of this study to reflect new developments in the field. The questions were intended to reflect an emphasis on the following areas of ethical best practice in supervision: monitoring of client progress, provision of feedback, explicit discussion of multiple roles and responsibilities, and a focus on the

supervisory relationship. The following list outlines changes made/questions added to Wall's original instrument:

- My supervisor systematically monitored patient progress, e.g., thorough review of outcome measures.
- My supervisor frequently provided formative feedback.
- My supervisor periodically elicited my feedback on the supervisory process.
- My supervisor outlined his/her responsibilities and multiple obligations (i.e., primary responsibility to client, followed by responsibility for trainee professional development, followed by gatekeeping duty).
- My supervisor attended to the supervisory relationship (i.e., demonstrated respect, empathy, trust, and integrity).

The bond scale of the working alliance inventory - supervision. The Bond Scale of the Working Alliance Inventory-Supervision (WAI-S) was also added to the measure in order to capture the nature of the supervisory working alliance. Previous research has identified the Bond Scale portion of the WAI-S as the subscale most closely related to trainee self-report of comfort in supervision (Ladany et al., 1999).

Procedures

Data were collected through the use of a web-based survey consisting of three sections, (a) Demographics Questionnaire, (b) EPSS-R, and (c) WAI-S.

Recruitment. Recruitment for the study commenced following approval by Pepperdine University's Institutional Review Board (IRB). Invitations to participate in the study were sent to internship training directors with a request to forward the recruitment letter and link to the Internet-based survey site to their current interns. The recruitment materials described the

purpose of the study and clarified that data were being collected about current interns' *previous* supervisory experience *prior to internship*. Recruitment materials are displayed in Appendices E and F.

Pilot study. A pilot study was conducted with a group of 12 doctoral students at Pepperdine University in order to determine the face validity of the EPSS-R and to solicit constructive feedback. On average, the instrument took less than 15 minutes to complete. Feedback collected during the pilot study was incorporated into the instrument with the goal of clarifying meaning and removing redundancies. Specific feedback that was incorporated included clarifying instructions for answering questions that were not applicable, for example, in the case of abuse reporting.

Human subjects protection. The study proposal was submitted for exempt review by the Pepperdine University IRB due to a minimal estimated risk of harm to participants. Risk to participants included potential discomfort in answering questions about experiences in supervision. Risk to participants was minimized by the fact that no identifying information was collected; the online survey program that was utilized to construct and disseminate the survey does not collect participants' IP or email addresses. In addition, participants were given explicit permission to refuse to answer any questions and/or to discontinue participation in the study at any time.

Consent for participation. A Waiver of Documentation of Informed Consent was requested from Pepperdine University's IRB due to an estimated low risk to participants as well as issues related to confidentiality, the sensitivity of the research question, and logistics related to methodology. Participants were provided with a document that describes the purpose of the study, procedures, and explicitly outlines their right to refuse participation as well as anticipated

benefits and risks (see Appendix D for informed consent document). Participants as well as internship training directors were given the option of receiving an abstract at the conclusion of the study.

Potential risks and benefits. It is estimated that the study posed no more than minimal risk to study participants. Possible risks include fatigue experienced during study participation and/or distress related to answering questions about previous supervisory experiences. To minimize risk, study participants were provided with contact information for both project investigator and project supervisor.

Data collection. Data was collected using a targeted survey disseminated via the Internet to reach current predoctoral interns at a variety of training sites around the country. The window for data collection was February 28, 2017 through March 24, 2017. The online data collection service Survey Monkey was used to house the instruments and raw data. There were no identifiable data collected from survey participants, including IP addresses. Data will be stored in a password-protected file following completion of the study and will be destroyed by the study investigator after a minimum of three years.

Data Analysis

Raw data from the EPSS-R are presented in table format and are compared, where relevant, to data from the Wall (2009) study. No statistical analyses comparing the data obtained by Wall and the data in this study were performed, given the small sample size.

Results

Results of the current study suggest that most supervisors are perceived as generally adhering to the ethical principles and codes of conduct. However, up to three-quarters of participants reported at least one ethical lapse by their previous supervisor. They indicated that the most frequent areas of supervisor non-adherence were in direct observation of clinical work, including live supervision, monitoring of patient progress (e.g., via outcome measures), use of familiar treatments, and use of a supervision contract. Results are discussed below in relation to the ethical imperatives in supervision identified by the APA (2010; 2015) and by experts in the field of clinical supervision (Falender et al., 2014). Table 1 lists supervisor non-adherence to each ethical practice in descending order.

Table 1

Percentage of Participants Reporting Supervisor Non-Adherence to Each Ethical Practice

Ethical practice	%
Regularly reviewed audio/videotapes	79.2
Conducted live supervision	59.8
Monitored patient progress, e.g., via outcome measures	48.6
Allowed use of treatment method with limited knowledge (+)	41.6
Utilized supervision contract	41.0
Scheduled supervision "as needed" or ended supervision early (+)	40.8
Outlined confidentiality in supervision	37.2
Supervisor ethical behavior questioned at least once (+)	33.3
Elicited feedback on supervisory process	29.2
Regularly reviewed charts/progress notes	29.0
Outlined multiple responsibilities/obligations of supervisor	28.6
Encouraged use of unfamiliar interventions (+)	21.3
Encouraged discussion of diversity issues	19.7
Outlined evaluation procedures	19.0
Frequently provided formative feedback	17.1
Discussed personal issues not related to clinical work (+)	17.0
Provided adequate feedback on performance throughout rotation	16.3
Communicated performance concerns	15.7
Requested that supervisor name be provided to clients	14.3
Worked on a case with inadequate knowledge of issues	13.4

(continued)

Ethical practice	%
Provided clear guidelines for handling crises/emergencies	12.4
Clearly defined roles of supervisor and supervisee	11.5
Ensured use of appropriate intervention or assessment procedures	11.1
Demonstrated awareness of research, theory, and treatment methods	10.5
Attended to supervisory relationship	10.5
Demonstrated multicultural competence	10.3
Appropriately discussed ethical issues	7.7
Ensured reporting of abuse disclosures	7.2
Provided clear guidelines for handling suicidal/homicidal clients	6.7
Requested that limits of confidentiality be discussed with clients	5.7
Acted as supervisor and not as counselor/therapist	4.7
Requested that supervisee status be disclosed to clients	2.9
Behaved in a seductive or sexually provocative way (+)	1.9

Directing the Process of Informed Consent and Discussing Limits to Confidentiality

The process of obtaining informed consent to supervision and the use of a supervision contract are essential to ethical practice in supervision. Both of these components encourage transparency and open communication in the supervisory relationship as well as model for the trainee how to contract with their own clients. A lack of informed consent and/or a lack of a supervision contract have been prominent areas of supervisor non-adherence in more recent studies of ethical practice in supervision (Ellis, 2014a).

Results of the current study suggest that this remains an area of ethical practice in which adherence is highly variable. Interestingly, while the majority of respondents reported that their supervisors had clearly defined the roles of supervisor and supervisee at the outset of supervision (80.9%), only about half of respondents reported that their supervisors had used a supervision contract (51.4%). Only about one-third indicated that their supervisors had discussed the limits of confidentiality as they apply to the supervisory relationship (35.2%).

Modeling Professionalism and Adherence to Ethical and Legal Standards and Ensuring Supervisee Knowledge of These Standards

Modeling ethical practice and professionalism as a supervisor is one of the most important contributors to client care as well as to the professional development of trainees in the field. Supervisees learn how to interact with clients and colleagues not just through direct or didactic instruction but also through intentional or unintentional behavioral modeling known as the hidden curriculum. Adherence to ethical and legal standards is also fundamental to ensure that clients receive quality services; a trainee who does not have ethical practice modeled by his or her supervisor may not gain the requisite knowledge to be able to adhere to these standards post-training.

Overall, this was an area in which the great majority of participants reported supervisor adherence. Specifically, study participants indicated that the majority of supervisors described how to handle potentially suicidal or homicidal clients (85.5%) as well as what procedures to follow and how to contact the supervisor in the event of other crisis issues (81.0%). Furthermore, of the respondents who encountered a case in which abuse reporting was required, the majority were instructed to disclose the abuse to the appropriate authorities (88.4%). The majority of respondents also indicated that their supervisors openly and appropriately discussed ethical issues with them. One-third of participants (33.3%) reported that they had questioned their supervisor's ethical judgment on at least one occasion.

Delineating Multiple Roles/Responsibilities of the Supervisor (e.g., Client Welfare, Gatekeeping, Trainee Development)

Clinical supervisors are in the unique role of having to maintain multiple roles and responsibilities within their professional sphere. According to current ethical standards,

supervisors are first responsible for the client's wellbeing, followed by a responsibility to the supervisee's professional development, and then to the field to provide a gatekeeping duty (Shafranske & Falender, 2016). Maintaining and clarifying these dual roles is a fundamental responsibility for any clinical supervisor. Only about half (52.4%) of the respondents reported that their supervisors had outlined their multiple obligations in terms of responsibility first and foremost to the client, then to the trainee's professional development, and then to the field as a whole by acting as a gatekeeper.

Addressing Boundary Issues/Multiple Relationships

Supervisors are responsible for maintaining appropriate boundaries with their supervisees throughout the training experience. Whereas boundary crossings may not be considered unethical according to the ethical codes and standards, situations in which a boundary becomes blurred between supervisor and supervisee may create ethical dilemmas for trainees. Furthermore, boundary violations, which do constitute an ethical breach, clearly have the potential to harm the wellbeing of a supervisee as well as his/her client.

Overall, respondents indicated that their supervisors maintained appropriate boundaries and adequately monitored multiple relationships. The great majority of participants (89.6%) reported that their supervisor had acted appropriately in their role as supervisor and did not act as a counselor/therapist. Of the study participants, 17.0% reported that their supervisor had discussed personal issues that did not seem to be appropriately related to their work with clients. Only 1.9% reported that their supervisor had behaved in a way that seemed to be seductive or sexually provocative.

Maintaining Supervisory Alliance

The APA (2015) Guidelines identify a strong supervisory working alliance as a critical component to effective supervision. Pakdaman et al. (2014) consider it an ethical imperative for supervisors to prioritize the working alliance. The majority of respondents reported that their supervisor attended to the supervisory relationship by demonstrating trust, respect, empathy, and integrity (81.9%). Of the participants who reported at least one ethical breach by their supervisor, the majority (79.4%) indicated that the breach negatively impacted trust in the supervisor. About two-thirds reported that a perceived ethical breach negatively affected the supervisory alliance (67.6%) as well as willingness to disclose information in supervision (67.6%). Over half (61.8%) indicated that the breach had a negative emotional impact. One-fifth (20.6%) indicated that perceived unethical behavior negatively impacted the quality of client care. Of the participants who reported an ethical breach, 8.8% reported that this experience negatively affected motivated to be in the field.

Table 2

Impact of Perceived Unethical/Unprofessional Supervisor Behavior on Trainee

Domain	*n*	%
Negatively affected the supervisory alliance	23	67.6
Negatively affected my trust in the supervisor	27	79.4
Negatively affected my willingness to disclose information	23	67.6
Negatively affected my motivation to be in this field	3	8.8
Negatively affected the quality of my client care	7	20.6
Negatively affected me emotionally	21	61.8

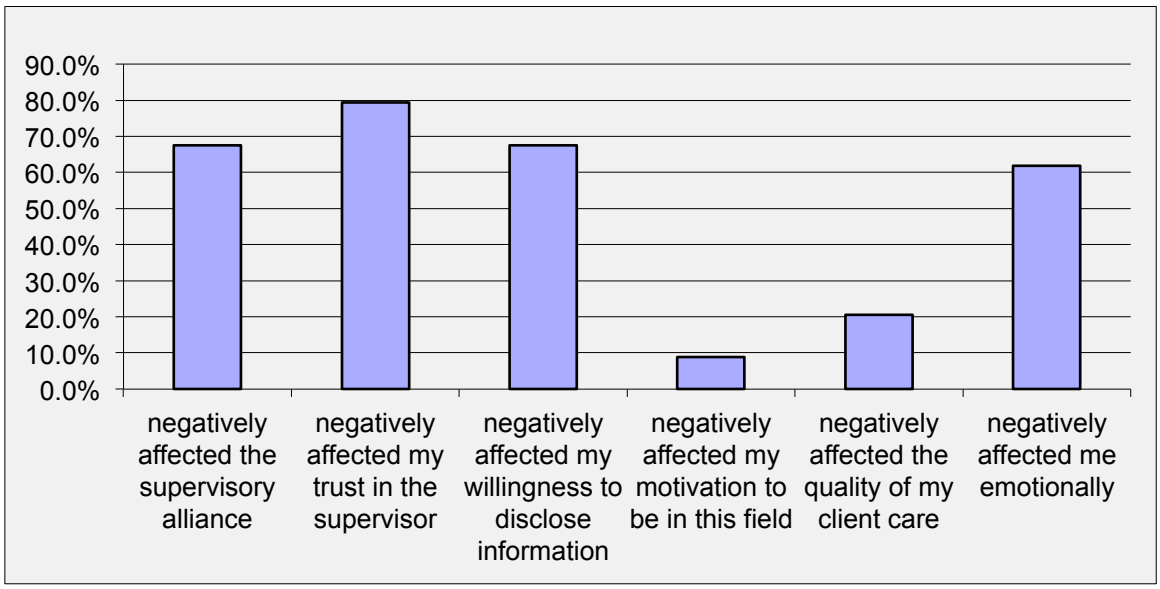

Figure 1. Impact of perceived unethical/unprofessional supervisor behavior on trainee. This figure illustrates how trainees were impacted by the experience of unethical/unprofessional supervisor behavior.

Maintaining Competence

Competence in supervision encompasses a range of important areas of practice including knowledge, skills, and attitudes/values related to client presenting issues, appropriate treatment modalities, diversity issues and multiculturalism, and the ability of the supervisor to recognize their own boundaries of competence.

Study results indicate that maintaining competence is an area of variability with regards to supervisor adherence. The majority of study participants (79.0%) indicated that their supervisor appeared to be aware of recent research, theory, or treatment methods that related to client presenting problems. Less than half of respondents indicated that their supervisors had allowed them to use a treatment modality in which they had been trained but in which their supervisor had little or no experience (41.6%). Only 13.4% of respondents reported that their supervisor had worked with them on a case involving issues or disorders with which (s)he had little or no experience.

Furthermore, approximately three-quarters of respondents reported that their supervisor had demonstrated multicultural competence in supervision. Specifically, participants indicated that they felt their supervisor was sensitive to issues of gender, sexual orientation, race, culture, religion, and disability status (77.6%). Supervisees also indicated that they were encouraged to discuss thoughts and feelings in supervision related to issues of gender, sexual orientation, race, culture, religion, and disability status (70.0%).

Evaluation and Feedback

The provision of timely and constructive feedback is one of the most important responsibilities of a supervisor. The most effective and useful feedback is derived from direct observation rather than relying solely on trainee self-report or chart and progress notes. A recent study by Ellis (2014a) suggested that supervisors provide feedback relatively infrequently and that less than half (39%) of supervisors did not review supervisee sessions with their clients.

About three-quarters of the current study participants reported that their supervisors had discussed expectations for evaluation and had provided regular feedback throughout the training year. Specifically, 71.4% of supervisors discussed at the beginning of the year how the trainee would be evaluated. Respondents reported that 76.0% of supervisors had provided adequate verbal and/or written feedback about their performance throughout the training rotation. Of the respondents who had performance concerns during their training year, 78.4% reported that their supervisors had communicated these concerns to them. Close to two-thirds of respondents reported that their supervisors had provided formative feedback throughout the training year (62.8%) and had periodically elicited trainee feedback on the supervisory process (63.2%).

Study results indicated some variability in supervisor observation of supervisee performance and professional activities. About two-thirds reported that their supervisors

regularly reviewed their chart/progress notes (68.2%). Less than half of supervisors conducted some form of live supervision with their supervisees, e.g., via participation in session or use of a one-way mirror or audio feedback system (40.2%). Participants indicated that only about one-fifth of supervisors regularly reviewed video or audiotapes of their sessions (19.8%).

Study results also indicated some variability in supervisor monitoring of supervisee performance and professional activities. The great majority of participants indicated that their supervisor made sure they were using appropriate treatment interventions or assessment procedures with their clinical cases (88.9%). Less than half of participants reported that their supervision times were often cut short if there were no pressing clinical issues or had supervision sessions scheduled on an as-needed basis rather than more consistently (40.8%). About one fifth of study participants reported that their supervisor encouraged them to attempt interventions or treatments for which they felt unprepared (21.3%). Respondents reported that less than half of supervisors regularly monitored patient progress, e.g., thorough review of outcome measures (42.0%).

Issues Related to Disclosure

Supervisees are legally and ethically mandated to disclose to their clients that they are trainees receiving supervision as well as to discuss limits to confidentiality. Study results suggest that disclosure was an area of ethical practice to which the vast majority of supervisors adhered. Nearly all respondents indicated that their supervisors had instructed them to discuss limits to confidentiality with their clients (92.4%) and to inform them that they were a trainee receiving supervision (92.3%). About three-quarters of respondents were instructed to provide their supervisor's name and contact number to clients (77.1%).

Table 3 displays consolidated results of the EPSS-R. The *Agree* column combines the percentages of participants who answered Agree and *Strongly Agree* for each question and the *Disagree* column combines the percentages of participants who answered Disagree and *Strongly Disagree* for each question. Percentages do not incorporate missing data or data from the *Not Sure* category. Percentages in parentheses represent the same calculations for Wall's 2009 survey data. These comparisons were made only for survey questions that appeared on both the EPSS and EPSS-R.

Table 3

Trainee Report of Supervisor Adherence/Non-Adherence to Each Ethical Domain

Domain	Agree	Disagree
Monitored supervisee performance and professional activities		
1. My supervisor made sure that I was using appropriate treatment interventions or assessment procedures with all of my clinical cases.	88.9% (87.8%)	11.1% (10.0%)
2. My supervisor met with me on an "as needed" basis (i.e., supervision times were not regularly scheduled OR if they were regularly scheduled, supervision time was cut short by the supervisor when there were no pressing clinical issues to be discussed.)	40.8% (31.1%)	56.6% (67.8%)
3. My supervisor encouraged me to attempt interventions or treatments for which I felt unprepared.	21.3% (12.3%)	74.0% (82.8%)
4. My supervisor systematically monitored patient progress, e.g., thorough review of outcome measures.	42.0% ----	48.6% ----
Observed supervisee performance and professional activities.		
5. My supervisor regularly reviewed video or audiotapes of my sessions.	19.8% (28.4%)	79.2% (67.9%)
6. My supervisor reviewed my charts/progress notes with me on a regular basis.	68.2% (68.9%)	29.0% (26.7%)
7. My supervisor at times conducted some form of live supervision (e.g., participated in a session with me or observed and commented with the use of a one-way mirror or video system).	40.2% (12.8%)	59.8% (67.9%)

(continued)

Domain	Agree	Disagree
Practiced multicultural sensitivity toward clients and supervisees.		
8. My supervisor's conduct and input in supervision suggested that he or she is multiculturally competent, possessing a good understanding of gender, sexual orientation, race, culture, religion, or disability status, etc.	77.6% (82.3%)	10.3% (9.5%)
9. My supervisor encouraged me to discuss any thoughts or feelings I had about gender, sexual orientation, race, culture, religion, or disability status.	70.0% (77.8%)	19.7% (15.5%)
Maintained appropriate boundaries and carefully monitored dual roles.		
10. My supervisor and I discussed personal issues that did not seem to be appropriately related to my work with clients. ("Personal issues" would not include simple disclosure of personal information such as whether either party is married, has children, etc. UNLESS significant supervision time is spent DISCUSSING one's relationship, family, etc.)	17.0% (14.5%)	80.2% (83.3%)
11. My supervisor appropriately acted as my supervisor and did not try to act in the role of my counselor/therapist.	89.6% (92.8%)	4.7% (3.4%)
12. My supervisor behaved toward me in a way that seemed to me to be seductive or sexually provocative.	1.9% (1.2%)	99.1% (96.1%)
Discussed the process of evaluation, provided regular feedback about supervisee performance and competence, and documented strengths and areas for improvement.		
13. My supervisor discussed with me at the beginning of the training year how I would be evaluated.	71.4% (72.8%)	19.0% (13.3%)
14. My supervisor gave me adequate verbal and/or written feedback about my performance throughout the training rotation.	76.0% (85.0%)	16.3% (10.6%)
15. I was made aware of any concerns my supervisor had regarding my performance. (Please leave blank if this question does not apply to you).	78.4% (86.7%)	15.7% (6.1%)
16. My supervisor frequently provided formative feedback.	62.8% ----	17.1% ----
17. My supervisor periodically elicited my feedback on the supervisory process.	63.2%----	29.2% ----
Supervised only therapist-client relationships in which (s)he was competent.		
18. My supervisor appeared to be aware of recent research, theory, or treatment methods in regard to the presenting problems of my clients.	79.0% (79.5%)	10.5% (8.3%)
19. My supervisor worked with me on a case that involved issues or disorders with which he or she had little or no experience.	13.4% (11.1%)	75.2% (77.2%)

(continued)

Domain	Agree	Disagree
20. My supervisor allowed me to use a treatment approach in which I had been trained, even though the supervisor had little knowledge or training in the approach.	41.6% (37.8%)	41.6% (46.7%)
Modeled professional principles, values, and ethics.		
21. My supervisor openly and appropriately discussed ethical issues with me.	86.6% (85.6%)	7.7% (8.3%)
22. I questioned my supervisor's ethical judgment or opinions on at least one occasion.	33.3% (25.5%)	64.8% (71.7%)
Legal Issues.		
23. My supervisor gave me adequate direction about how to handle potentially suicidal or homicidal clients. (Please leave blank if this question does not apply to you).	85.5% (81.7%)	6.7% (7.2%)
24. My supervisor gave me a clear understanding of how crises or emergencies with clients were to be handled, as well as how he or she could be contacted in the case of an emergency/crisis situation and what I should do if I could not reach him or her.	81.0% (83.9%)	12.4% (10.6%)
25. My supervisor directed me to report disclosures of abuse (e.g., child, elder, etc.) by clients to the appropriate authorities. (Please leave this question blank if you never encountered a case in which abuse reporting was required).	88.4% ----	7.2% ----
Ensured adequate disclosure to client.		
26. My supervisor instructed me to disclose to my clients that I was receiving supervision.	92.3% (85.6%)	2.9% (6.2%)
27. My supervisor directed me to inform my clients of the limits of confidentiality (such as the supervisor is also privy to information discussed in the counseling session).	92.4% ----	5.7% ----
28. My supervisor directed me to provide my clients with his or her name, should they have concerns about the treatment they were receiving.	77.1% (62.8%)	14.3% (21.7%)
Identified parameters of supervision.		
29. My supervisor clearly defined his or her role as my supervisor and my role as supervisee when I began the training year.	80.9% (76.6%)	11.5% (15.0%)
30. My supervisor outlined his/her responsibilities and multiple obligations (i.e., primary responsibility to client, followed by responsibility for trainee professional development, followed by gatekeeping duty).	52.4% ----	28.6% ----
31. My supervisor asked me to sign a supervisory agreement contract (describing supervisor and supervisee responsibilities and procedures) when I began the training year.	51.4% (43.9%)	41.0% (42.2%)
32. My supervisor stated or implied that what I shared in supervision was confidential and would not be shared as part of the evaluation process.	35.2% (35.0%)	37.2% (35.0%)
33. My supervisor attended to the supervisory relationship (i.e., demonstrated respect, empathy, trust, and integrity).	81.9% ----	10.5% ----

WAI-S Bond Scale

Results of the WAI-S bond scale indicate that overall, most participants had positive experiences with their supervisors. Less than 10% of respondents indicated that they *Occasionally* or *Rarely* experienced mutual respect and/or felt liked by their supervisor, and *Always* or *Very Often* felt that their supervisor was not completely honest with them. Between 10 and 14% of respondents indicated that they Occasionally or Rarely experienced mutual trust or understanding in the supervisory relationship, felt that their supervisor was concerned about their welfare, or felt appreciated in the relationship. Over 12% lacked confidence in their supervisor's ability to supervise. Less than 20% felt that the supervisory relationship was Occasionally, Rarely, or *Never* very important. Similarly, less than 20% reported that they Occasionally, Rarely, or Never felt that their supervisor cared about them even if they did not approve of their actions. Over 20% Always, Very Often, or *Often* felt uncomfortable in the supervisory relationship. Over 25% reported that they Always or Very Often felt that it was important to say or do the *right* thing in supervision.

Discussion

This study examined psychology interns' perceptions of their supervisors' ethical behavior during their last practicum rotation prior to internship. These findings extend previous research examining ethics in clinical supervision (Wall, 2009) by integrating the *Guidelines for Clinical Supervision in Health Service Psychology* adopted by the APA in 2015. The survey questions were intended to reflect an emphasis on the following areas of ethical best practice in supervision: monitoring of client progress, provision of feedback, explicit discussion of multiple roles and responsibilities, and a focus on the supervisory relationship.

Results are largely consistent with previous studies on ethics in supervision. Of the 111 participants in the current study, up to two-thirds reported at least one ethical lapse by their previous supervisor. Supervisor non-adherence was most frequently cited in direct observation of clinical work, live supervision, monitoring of patient progress (e.g., via outcome measures), use of familiar treatments, and use of a supervision contract. Additionally, 35 (33.3%) answered affirmatively that they had questioned their supervisor's ethical judgment on at least one occasion during the training year. The 1999 study by Ladany et al. found that 33% of ethical violations by supervisors were also related to evaluation and feedback, such as failure to review taped sessions. In 2009, Wall found that of 180 participants, 26% had questioned the ethical judgment of their supervisor at least once; the most frequently cited areas of supervisor non-adherence were in direct observation of clinical work, supervision contracts, confidentiality, and supervising in a treatment modality in which the supervisor is untrained. A study by Hardy (2011) found that about one third of participants perceived boundary violations on the part of their supervisor. A study by Crall (2011) noted that the perceived frequency of ethical breaches by supervisors was also around 33%.

Overall, supervisors appear to be adhering to the majority of ethical principles on a mostly regular basis. However, findings are mixed and complex with regards to varying levels of knowledge about ethics in supervision as well as likely variability in the quality of supervision experiences. Study participants indicated that their supervisors ensured that they used appropriate treatment interventions with their clients, attended to ethical and legal issues including crises and mandated reporting issues, maintained appropriate boundaries, and demonstrated multicultural competence. However, while the great majority did not report boundary violations such as sexual exploitation or a supervisor inappropriately acting as a therapist for a trainee, data suggest that there are other aspects of ethical practice that are areas of concern.

According to study participants, feedback, evaluation, and direct observation of clinical work were areas of variability with regards to supervisor adherence. Study participants indicated that it was not uncommon for supervisors to cut short supervision times when there were no pressing issues to discuss. This could be interpreted critically as a supervisor's unwillingness to spend the allotted amount of time for supervision. Alternatively, the tendency to meet on an "as-needed" basis could be interpreted to mean that supervisors are demonstrating flexibility in scheduling. Supervisees also reported that their supervisors may not have discussed at the outset of supervision how they would be evaluated over the course of the training year and often did not elicit feedback on the process of supervision. Many did not use a supervision contract or outline the multiple roles of the supervisor. Other supervisees reported that issues of confidentiality were not discussed as they relate to supervision. Additionally, many trainees reported that their supervisors did not or may not have provided formative feedback. A relatively high percentage (20%) reported that they were Not Sure if they were provided with formative feedback. This

may be a result of unfamiliarity with the term "formative" and how this differs from evaluative feedback.

Supervisor observation of their trainee's clinical work was another area of variability. Less than half of participants reported that their supervisors conducted some form of live supervision. This may be a result of several factors, including limited access to resources such as therapy rooms equipped with one-way mirrors or video/audio monitoring systems. Additionally, most supervisees were in their third or fourth year of clinical training during the time period under study; many supervisors may have considered supervisees in their third or fourth year of training as more advanced therapists who are no longer in need of live observation. However, the recent *Standards of Accreditation for Health Service Psychology* adopted by the APA Council of Representatives specifies that each intern evaluation must be partly based on direct observation of trainee performance, either through live observation or review of electronic recordings (APA, 2017). This standard is applied to all psychology interns, regardless of training or developmental level.

Most striking were the data reported in other areas of direct observation. Only 42% of participants reported that their supervisor monitored patient progress by reviewing outcome measures. Perhaps most surprisingly, only about 20% of supervisors engaged in regular review of their supervisees' audio or video recordings of therapy sessions. Since the great majority of respondents reported that their supervisor frequently monitored their therapy sessions and ensured they were using appropriate interventions, it follows that the majority of feedback was based on supervisee self-report rather than some form of direct observation. Approximately 33% of supervisees in Ladany et al.'s 1999 study reported ethical violations in the areas of inadequate feedback and infrequent provision of direct feedback. Wall's 2009 study highlighted a similar

result; approximately 66% of participants indicated that their supervisor did not directly observe their clinical work, instead relying on self-report and/or progress notes.

More recent studies also found that direct feedback to supervisees occurred relatively infrequently (Ellis et al., 2014a). This is worrisome given the fact that client outcomes and trainee professional development rely heavily on accurate assessment and feedback from supervisors.

The current study also adds to a growing body of research that identifies the supervisory alliance as one of the most important factors in ensuring effective supervision. Study data suggest that the supervisory alliance was impacted in several different ways by perceived unethical behavior. As previously discussed, about 60-80% of respondents who reported perceived unethical behavior by their supervisor reported that the experience negatively impacted the supervisory alliance, the supervisee's emotional state, trust in the supervisor, and/or willingness to disclose in supervision. About 20% reported that the breach negatively impacted client care. These findings are important when considering the essential role that supervision plays in the development of the next generation of professionals. They are also striking with regards to recent research that suggests a correlation between a weak supervisory alliance and less disclosure in supervision. Additionally, while a relatively small percentage (8.8%) of respondents reported that the experience negatively impacted their motivation to be in the field, it is important to recognize the potential long-term consequences of a perceived ethical breach; trainees who lose faith in the profession are less well-equipped to serve clients and may be at a greater risk of leaving the field altogether.

Study results indicated that the majority of supervisors appropriately monitored interventions, provided regular feedback, ensured discussions of diversity issues, appropriately

handled ethical and legal issues including boundary issues inherent in the supervisory dyad, and attended to the supervisory alliance. However, supervisors were less consistent in engaging in direct observation of their supervisees' clinical work, monitoring client progress, utilizing a supervision contract, and supervising in modalities with which they were familiar. In addition, whereas the majority of supervisory dyads involved mutual trust, respect, and honesty, many supervisees reported that they often felt uncomfortable in supervision and that they frequently felt that they had to say or do the right things in supervision. These findings highlight the importance of supervisor behavior on the personal and professional development of psychology trainees. Implications for clinical training are discussed below.

Implications for Clinical Training

The continuing trend of infrequent direct observation of supervisee work is an area of particular concern, especially when taking into consideration the inherently skewed nature of supervisee self-report. Supervisors may remedy this ethical lapse by setting aside dedicated time to review audio or video recordings either during supervision or between supervision sessions. While tape review is more time-consuming than listening to supervisee direct reports, it is a more accurate form of observation that can improve the quality of supervision and by extension, client care. Infrequent and/or inadequate direct feedback provided to supervisees has negative implications in terms of trainee professional development over the long term and may negatively impact a supervisor's gatekeeping responsibilities with regards to advancing supervisees in the field.

It will be important for supervisors to continue to clarify expectations regarding supervision at the beginning of the training year. This can be at least partially accomplished through the use of a supervision contract that outlines expectations for the supervisory

relationship throughout the year. In addition, supervisees may need to take a more proactive role in asking for clarification around the supervision process, including specific expectations regarding evaluation, feedback, and appropriate disclosure, as well as how to address perceived boundary crossings and/or violations.

It is also important to consider variations in trainee developmental level and supervisor professional development when considering trainee expectations for supervision. Trainees enter their internship year with varying levels of training in different areas. As a result, there are likely large variations in trainee knowledge regarding ethics in supervision and expectations for the supervision process. While the great majority of study participants reported perceived supervisor adherence to well-known ethical standards such as the prohibition against sexual relations, there were lower levels of perceived adherence to more nuanced ethical best practices, such as expectations regarding direct observation of clinical work. These results may also be partly attributable to supervisor ongoing professional development and how well informed supervisors are in relation to ethical best practices in supervision.

Limitations

A major limitation of the current study is generalizability. Specifically, results of the current study are unlikely to be generalizable to the larger psychology intern population since the sample of participants may not be representative of the larger population of psychology interns. This is especially true given that participants were sampled only from internship sites registered with APPIC. However, the response rate of the current study ($N = 111$) is on par with similar studies surveying interns about their experiences in clinical supervision. Recent surveys of psychology interns administered via the Internet have similar response rates; for example, Hardy

(2011) received 84 responses, Kirk (2014) received 104 responses, and Eisenhard and Muse-Burke (2015) received 114 responses.

One delimitation to the current study is the inclusion of only pre-doctoral psychology interns. This target population represents advanced trainees in the field (i.e., individuals who have qualified for and matched to an internship program) and have thus had at least a few years of experience as a supervisee. A second delimitation is the inclusion of only closed-ended survey questions using a Likert scale as opposed to open-ended, free-form questions that have the potential to garner richer responses. Additionally, the Likert scale is inherently imprecise, since there is no way to determine how individual respondents chose between categories such as Agree or Strongly Agree, etc.

Directions for Future Research

Future research may aim to better understand contributing factors to the high frequency of supervisor non-adherence in the areas of direct observation. Specifically, future studies may wish to survey current supervisors about their multiple ethical responsibilities and barriers to adherence. This would likely include an inquiry into the state of training for clinical supervisors and may seek to elicit feedback from supervisors regarding the nature of their training experiences in supervision, as well as their expectations about what constitutes effectiveness in supervision. There is some evidence that supervisors respond positively to efforts to adopt an evidence-based approach to training in the field (Milne, 2010). Additionally, a recent review by Reiser and Milne (2014) suggested that markers of effectiveness in supervision should move beyond a traditional focus on client clinical outcomes.

Additionally, the field of clinical supervision may benefit from inquiries into areas of ethical practice not addressed in the current study, such as attention to the practice of self-care

and self-reflection in supervision. The practice of self-reflection in supervision has already been identified as a useful contribution to trainee professional development (Moffett, 2009; Orchowski, Evangelista, & Probst, 2010). Future studies may aim to better understand both trainees' and supervisors' experiences of self-reflection in supervision.

Conclusion

According to Shafranske and Falender (2016), the practice of clinical supervision requires the coordination and maintenance of several processes including strong working alliance; identification of training goals and expectations; evaluation and gatekeeping responsibilities; and the facilitation of ongoing professional development. While all psychologists who join the APA are expected to adhere to the organization's ethical standards, there are certain ethical principles that apply specifically to the practice of clinical supervision: maintaining respect for the human dignity of clients and supervisees; maintaining boundaries of competence; providing timely, direct feedback to supervisees; and avoiding harm or exploitation of supervisees.

The purpose of this study was to expand on previous work examining the ethical behavior of supervisors as perceived by their supervisees. Survey results indicated that the most frequently-reported areas of supervisor non-adherence to ethical standards were in the areas of direct observation of clinical work, including live supervision, monitoring of client progress, use of familiar treatments, and use of a supervision contract. The results are consistent with previous studies of ethical practice in supervision and highlight the need for continued study of how ethical guidelines are applied in the practice of clinical supervision.

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APPENDIX A

Summary Table of Selected Literature – Theoretical Studies

Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
American Psychological Association (2010).	Ethical principles of psychologists and code of conduct. - Delineates ethical principles for professional practice including supervision	-Ensuring competence is an ethical imperative – obtaining supervision to ensure competence may be necessary - Supervisors respect the human dignity of both clients and supervisees - Diversity competence is considered an "ethical imperative" in clinical practice - Feedback should be provided in a timely manner and directly linked to distinct competencies and observed behaviors in order to be effective - No exploitation of supervisees - Clients under care of trainee must be informed and given name of supervisor. - Must take reasonable steps to avoid harm to supervisees - Supervisee not required to disclose personal information unless 1) informed of this requirement ahead of time 2) information necessary for safety reasons - No sexual relationships
American Psychological Association (2015).	Guidelines for clinical supervision in health service psychology. - First set of consensually-established guidelines derived from the literature on supervision.	- Purpose is to "delineate essential practices in the provision of clinical supervision." - Seven domains: 1) Supervisor competence 2) Diversity 3) Relationships 4) Professionalism 5) Assessment/evaluation/feedback 6) Problems of Professional Competence 7) Ethical, legal, and regulatory considerations - "Competence entails performing one's professional role within the standards of practice." - Supervisors are expected to have "knowledge, skills, and values with respect to multiculturalism and diversity, ethical and legal parameters, and management of supervisees who do not meet criteria for performance" (p. 34). - protection of the client and public considered the "highest duty" of the supervisor (p. 41). - Supervisors must "model ethical practice and decision making…" (p. 41) - "Supervisors ensure that supervisees develop the knowledge, skills, and attitudes necessary for ethical and legal adherence. The supervisor is a role model for ethical and legal responsibility" (p. 41) - The "highest duties" of supervision are "ensuring the protection of patients, the public, and the profession" (p. 43)

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Barnett (2014)	Provide overview of state of clinical supervision and highlight work of authors in the field.	- Clinical supervision as "essential aspect" of professional development, training, and competence. - Poor supervision during training has direct negative effect on clinical work - Supervisors are ideally aware of competencies and seek training to be more effective in supervisory role. - Important to integrate multiple competencies and to conceive of supervisory experience as process of "lifelong learning." - Important for supervisors to be familiar with literature on clinical supervision. - "…clinical supervision must be treated like any other area of clinical competence in the practice of psychology."
Barnett, Cornish, Goodyear, & Lichtenberg (2007)	Overview of clinical supervision and issues of competency. Includes three commentaries from supervision experts.	- Overview of "effective supervisor" traits, e.g., commitment to development, emotional investment, etc. [see cited works]. - Importance of "safe environment" so as not to preclude openness and disclosure on the part of the supervisee. - "A desire to train and an investment in supervision are necessary but not sufficient conditions for successful supervision." - Important for supervisor to consider supervisee's stage of development and be able to adjust how provide supervision. - Effective supervisors consistently model ethical and professional behavior; they also focus on ongoing ethical practice. - Ethical practice in supervision should include the following: assessing training needs; agreement on nature of supervision; provision of feedback; appropriate boundaries; maintaining confidentiality; being mindful of own areas of competence; self-care; addressing issues of diversity. - "Ethical supervisors" practice within their areas of competence, maintain quality of supervision by being mindful of how many supervisees they supervise at one time, and serve a gatekeeping function.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Barnett & Molzon (2014)	Ethical issues that arise in supervision and recommendations for addressing them are discussed.	Primary outcomes if supervision: 1) impart knowledge; 2) enhance skills; 3) prepare supervisees for subsequent training/practice. - Tailor supervision to training needs (part of this is determining strengths and weaknesses from the beginning) and be aware that training needs change over time. - Two types of competence necessary: 1) in clinical area that supervising and 2) in practice of supervision. Consistent with Standard 2.01 of APA Ethics Code (2010) Boundaries of Competence. - Competence on a continuum, i.e., never fully competent or incompetent. - Informed consent, ideally in form of supervisory contract that is updated as part of an ongoing process. Consistent with Standard 3.10 of APA Ethics Code (2010) Informed Consent. (see Bernard & Goodyear, Falender, and Thomas for specific components of supervision contract). - Supervision as developmental process, i.e., supervisor more active at beginning and then allows for more supervisee autonomy. Fluid progression based on needs of supervisee. - Supervisors be open to receiving feedback from supervisee - Informal feedback should be provided - Taking gatekeeper role seriously is important – remediation first, then ensuring no further progression. - Supervisor as "professional role model" and also as mentor. - Diversity competence in 1) relationship between supervisor and supervisee and 2) between supervisee and client. (see Barnett). - Should aspire "to achieve the highest ethical ideals of our profession in all we do professionally." Thus, legal and ethical issues should be taught via 1) modeling and 2) didactics - "It is important that supervisees develop a sophisticated approach to addressing ethical challenges and dilemmas that involves the application of a process of ethical decision making rather than looking for the 'right answer.'" - "Ethical supervisors will promote their own psychological wellness by actively practicing self-care strategies." - Important to document supervision sessions (see Falender & Shafranske). - Model appropriate management of boundaries (see Barnett & Johnson) Consistent with Standard 3.05 of APA Ethics Code (2010) Multiple Relationships. (See Thomas for benefit of multiple relationships). - Supervisor needs to be available or otherwise provide emergency coverage.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Cornish (2013)	Introduction to Ethical Issues in Training and Supervision	- Notable that most work on ethics in supervision is theoretical with the goal of initiating ongoing development of standards of practice. Most empirical studies rely on Internet surveys which have the drawback of an unknown response rate and in which postdoctoral trainees are underrepresented. - Ethics Code is limited in that it cannot address all potential ethical dilemmas. - "…self-care has been described as an ethical obligation." (see Barnett, Baker, Elman, & Schoener, 2007). [Should add a question about how supervisor demonstrates and checks-in around self-care?]
Falender, & Shafranske (2004)	Supervision "proposed as a core competency…for which a number of elements reflecting specific knowledge, skills, and values must be addressed to ensure adequate training and professional development of the trainee." Authors present a competency framework.	- Professional development requires lifelong commitment to legal and ethical issues (among others). Developmental process. - "Training permits the integration of knowledge (from theory and empirical research) with technical skills and personal values." - Metaknowledge also important ("the knowledge of what one knows") -Psychologists who act as supervisors have an "ethical responsibility to acquire competence in supervision." - "It was the consensus of the supervision workgroup that supervision is a distinctive professional competency and as such should be developed through systematic graduate education and clinical training." - Five essential factors: 1) supervision competency is lifelong, developmental process; 2) attention to diversity is a specific competence; 3) essential to attend to legal and ethical issues; 4) training "influenced by both personal and professional factors"; 5) essential to have frequent self-assessment and peer-assessment throughout development of supervisor competency. -Supervision Competencies Framework includes specific knowledge (6), skills (12), values (10). Specific to ethical practice, supervisor must have "knowledge of ethics and legal issues specific to supervision" and must "value ethical principles."

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Falender & Shafranske (2007)	Review of competence as a construct and provide definition of "competency-based clinical supervision." Particular attention is paid to ethical and legal issues, among others.	- Competence is an "ethical principle that informs the practice of psychology" and includes "requisite knowledge, skills, and values for effective performance." -Ongoing difficulty in establishing a "gold standard" of competence in the field, e.g., easier to identify lack of competence. - "…efforts to articulate and to apply the construct of competence are salient to the profession and particularly to supervision, because supervised clinical training provides the context for competence to be developed as well as for foundational attitudes and practices, which encompass professionalism, to be instilled." - Metacompetence is "the ability to assess what one knows and what one doesn't know." Crucial in ongoing process of developing competence. - "Competency-based supervision is defined as an approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and requirements of the local clinical setting." - "Supervision plays an essential role in guiding the development of metacompetence. This is achieved by encouraging and reinforcing the supervisee's development of skills in self-assessment." - "A competency-based approach, together with skills in metacompetence, provides the supervisor with an orientation to a developmental process that results in professionalism both at the point of entry into the profession and in continuous professional development." - "Ethical competence is often narrowly construed, placing emphasis on behavioral outcomes related to correct or incorrect decisions, rather than directing attention to the underlying processes and values involved in ethical decision-making." - "Overemphasis on 'worse-case scenarios' involving ethical lapses or legal violations may obfuscate the perspective that 'professional conduct always involved ethics' and that as a profession, psychology bears a particular responsibility for advancing ethics within its sphere of influence." - "Self-assessment untethers ethical competence from the constraints of worst-case scenarios and expands focus on the everyday practice of ethics." [-reference to gottlieb.handelsman, etc – being an ethical professional is more than following a set of rules] - "Supervisors play a crucial role in modeling ethical practice and guiding exploration of the application of ethics and professional standards throughout the clinical training experience." -[honesty, personal responsibility, and integrity are ethical factors] - "Ethical competence…requires not only an understanding of the Ethics Code, but also a broad-based understanding of the values affecting practice, the ethical decision-making model one uses, and post-conventional moral reasoning." - Diversity and multicultural competence is an ethical standard and should be an ongoing focus of self-assessment.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Falender, Shafranske, & Ofek (2014)	Literature review on effective clinical supervision and knowledge/skills/attitudes that make up competent supervision.	"Clinical supervision…facilitates the acquisition of professional attitudes that provide the foundation for ethical practice throughout one's career." - "…competency-based clinical supervision provides an evidence-based model for the practice of supervision." - Important attitude for effective supervisor to hold is a respect for ethical principles and ethics code. - Important skill for effective supervisor is "remaining mindful and attuned to ethical and legal aspects of supervision and practice including appropriate boundaries, informed consent, and confidentiality." - "Fostering a strong supervisory alliance is a key component of evidence-supported supervision practices." (and is also a "core competency in the practice of supervision." - Multicultural and diversity competence is an "ethical imperative in clinical care….and also in supervision" [(Falender, Shafranske, & Falicov 2014)]. - "A supervisor's lack of awareness of power, privilege, diversity issues, and multiple identities operating within the supervisory dyad and within the trainee-client dyad has a deleterious effect on supervision" [(Falender & Shafranske, 2014; Falender et al. 2014)]. - Ethical and legal competence = "Competence in ethical and legal issues in supervision includes facility in the identification of and application of ethical, legal, and professional standards to complex legal and ethical issues along with proactively addressing them in supervision [(Fouad et al., 2009)]. Nonetheless, supervisees perceived that approximately half of their supervisors committed ethical violations that impacted the quality of supervision [(Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Wall, 2009)]. The most frequently reported violations of ethical guidelines included issues around performance evaluation, confidentiality in supervision, and ability to guide interventions from other theoretical perspectives." - "Supervisors have the primary responsibility to ensure client welfare, while also monitoring and promoting trainee competence, building and maintaining a strong supervisory alliance, providing positive and corrective feedback, providing evaluations to graduate programs and training institutions, maintaining statistics for accrediting bodies concurrent with performing gatekeeping functions, and simultaneously managing their own (often additional) job responsibilities within the institution." - Specific behaviors that comprise legal and ethical competencies on the part of the supervisor: 1) presenting informed consent; 2) discussing limits to confidentiality; 3) modeling adherence to ethical and legal standards and ensuring supervisee knowledge of these standards; 4) being clear about multiple roles/responsibilities (eg, client welfare, gatekeeping, trainee development); 5) maintaining records of supervision; 6) describing remediation procedures; 7) describing due process/remediation procedures.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Goodyear (2014)	-Hypothesis is that effects of four learning strategies (modeling, feedback, direct instruction, self-directed learning through reflective practice) are mediated by quality of supervisory relationship. Supervisees learn through these supervisory strategies -Modeling, feedback, direct instruction, and self-directed learning through reflective practice are the four most important strategies to promote supervisee learning - Also highlights importance of feedback in moving trainee from novice to self-reflective professional	- Important to consider theories of learning in process of supervision, not just working alliance. - "Lens" diagram - Modeling can take the form of vicarious learning (Bandura 1982), intentional modeling, or unintentional modeling (e.g., "incidental learning" (Bandura & Huston)) - [Supervisors have important effects on supervisees' professionalism and ethical behavior (Grus & Kaslow 2014)]. "Feedback is indispensible to supervisee learning." [Reference Ladany et al. (1999) finding that inadequate feedback is most common ethical complaint from supervisees (accounted for 1/3 of ethical complaints.] "…learning requires feedback specificity: The best feedback is clear, direct, and based on clearly specified criteria" (p. 88) Must be a direct observation of supervisee work in order to provide this. - Feedback specificity, valence, and formality. - "unintentional modeling" – informal feedback. "Feedback leakage cues." - Summative feedback (eg, end of training evaluation) vs. formative feedback (eg, throughout training) - "…formative feedback is more immediate in its effects on supervisee learning" (p. 89). - Reference to (Bernard & Goodyear, 2014) "supervisee development" = "how supervisees' motivation, behavior, and attitudes change as they gain experience." Consistent finding – supervisees early in training rely more on "specific direction" and those in later stages of training prefer more autonomy and ability to consult with supervisor. - Direct instruction = telling/showing/modeling how to do something and then giving corrective feedback while observing supervisee doing it. - When trainee first learning skill set, "direct and immediate feedback" is most effective for learning. - "self-regulated learning through reflective practice" – reflection as important competency to develop - Supervisees learn to be reflective through ongoing engagement with their supervisors. Involves some "hypothesis testing." -Both "internal feedback" (eg, performance dissonant with internalized standards) and "external feedback (eg, from supervisor) can trigger self-reflective practice. - Continuum of direct instruction to self-directed learning and with feedback as omnipresent.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Gottlieb, Robinson, & Younggren (2007)	Discussion of potential ethical issues related to multiple relationships in supervision (not addressed by 2002 ethics code)	- Multiple relationships that are not clearly unethical (eg, sexual relationships) – even those that can be beneficial – can still pose problems in terms of figuring out how to manage boundaries and can sometimes move into the territory of boundary crossing or boundary violation - Potential for harm when a supervisor's personal interests are a factor and/or (s)he loses objectivity. - Boundary crossings are common - Ladany et al. (1999) supervisees' perceptions of supervisory behavior showed more than half perceived at least one ethical violation on the part of their supervisor. 6% violated dual-role. 35% discussed violation with supervisor. 54% discussed with someone else. 14% of cases someone in authority aware but did nothing. - "…a fundamental problem in ethical decision making [is when] ethical dilemmas arise, they are often less about what objectively occurred and far more about how they were perceived" (p. 242) - "…supervisory relationships entail power differentials and create unique vulnerabilities for supervisees" (p. 242) - "…supervisors should remain mindful that multiple relationships can be harmful and that boundaries must be managed carefully." (p. 242) - Some assumptions regarding boundary management – "Supervisors are ethically and legally required to act in the best interest of their supervisees…[they] are also mindful that they serve as role models for appropriate professional behavior in a variety of contexts" (p. 244). Power differential creates vulnerability on the part of the supervisee; boundaries important to protect supervisee from harm/exploitation; multiple relationships not necessarily unethical; supervisors manage multiple roles – but as number of roles with supervisee increases, risk also increases; boundaries esp important if supervisee or supervisor having personal or professional issues that require monitoring; potential new relationship should be considered from supervisee's perspective. - "Adverse outcomes leading to exploitation are most often due to a supervisor's loss of objectivity, poor judgment, incompetence, or impairment" (p. 244) - Recommendation specific to the supervisor-supervisee relationship: additional roles should be added only if compatible with supervisory relationship. - "Harming supervisees is unethical and potentially illegal; if it were reasonable to anticipate that [a] proposed relationship would be harmful, pursuing it would be unacceptable" (p. 245) - Also recommended that supervisees should: "inform themselves" and sign informed consent; know the APA ethics code – including limitations – so that they can be more empowered; seek out other resources if feel uncomfortable - "Supervisees are well advised to be alert for boundary crossings that may themselves appear harmless, such as excessive touch; needless self-disclosure; inappropriate attire or jokes; and efforts to gain approval by offering friendship, gifts, or special treatment.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Handelsman, Gottlieb, & Knapp (2005)	Discussion of process of "ethical acculturation" in clinical psychology with specific recommendations for professors and trainees	- Idea that every individual enters the field with his/her own morals and values and then learns how to apply ethics over the course of professional training. Sometimes ethics of the field may be in contrast to an individual's "ethics of origin." - "Becoming an ethical professional is more complex than simply following a set of rules or doing what one sees one's mentors do…" (p. 59). - Ethics training is complication b/c 1) ethical principles outlined in ethics codes can be vague; 2) learning through observation only is insufficient; and 3) ethics is often taught as a risk management strategy than as a way to understand and adopt best practices.
Ladany (2014)	- Discusses discreet behaviors that may lead to "supervisor failure"	- Behaviors that lead to "supervisor failure" = 1) lack of respect, 2) multicultural incompetence, 3) modeling unethical bx, 4) poor choice of evaluation instruments, 5) being a narcissist, 6) apply therapy models to supervision assuming empirical/theoretical basis, 7) treating supervisee like a child, 8) colluding, 9) acting like supervisee is personal therapist, 10) dating supervisee. - "…it is frequently the accumulation of multiple supervision missteps that sets supervision experience down a troubling path" (p. 1094). - "When the supervisory alliance is weak, trainees tend to disclose less to their supervisors (Ladany & Lehrman-Waterman, 1999), and experience greater role conflict and ambiguity (Ladany, Friedlander, & Nelson, 2005) and feel greater anxiety (Mehr, Ladany, & Caskie, 2010)." - "The primary mechanism, or supervisor skill, for strengthening the alliance, particularly early in the supervisory relationship, is empathy" (p. 1096) - "Particularly damaging are behaviors that weaken the [supervisory] relationship by psychologically trapping the trainee" (p. 1096) - "The empirical literature on supervisor ethics is sparse; however, it points to how and how often supervisors behave unethically (Crall, 2010, 2011; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). In terms of frequency, two studies have examined adherence to ethical guidelines by supervisors, as perceived by trainees. In this limited literature (Crall, 2011; Ladany et al., 1999), it appears that supervisors are behaving more ethically in the last decade as evidenced by the perceived frequency of nonadherence (i.e., 51% in 1999 and 33% in 2011). The primary guideline that continues to pose ethical challenges to supervisors is evaluating trainees (e.g., writing evaluations without ever witnessing the trainee conduct psychotherapy; no evaluations)." - "…generally…it seems that many supervisors do not attend as scrupulously to the ethical imperatives of supervision as they do when it comes to psychotherapy per se" (p. 1097). - a supervisor "too often models poor behavior to future supervisors….In the worse case, abhorrent behaviors are passed on to the trainee – for example, when the trainee adopts the same poor behaviors when he or she becomes a supervisor" (p. 1097).

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Reiser & Milne (2014)	Make a case for EBP in supervision	- There is a "paradoxical imbalance between the critical importance of supervisors on the one hand, and the limited efforts that have been made to train supervisors on the other…" (p. 140). - … "we need EBP because it provides a system of quality control, a means of ensuring that therapist drift and variable competence can be 'checked by experts' (e.g., through audits or outcome benchmarking), alongside other forms of corrective feedback" (p. 141) - "EBCS provides guidelines on what works in terms of practices likely to be effective, and this provides a form of protection from legal and other challenges to one's professional competence (p. 143) - [Reference Fouad (2009) supervision competencies formally integrated into core competencies model].
Minnes (1987)	Discussion of ethical dilemmas in supervision and recommendations to reduce the chance of - "violating ethical standards."	- "…for many supervisors, their own supervisory experience has been their only preparation." (p. 285) - "Regardless of the content and style of supervision, its ultimate success depends to a large extent upon the quality of the supervisor/supervisee relationship" (p. 285) - Ethics may be compromised if countertransference impact relationship or evaluation of trainee. Also problematic if supervisor operating for their own benefit rather than for benefit of supervisee. - Multiple roles identified as particularly problematic from an ethical standpoint. - Encourages informed consent to supervision which encourages "active participation" by the supervisee as a way to offset the inherent power differential. Contract should also be flexible enough to allow for changing needs of the supervisee. - Recognition that difficult for supervisors when needs of supervisee and needs of client (as perceived by supervisor) are in conflict.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Nagy (2011) Chpt 12 "Ethics in Teaching, Training, and Supervision"	Overview of ethical issues that may arise in supervision	- Licensing boards are starting to require ongoing training in supervision in order to accept hours of their trainees, e.g., towards licensure.
Pettifor, Sinclair, & Falender (2014)	Exploration of ethics and multiculturalism and how impacts practice of supervision	- [References "…an increasing emphasis on competency-based clinical supervision (Falender, Shafranske, & Falicov, 2014)"] - In increasingly global world, there is a need to integrate ethics and cultural diversity. - Proposes framework for supervision consistent with concept of "enlightened globalization" (consider ethical principles in responding to cultural differences and engage in "respectful collaborative process" and "the effect of the worldviews of supervisor, supervisee, and client are addressed…") instead of "unilateral globalization" (behavioral rules apply to all cultures) - "Never before in history have supervisors and supervisees come from so many different cultures with different worldviews…" (p. 202). - "Supervisee willingness to introduce diversity issues may be substantially diminished by the power differential and perceived lack of integration into supervision of the issues of culture, ethics, and globalization, and their interrelationship" (p. 203). - "The factors of supervisor privilege and supervisee lack of power result in supervisees generally feeling less empowered, and especially less empowered to discuss ethics, cultural dimensions, or their intersection with supervision, especially without an articulated collaborative process" (p. 204). - Some background of supervision in the U.S. - Mention of the Universal Declaration of Ethical Principles for Psychologists (2008; Gauthier & Pettifor, 2011, 2012) as most recent example of efforts to develop global ethical standards in the profession. - It is imperative that supervisors are knowledgeable about The Universal Declaration because it: 1) has promoted global discussion of ethics [(citations provided)] 2) is contributing to revisions of current national ethics codes [(citations provided)] 3) and may aid in the process of ethical decision-making as opposed to "reliance on specific rules." [(citations provided)]. - [Reference Falender et al. (2014) notion of "cultural humility" as willingness to engage in ongoing self-evaluation]. - Supervisors have greater responsibility than supervisees (b/c of power differential) for increasing awareness of cultural diversity in supervision and practice. - "Culturally responsive supervision fosters enlightened globalization. It also fosters the harmony, trust, and understanding necessary for effective learning" (p. 207). - There is an "urgent need" for more graduate training in supervision.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Falender, Shafranske, & Falicov (2014) Chpt 8	Discussion of religiousness and spirituality (R/S) as cultural factors/ethical imperative	- "Taking into consideration the religious and spiritual backgrounds of clients is not only clinically useful, it is ethically required" (p. 182). - Supervisors must respect supervisee's worldview as much as the client's. - "Supervision addressing the R/S dimension of professional practice is founded on respect and tolerance and is facilitated by providing a context for supervisees to examine the ways in which their own beliefs and values influence their understanding of the client" (p. 186). - "Careful consideration of ethics is always warranted when considering direct integration of R/S resources" [(citations provided)]. - "Self-reflection and self-assessment are essential to ethical practice and the development of competence (Falender & Shafranske, 2007)."
Falender & Shafranske (2014b) State of the Art	Overview of current status of "effective clinical supervision."	- Clinical supervision now recognized as a core professional competence. More attention now focused on ensuring that supervisors are competent and providing effective supervision. - Variety of definitions of supervision – some highlight different aspects of supervision while others highlight the function of super version. - Ongoing challenge is to create a definition that is inclusive enough to allow for many variations while precise enough to facilitate ongoing research. - Metafactors added to original definition: 1) integrity-in-relationship 2) ethical, values-based practice "across the supervision triad" of supervisor-supervisee-client 3) appreciation of diversity 4) evidence-based practice - "Effective supervision is defined as practice that encourages supervisee development and autonomy, facilitates the supervisory relationship, protects the client, and enhances both client and supervisee outcomes" (pp. 1031-1032). - 15 specific components of effective supervisor practices. - Alliance is critical component. "The alliance is developed through a collaborative process in which goals and the tasks to achieve these are identified, based in part on the supervisee's self-assessment of competence" (p. 1032) - [Reference Inman & Ladany (2008) from the supervisee's perspective, the alliance is associated with supervision outcomes]. - "Supervision diversity competence" is an ethical imperative. - Supervisors are in a position to constantly assess a supervisee's professionalism and compliance with ethical standards. - [Reference Thomas (2010) supervision contract brings together all components of supervision and fulfills ethical imperative of informed consent]. - Contract as "living document" that covers both general information and information specific to the setting.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Thomas (2007)	Discussion of purpose and benefits of informed consent to supervision. Relevant ethical standards highlighted	- With regards to the supervision contract: "Such clarification establishes a clear professional boundary, sets the tone for the supervisory relationship, and provides a model for supervisees" (p. 222). - …informed consent is a process that begins at the outset or even before the supervision commences, and it continues through the duration" (p. 223) - "Obtaining the informed consent of supervisees at the outset of supervision is critical to minimizing risks and maximizing the benefits" (p. 225) "…ethical standards require…that informed consent be obtained in writing" (p. 225) - Three components: 1) professional disclosure statement 2) learning contract 3) signature page - Contract components (not exhaustive and not all necessary all the time): 1) supervisor's background 2) supervisory methods 3) supervisor's responsibilities and requirements 4) supervisee's responsibilities 5) potential supplemental requirements 6) confidentiality policies 7) documentation of supervision 8) financial policies 9) risks and benefits 10) evaluation 11) complaint procedures and due process 12) professional development goals 13) endorsement 14) duration and termination of the supervision contract - Outcome of clearly articulated informed consent process using a supervision contract is likely to lead to more effective supervision and higher rates of satisfaction. - The duration, frequency, and format of supervision must be explicitly detailed. - Information regarding availability of supervisor, particularly in crisis scenarios. - "…supervisors must ensure that supervisees have a clear understanding of which cases they must present, how to prioritize these cases, and when they must notify their supervisors" (p. 159)
Thomas (2010) Chpt 1	Overview of ethical practice of supervision (and consultation)	- "A significant component of the development of all psychologists and mental health professionals is learning and internalizing the ethics of their professions" (p. 4) - Clinical supervision is major way that clinical psychology trainees learn how to implement ethical principles in professional practice. - [Reference Bernard and Goodyear (2009) definition of supervision and Falender and Shafranske (2004) definition of supervision].

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Thomas (2010) Chpt 2	Overview of ethical practice standards for supervision (and consultation)	- Discussion of APA Ethics Code (2002) "…the ethical standards establish the minimum criteria for acceptable practice that form the basis for determining violations" (p. 18). - 2002 Ethics Code does not include some issues related to supervision and consultation such as: 1) crisis procedures 2) due process for supervisees 3) endorsement of supervisees for professional credentials 4) methods for supervision and consultation - Provides overview of several ethics codes including: 1) Association for Counselor Education and Supervision (ACES) – Ethical Guidelines for Counseling Supervisors 2) Association of State and Provincial Psychology Boards (ASPPB) Supervision Guidelines 3) Center for Credentialing and Education (CCE) – The Approved Clinical Supervisor (ACS) Code of Ethics
Thomas (2010) Chpt 5	Overview of boundaries and multiple relationships	- Discussion of 7 specific areas related to multiple relationships in supervision/consultation: 1) boundaries 2) exploitation and abuse of power 3) psychotherapy with supervisees 4) sexual harassment and sexual exploitation 5) sexual contact with supervisees 6) impaired objectivity and judgment 7) unforeseen or unavoidable multiple relationships - Do not engage in MR if may impair objectivity/competence/effectiveness or risk of exploitation or harm - Supervisors cannot require supervisees to disclose personal info unless notified in advance or necessary to seek help - ACES provides detailed guidance on boundaries in supervision - "The ethical dimensions of supervisory and consultative relationships are best examined in the context of power and influence" (p. 104). - "The unique power differential in a given supervisory or consultative relationship is determined by the confluence of multiple factors – factors that continually evolve" (p. 106). Eg, must take into consideration stage of training, vulnerability factors of each party, etc. - "Particularly in supervision, novice clinicians may not understand what is appropriate behavior for supervisors" (p. 107) - "Whether a particular action on the part of a supervisor or consultant constitutes a boundary crossing, boundary violation, helpful intervention, or just a neutral, inconsequential interaction depends on many factors" (p. 107) - More formal roles of supervisor are as teacher, evaluator, endorser, and mentor. More informal roles are advocate, role model, support person, and career resource. - "Generally, the more discrepant a secondary role is from the primary role, the greater the risk of harm" (p. 113). May be unethical for supervisor to engage in incompatible secondary role with a supervisee.

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Author/Year	Research Questions/Objectives	Major Findings / Standards of Practice
Thomas (2010) Chpt 6	Overview of informed consent to supervision (and consultation)	- Some of same principles of informed consent in therapy apply to informed consent in supervision, e.g., length of term, limits to privacy, risks and benefits, etc. - "Further, consumers of both treatment and supervision benefit from obtaining information about the provider's professional background, theoretical approach, and credentials" (p. 142) - "Ethically, consent must be truly informed…and voluntary…" (p. 142) but these are limited in supervision, e.g., supervisees are mandated to obtain supervision in order to advance to the next stage of training. Supervisees are also unlikely to have a say in who will supervise them. - Most effective to obtain informed consent to supervision in writing and orally and also improves satisfaction for both supervisor and supervisee. - Explicit discussion of expectations and potential conflicts also helps to establish the professional boundary in supervision. - The process of obtaining informed consent also models for supervisees how to do this effectively with their clients. - Reference APA Ethics Code – need for supervisees to inform clients that being supervised and obtain permission to discuss case in supervision. - Supervisors should get written consent from supervisees for supervisor to communicate to others about particular aspects of supervision.
Watkins (2012)	Review of six papers; offers predictions/observations regarding future of supervision	- "The supervision relationship, individualization, developmental differentiation, and self-reflection (for supervisee and supervisor) appear to be crucial cornerstones….to [the] supervision process" (p. 193) - "…three emphases – competency-based supervision, evidence-based practice, and accountability – will continue to substantially influence, affect, and inform psychotherapy supervision practice…" (p. 193) "From my perspective, psychotherapy supervision is an educative process by which and through which we as supervisors strive to embrace, empower, and emancipate the therapeutic potential of the supervisees with whom we have the privilege to work" (p. 193) - Review of some literature on competency movement and evidence-based supervision practice (EBSP) literature. - Discussion of supervision from different theoretical orientations - Cites empirical studies of supervisory alliance - [after review of six papers]… "self-reflection appears to be readily recognized as a sine qua non for the instigation of an effective supervision process" (p. 199)

APPENDIX B

Summary Table of Selected Literature - Empirical Studies

Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Budz (2014)	How appropriate is it for trainees/students to interact with professors/supervisors via social media, particularly when may lead to "ethical transgressions"?	Quantitative survey plus qualitative analysis of vignettes	Online survey/case vignettes	69 students enrolled in doctoral clinical or counseling psych program	Consequence arising from social media use is "blurring" of professional boundaries, e.g,. acceptance of a supervisor's friend request as boundary crossing.
Cikanek, Veach, & Braun (2004)	Investigation of current (advanced) doctoral students' knowledge/understanding of clinical supervisors' ethical responsibilities (with idea that students will be "next generation" of supervisors	Qualitative/Inductive analysis (7 themes identified)	Semi-structured telephone interview	10 counseling psych doctoral students	Themes: 1) could not describe how supervision addressed in ethics code; 2) could not identify all responsibilities of supervisor; 3) could not identify all "self-protection" strategies; 4) uncertainty around use of informed consent in supervision; 5) identified limited number of ways to address supervisee competence issues; 6) minimized accountability to certain regulatory bodies; 7) vague differentiation between supervisor legal and ethical responsibilities

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Ellis, Berger, Hanus, Ayala, Swords, & Siembor (2014a)	Two studies. Study 1: 1) test framework for inadequate and harmful supervision; 2) develop operational definitions for de facto inadequate supervision and de facto harmful supervision. Study 2: 1) preliminary data on frequency of both inadequate and harmful supervision from the perspective of the trainee (using taxonomy derived in Study 1).	Study 1: 10 criteria for "minimally adequate" supervision and refined definitions of inadequate and harmful supervision via expert rating	Study 1: consensus validation approach w/ supervision experts	34 supervision experts (study 1) and 363 supervisees (study 2)	Study 1: 1) prior definition assumed inadequate and harmful were mutually exclusive but found that harmful is by definition inadequate; 2) identification of 37 supervision descriptors that captured definitions for DFHS and DFIS; 3) disconnect btw ethical guidelines/supervision literature and endorsement of supervision experts. Study 2: 93% of supervisees were receiving inadequate supervision and 36% were receiving harmful supervision. Over half had received harmful supervision at some point. 54.2% had no consent or contract; 39.7% did not have sessions reviewed (these two were most common descriptors endorsed for inadequate supervision). 67% who had harmful said it was ongoing and 63% did not report to agency. - Provides criteria for "minimally adequate supervision" as precursor to criteria for "inadequate supervision." Provides comprehensive definition of "harmful supervision." Table of inadequate and harmful supervision ratings; of note: "no evaluative feedback," "behaves unethically"

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Hardy (2011) Dissertation	Examined graduate students and postdoctoral supervisees' perceptions and experiences of supervisor boundary crossings and boundary violations RQ1 = "How do clinical and counseling psychology supervisees perceive boundary crossings and boundary violations in the supervisory relationship?" RQ2 = "What is the incidence of perceived boundary violations in the supervisory relationship as reported by this sample of clinical and counseling psychology supervisees?" RQ3 = "How does the experience of a boundary violation affect supervisees personally and professionally in the short and long term?"	Mixed design	Online survey; chi square - Asked to provide definitions of BV and BC on own before being provided with definitions and asked to rate vignettes as BVs or BCs -Same for a panel of supervision experts	84 practicum, intern, and postdoc supervisees	- 33.3% of participants reported experiencing a boundary violation in supervision (majority during practicum as opposed to internship or postdoc) - 92.9% told someone about the experience - Majority who experienced BV had "profoundly negative effects" on 1) their personal ??, 2) relationship with supervisor 3) relationship with subsequent supervisors and 4) patient care. - 30.7% BV had somewhat or very negative impact on subsequent supervisory relationships - Example of positive impact on client care bc clinician openly acknowledged power differential in relationship - Most common BV was sexual in nature (27% of those who reported a BV). - Other BVs = "poor supervisee tx." "conspiracies of silence in clinical training," - Familiarity with APA Ethics Code and number of ethics courses taken did not serve as protective factors against experiencing a supervisory BV. Most likely due to power differential and fact that supervisors are primarily responsible for maintaining appropriate boundaries with supervisees. -Conclusion that "…knowledge and awareness are not enough to ensure psychology trainees' safety, nor do they necessarily empower them to deal with boundary violations that do occur." - Most (98.8%) had taken at least one ethics course.

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Kirk (2014) Dissertation	Association between supervisory alliance, counterproductive events during supervision, and trainee self-efficacy RQ1 = "What is the relationship between the presence of counterproductive events and the supervisory working alliance as perceived by the trainee?" RQ2 = "What is the relationship between the supervisory working alliance, the presence of counterproductive events, and the trainee's level of self-efficacy?" RQ3 = "What is the independent contribution of the Supervisory Working Alliance, presence of counterproductive events, years of experience, and gender of self-efficacy?"	Quantitative design	Multiple regression	102 doctoral students under supervision	- "Counterproductive event" = event that occurs in supervision that is perceived by the supervisee to have harmed growth/development - [Reference lots of working alliance studies] - More CEs and weaker working alliance corresponded to lower trainee self-efficacy. - Fewer CEs and more yrs of experience corresponded to higher self-efficacy. -CEs were related to weaker working alliances - Higher rates of CEs and weaker alliances correlated with lower self-efficacy

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Kozlowski, Pruitt, DeWalt, & Knox (2014)	Can boundary crossings in clinical supervision be beneficial?	Qualitative (Consensual Qualitative Research)	Interview format. Pilot interviews conducted then protocol revised	11 doctoral trainees (9 advanced practicum students and 2 interns)	- Examples of "positive boundary crossings" (PBCs), e.g., supervisor self-disclosure, socializing, sharing rides. - Most saw PBCs as positive, i.e, "enhancing the supervisory relationship" but others reported resulting "role confusion." - Supervisors should be wary of initiating a boundary crossing bc different supervisees may interpret same crossing differently and even if doesn't classify as BV, this study showed that many supervisees experience role confusion as a result of a BC. - In only 2 of 11 cases was the BC discussed in supervision with the goal of clarifying role confusion - Supervisees either considered the BC normal or were worried about negative reaction from supervisor if brought it up for discussion - Recommend that supervisors initiate discussion of BC in supervision – even if was perceived as positive – would benefit both parties AND …would be a way for supervisors to demonstrate "…modeling ethical supervision practice and guard against charges that the crossings are harmful for supervisees." (p. 121) - Supervisees in this study demonstrated some confusion with regards to how to define boundaries in supervision. - Benefits of BC can be: improving supervisory relationship and potential development of a mentoring relationship and more disclosure and honesty on the part of the supervisee.

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Ladany, Ellis, & Friedlander (1999)	Found that changes in supervisory alliance not predictive of changes in supervisee self-efficacy (contrary to Bordin 1983 prediction).	Do changes in supervisee perception of supervisory alliance over time predict supervisory outcomes?	Self-report questionnaires 1) Working Alliance Inventory-Trainee version (WAI-T) 2) Self-Efficacy Inventory (SEI) 3) Trainee Personal Reaction Scale – Revised (TPRS-R)	107 practicum and intern-level supervisees	- Emotional bond was the discreet variable found to be associated with satisfaction - found that stronger emotional bond between supervisor and supervisee associated with greater satisfaction.
Ladany & Lehrman-Waterman (1999)	1) "The purpose of this study was to evaluate the nature and extent of supervisor self-disclosures and how these self-disclosures were related to supervisor style and the supervisory relationship." 2) Secondary purpose is to "determine how supervisor style, or approaches and responses to trainees, was related to the frequency with which supervisors self-disclose." 3) "examine how supervisor self-disclosures influenced the supervisory relationship, especially the supervisory working alliance."	Supervisor style = 1) attractive 2) interpersonally sensitive, 3) task-oriented H1 = Supervisors with an attractive style (open, warm, supportive) more likely to self-disclose	1)Supervisor Self-Disclosure Questionnaire (SSDQ) – elicited free-form responses 2) Supervisor Self-Disclosure Index (SSDI) self-report 3) Supervisory Styles Inventory (SSI) self-report 4) WAI-T	109 supervisees	- Self-discloser may enhance alliance -Supervisor style impacts self-disclosure

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
**Ladany, Lehrman-Waterman, Molinaro, & Wolgast (1999)	1) Review of literature on ethical guidelines related to clinical supervision 2) "supervisee perceptions of their supervisors' adherence to ethical guidelines, supervisee reactions to ethical violations, and the relationships among supervisor ethical behaviors, the supervisory working alliance, and supervisee satisfaction."	RQ1 = Understand nature and extent of supervisors' adherence to ethical practices as perceived by their supervisees RQ2 = Determine specific supervisee reactions to their supervisors' nonadherence to ethical practices as well as the potential impact these practices had on the supervisees' work with clients. RQ3 = determine the relationship between supervisor ethical practices and the quality of the supervisory relationship, specifically the supervisory working alliance. RQ4 = determine the relationship between adherence to ethical practices and supervisee satisfaction with supervision. H1 = supervisees would generally not address ethical breach with supervisor H2 = not discuss with other supervisors but would with peers	Created list of 12 ethical guidelines covering most salient aspects of supervision (based on Association for Counselor Education and Supervision guidelines) plus 3 additional guidelines deemed important - Total of 15 ethical guidelines for supervision - Two measures developed for the study: 1) Supervisor Ethical Practices Questionnaire (SEPQ) descriptive/ open-ended questions 2) Supervisor Ethical Behavior Scale (SEBS) quantitative /closed-ended questions	151 practicum and intern-level supervisees	- 51% reported at least one ethical violation. - Most frequent violations fell into the categories of 1) inadequate evaluation, 2) issues of confidentiality, and 3) competence with regards to alternative perspectives. - Less adherence to ethical guidelines associated with weaker working alliance and less supervisee satisfaction. - 12 areas of ethical practice in supervision: 1) performance evaluation and monitoring of supervisee activities 2) confidentiality issues in supervision 3) ability to work with alternative perspectives 4) session boundaries and respectful treatment 5) orientation to professional roles and monitoring of site standards 6) expertise and competency issues 7) disclosure to clients 8) modeling ethical behavior and responding to ethical concerns 9) crisis coverage and intervention 10) dual roles 11) differentiating supervision from psychotherapy and counseling 12) sexual issues 13) multicultural sensitivity toward clients 14) multicultural sensitivity toward supervisees 15) client termination and follow up issues

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
**Wall (2009)	"…examined ethical adherence by supervisors as perceived by their supervisees and addressed the practice of supervision and supervision as a distinct competency."	Examination of "ethical practices of supervisors as perceived by supervisees and impact of ethical breaches on supervisee attitudes and behavior." - expands on previous research by addressing supervision as a distinct competency - Did supervisor nonadherence to one or more ethical principles have an impact on the supervision process by negatively impacting supervisory alliance, trust in supervisor, or willingness to disclose in supervision? Did the unethical or unprofessional behavior negatively impact motivation to be in the field, negatively impact quality of care for clients, or negatively impact emotional well-being? (Of these, trust in supervisor and working alliance were most frequently – negatively – impacted)	Internet survey; Ethical Practices in Supervision Scale (EPSS) developed for this study (modified instruments used in Ladany et al. 1999 – SEBS and SEPQ)	180 psychology interns	- "high frequencies" of perceived nonadherence in areas of: 1) observation of trainee performance and professional activity 2) administration of supervisory contracts 3) confidentiality in supervision 4) use of intervention methods by trainees in which supervisor was not trained. -Reported that ethical nonadherence negatively impacted: 1) supervisory alliance 2) trust in supervisor 3) willingness to disclose information 4) motivation to be in the field 5) emotional well-being -23% reported at least one ethical lapse/violation -26% had questioned supervisor's ethical judgment on at least one occasion -Almost a third reported supervisor did not regularly meet during scheduled supervision times. -Highest frequency of ethical misconduct = 2/3 reported supervisor did not use observation as evaluation method (eg, listening to tapes or videos) although regularly monitored progress notes/charts. -Majority did not report boundary issues (crossings or violations) -38% allowed supervisee to use treatment that supervisor not trained in - 2nd highest area of unethical conduct: 42% reported supervisor did not use contract (2 out of 5).

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Ladany, Mori, & Mehr (2013)	1) Delineated most effective and ineffective supervisor skills, behaviors, and techniques. 2) Examined the relationship btw effective and ineffective supervisor bxs and supervision process and outcome (i.e., working alliance, supervisor style and self-disclosure, and supervisee nondisclosure and evaluation).	What supervisor skills, behaviors, and techniques were effective in facilitating supervisee growth and which were ineffective and limited growth?	Mixed-method design; examined multiple supervision experiences of same group of supervisees - Each participant reported one "best" and one "worst" supervisor; 1) qualitative questionnaire 2) WAI-S 3) SSI 4) SSDI 5) Trainee Disclosure Scale (TDS) 6) Evaluation Process within Supervision Inventory (EPSI); online survey	128 students and post-docs	Most <u>ineffective</u> characteristics: 1) depreciated supervision 2) ineffective client conceptualization and tx 3) weak relationship (others were insufficient knowledge and skill development; insufficient observation and feedback; emphasis on evaluation and limitations; negative personal/professional qualities; lack of and misapplication of theory) Most <u>effective</u> characteristics: 1) encouraged autonomy 2) strengthened relationship 3) facilitated open discussion (others were positive personal/professional qualities; demonstration of clinical skill/knowledge; provide constructive challenge; offering feedback/reinforcements; engage and value supervision) - … "the identified effective supervisor skills, techniques, and behaviors arguably can be seen as a primer for supervisor competencies" (p. 41) -Consistent bxs were identified across both "best" and "worst" supervisors - Unique finding = supervisee empowerment is important value for supervisees (consists of "encouraging autonomy and facilitating openness to the supervisees' ideas…" (p. 41) - Other helpful aspects as identified by supervisees was self-disclosure for benefit of supervisee and providing "positive and challenging" feedback (p. 41)

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Mehr, Ladany, & Caskie (2010)	1) Examine content of and reasons for supervisee nondisclosure 2) influence of supervisee anxiety and perception of working alliance on amount of nondisclosure and willingness to disclose	Mixed-method; qualitative and quantitative data collected about a single supervision session	1) Supervisee Nondisclosure Survey 2) Trainee Disclosure Scale 3) WAI-S 4) Trainee Anxiety Scale	204 supervisees	- In the single session being queried, 84.3% reported withholding info from supervisor - Most common nondisclosure was related to perceived negative experience in supervision -Perception of stronger working alliance related to less nondisclosure and willingness to disclosure - Higher anxiety associated with greater nondisclosure and less willingness to disclose - Reasons for nondisclosure most often related to impression management, deference to supervisor, and perceived negative consequences - [Most often relates to supervision issues but can also include clinical issues and/or personal issues]. - [Reference several studies of reasons for nondisclosure (p. 104)]
Mehr, Ladany, & Caskie (2015)	Built on 2010 study; hypothesized relationships between self-efficacy, anxiety, and willingness to disclose.	H1 = higher self-efficacy would predict less anxiety in supervision H2 = perception of stronger working alliance would predict less anxiety in supervision H3 = perception of a stronger working alliance would predict higher willingness to disclose H4 = lower levels of anxiety in supervision would predict higher willingness to disclose	1) Trainee Anxiety Scale 2) State-Trait Anxiety Inventory 3) WAI-S 4) Counseling Activity Self-Efficacy Scales 5) Self-Efficacy Inventory 6) Trainee Disclosure Scale 7) Self-Disclosure Index	201 doctoral students	- Hypotheses supported: 1) higher self-efficacy predicted less anxiety in supervision 2) perception of stronger working alliance predicted less anxiety in supervision 3) perception of stronger working alliance predicted higher willingness to disclose (Other two hypotheses not supported) - [Reference Bernard & Goodyear (2009) supervisee nondisclosure could have serious impact on supervisor since responsible for unethical behavior on the part of the trainee].

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Pakdaman, Shafranske, & Falender (2014)	Investigation of influence of relationship between supervisor and supervisee on supervisee's countertransference disclosures. Replication and expansion of previous study (Daniel, 2008)	Quantitative design; online survey	1) WAI-S 2) Personal Reaction Disclosure Questionnaire - Respondents answered questions re: vignettes	332 Doctoral trainees (clinical and counseling)	- "Clinical supervision provides the foundation for cultivating ethical practice and professionalism for mental health trainees" (p. 427). - "Exploration and management of a supervisee's personal reactivity or countertransference (CT) is a critical component of supervision and has clear ethical implications for clinical management and the development of clinical competence" (p. 427) - positive correlation between supervisory alliance and comfort AND likelihood of CT disclosures - highlights importance of interpersonal bond and supervisors' responsibility in fostering this bond. - "Supervisors facilitate the development of clinical competence through oversight and by engaging trainees to reflect upon and apply principles of evidence-based practice…incorporating ethics throughout" (p. 427) "…ethics govern every aspect of conduct, leading to professionalism" (p. 427) - "Among the competencies that are addressed in supervision, management of CT, also referred to in other theoretical frames as reactivity, is integral to ethical and effective practice" (p. 428). Managing CT is an ethical requirement. - Section 7.04 of Ethics Code says supervisees not required to disclose personal info, but have to disclose as relates to problems working with clients.

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Author/Yr	Research Question/Objective	Research Approach/Design	Methods	Sample	Major Findings/General Discussion
Papile (2013) Dissertation	Exploration of "critical incidents" within supervision that "help or hinder" a supervisee's competence		Interviews using Critical Incident Technique	Masters and Doctoral trainees; clinical supervisors	Helpful incidents grouped into following categories: 1) Direct support 2) Feedback 3) Empowerment and Encouragement 4) Process-based supervision 5) Supervisor as teacher and role model 6) Supervisor vulnerability Hindering incidents: 1) Feeling unsupported 2) Critical and attacking behaviors 3) Conflicts with feedback and evaluation -Results did not support use of Integrative Developmental Model in supervision - An essential part of supervision is "involving supervisees in ethical decision-making and exploring the challenges surrounding ethical practice…" (p. 123).
Powers (2015) Dissertation	Factors contributing to assessments of problematic (but adequate) inadequate, and harmful supervision experiences				- Largest difference (seen in 9 of 10 factors) between categories of problematic and harmful. - Differentiation btw problematic and inadequate in 7 of 10 factors -Differentiation between inadequate and harmful in 3 of 10 factors.

APPENDIX C

Summary Table of Selected Literature References

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APPENDIX D

Additional Tables

Table A1

Participant Demographics (N = 111)

Characteristic	n	%
Gender		
Female	98	88.3
Male	12	10.8
Other	1	0.9
Not reported	0	0.0
Racial/ethnic identification		
African American/Black	7	6.3
American Indian/Alaska Native	1	0.9
Asian/Pacific Islander	6	5.4
Hispanic/Latino	8	7.2
White (Non-Hispanic)	88	79.3
Biracial/Multiracial	2	1.8
Other	5	4.5
Not reported	0	0.0
Sexual orientation		
Heterosexual	96	86.5
Gay Male	4	3.6
Lesbian	1	0.9
Bisexual	7	6.3
Other	3	2.7
Not reported	0	0.0
Primary theoretical orientation		
Behavioral	2	1.8
Biological	0	0.0
Cognitive Behavioral	43	39.4
Eclectic	6	5.5
Humanistic/Existential	5	4.6
Integrative	21	19.3
Interpersonal	8	7.3
Psychodynamic/Psychoanalytic	16	14.7

Systems	2	1.8
Other	6	5.5
Not reported	2	1.8
Type of doctoral program		
Clinical	91	82.0
Counseling	13	11.7
School	5	4.5
Combined (e.g., clinical-school)	0	0.0
Other	2	1.8
Not reported	0	0.0
Degree sought		
Ph.D.	52	46.8
Psy.D.	58	52.3
Ed.D	0	0.0
Other	1	0.9
Not reported	0	0.0
Number of practicum training experiences in doctoral program prior to internship		
One	3	2.7
Two	6	5.5
Three	47	42.7
Four	33	30.0
Five or more	21	19.1
Not reported	1	0.9
Most recent practicum training site		
Armed Forces Medical Center	0	0.0
Child/Adolescent Psychiatric/Pediatrics	6	5.5
Community Mental Health Center	25	22.9
Consortium	0	0.0
Medical School	1	0.9
Prison/Other Correctional Facility	3	2.8
Private General Hospital	4	3.7
Private Outpatient Clinic	12	11.0
Private Psychiatric Hospital	4	3.7
Psychology Department	5	4.6
School District	2	1.8
State/County/Other Public Hospital	8	7.3
University Counseling Center	7	6.4
Veterans Affairs Medical Center	11	10.1
Other	21	19.3
Not reported	2	1.8

Percentage of individual psychotherapy at most recent practicum training site		
100 %	2	1.8
75-99 %	27	24.8
50-74 %	29	26.6
25-49 %	18	16.5
Less than 25 %	33	30.3
Not reported	2	1.8

Table A2

Supervisor Demographics

Characteristic	n	%
Gender		
Female	63	57.8
Male	46	42.2
I don't know	0	0.0
Other	1	0.9
Not reported	2	1.8
Racial/ethnic identification		
African American/Black	8	7.3
American Indian/Alaska Native	2	1.8
Asian/Pacific Islander	4	3.7
Hispanic/Latino	6	5.5
White (Non-Hispanic)	85	78.0
Biracial/Multiracial	3	2.8
Other	2	1.8
Not reported	2	1.8
Sexual orientation		
Heterosexual	88	80.7
Gay Male	1	0.9
Lesbian	5	4.6
Bisexual	0	0.0
I don't know	15	13.8
Other	0	0.0
Not reported	2	1.8
Primary theoretical orientation		
Behavioral	8	7.4
Biological	3	2.8
Cognitive Behavioral	39	36.1
Eclectic	6	5.6
Humanistic/Existential	3	2.8
Integrative	19	17.6
Interpersonal	4	3.7
Psychodynamic/Psychoanalytic	21	19.4
Systems	2	1.9
Other	3	2.8

Not reported	3	2.8
Primary supervisor was		
A licensed psychologist	102	93.6
An unlicensed psychologist	3	2.8
A licensed professional in another discipline	4	3.7
Other	0	0
Not reported	2	1.8

Table A3

EPSS-R Item Number and Competency Measured

Competency Benchmark(s)	EPSS-R Item Number	Results*	
Monitored supervisee performance and professional activities	Item 1 (+)	Agree: 88.9%	Disagree: 11.1%
	Item 2 (-)	Agree: 40.8%	Disagree: 56.6%
	Item 3 (-)	Agree: 21.3%	Disagree: 74.0%
	Item 4 (+)	Agree: 42.0%	Disagree: 48.6%
Observed supervisee performance and professional activities	Item 5 (+)	Agree: 19.8%	Disagree: 79.2%
	Item 6 (+)	Agree: 68.2%	Disagree: 29.0%
	Item 7 (+)	Agree: 40.2%	Disagree: 59.8%
Practiced multicultural sensitivity toward clients and supervisees	Item 8 (+)	Agree: 77.6%	Disagree: 10.3%
	Item 9 (+)	Agree: 70.0%	Disagree: 19.7%
Maintained appropriate boundaries and carefully monitored dual roles	Item 10 (-)	Agree: 17.0%	Disagree: 80.2%
	Item 11 (+)	Agree: 89.6%	Disagree: 4.7%
	Item 12 (-)	Agree: 1.9%	Disagree: 99.1%
Discussed the process of evaluation, provided regular feedback about supervisee performance and competence, and documented strengths and areas for improvement	Item 13 (+)	Agree: 71.4%	Disagree: 19.0%
	Item 14 (+)	Agree: 76.0%	Disagree: 16.3%
	Item 15 (+)	Agree: 78.4%	Disagree: 15.7%
	Item 16 (+)	Agree: 62.8%	Disagree: 17.1%
	Item 17 (+)	Agree: 63.2%	Disagree: 29.2%
Supervised only therapist-client relationships in which (s)he was competent	Item 18 (+)	Agree: 79.0%	Disagree: 10.5%
	Item 19 (-)	Agree: 13.4%	Disagree: 75.2%
	Item 20 (-)	Agree: 41.6%	Disagree: 41.6%
Modeled professional principles, values, and ethics	Item 21 (+)	Agree: 86.6%	Disagree: 7.7%
	Item 22 (-)	Agree: 33.3%	Disagree: 64.8%
Legal issues	Item 23 (+)	Agree: 85.5%	Disagree: 6.7%
	Item 24 (+)	Agree: 81.0%	Disagree: 12.4%
	Item 25 (+)	Agree: 88.4%	Disagree: 7.2%
Ensured adequate disclosure to client	Item 26 (+)	Agree: 92.3%	Disagree: 2.9%
	Item 27 (+)	Agree: 92.4%	Disagree: 5.7%
	Item 28 (+)	Agree: 77.1%	Disagree: 14.3%

Identified parameters of supervision	Item 29 (+)	Agree: 80.9%	Disagree: 11.5%
	Item 30 (+)	Agree: 52.4%	Disagree: 28.6%
	Item 31 (+)	Agree: 51.4%	Disagree: 41.0%
	Item 32 (+)	Agree: 35.2%	Disagree: 37.2%
	Item 33 (+)	Agree: 81.9%	Disagree: 10.5%

* Results are displayed as the combined percentages of "Agree" and "Strongly Agree" and the combined percentages of "Disagree" and "Strongly Disagree." Percentages do not included "Not Sure" or data not reported.

Table A4

Results of EPSS-R

Item Number	n	%
1. My supervisor made sure that I was using appropriate treatment interventions or assessment procedures with all of my clinical cases.		
Strongly Disagree	4	3.7
Disagree	8	7.4
Not Sure	0	0.0
Agree	47	43.5
Strongly Agree	49	45.4
Not reported	3	2.8
2. My supervisor met with me on an "as needed" basis (i.e., supervision times were not regularly scheduled OR if they were regularly scheduled, supervision time was cut short by the supervisor when there were not pressing clinical issues to be discussed).		
Strongly Disagree	31	28.7
Disagree	30	27.8
Not Sure	3	2.8
Agree	26	24.1
Strongly Agree	18	16.7
Not reported	3	2.8
3. My supervisor encouraged me to attempt interventions or treatments for which I felt unprepared.		
Strongly Disagree	25	23.1
Disagree	55	50.9
Not Sure	5	4.6
Agree	17	15.7
Strongly Agree	6	5.6
Not reported	3	2.8
4. My supervisor systematically monitored patient progress, e.g., thorough review of outcome measures.		
Strongly Disagree	18	16.8
Disagree	34	31.8
Not Sure	10	9.3

Agree	33	30.8
Strongly Agree	12	11.2
Not reported	4	3.6

5. My supervisor regularly reviewed video or audiotapes of my sessions.

Strongly Disagree	61	57.5
Disagree	23	21.7
Not Sure	1	0.9
Agree	17	16.0
Strongly Agree	4	3.8
Not reported	5	4.5

6. My supervisor reviewed my charts/progress notes with me on a regular basis.

Strongly Disagree	14	13.1
Disagree	17	15.9
Not Sure	3	2.8
Agree	41	38.3
Strongly Agree	32	29.9
Not reported	4	3.6

7. My supervisor at times conducted some form of live supervision (e.g., participated in a session with me or observed and commented with the use of a one-way mirror or video system).

Strongly Disagree	39	36.4
Disagree	25	23.4
Not Sure	0	0.0
Agree	28	26.2
Strongly Agree	15	14.0
Not reported	4	3.6

8. My supervisor's conduct and input in supervision suggested that he or she is multiculturally competent, possessing a good understanding of gender, sexual orientation, race, culture, religion, age, disability status, etc.

Strongly Disagree	2	1.9
Disagree	9	8.4
Not Sure	13	12.1
Agree	43	40.2
Strongly Agree	40	37.4
Not reported	4	3.6

9. My supervisor encouraged me to discuss any thoughts or feelings I had about gender, sexual orientation, race, culture, religion, age, or disability status.

Strongly Disagree	2	1.9
Disagree	19	17.8
Not Sure	11	10.3
Agree	39	36.4
Strongly Agree	36	33.6
Not reported	4	3.6

10. My supervisor and I discussed personal issues that did not seem to be appropriately related to my work with clients. ("Personal issues" would not include simple disclosure of personal information such as whether either party is married, has children, etc. UNLESS significant supervision time is spent discussing one's relationship, family, etc.)

Strongly Disagree	39	36.8
Disagree	46	43.4
Not Sure	3	2.8
Agree	15	14.2
Strongly Agree	3	2.8
Not reported	5	4.5

11. My supervisor appropriately acted as my supervisor and did not try to act in the role of my counselor/therapist.

Strongly Disagree	0	0.0
Disagree	5	4.7
Not Sure	6	5.7
Agree	33	31.1
Strongly Agree	62	58.5
Not reported	5	4.5

12. My supervisor behaved toward me in a way that seemed to be seductive or sexually provocative.

Strongly Disagree	103	97.2
Disagree	2	1.9
Not Sure	0	0.0
Agree	0	0.0
Strongly Agree	1	1.9
Not reported	5	4.5

13. My supervisor discussed with me at the beginning of the training year how I would be evaluated.

Strongly Disagree	2	1.9
Disagree	18	17.1
Not Sure	10	9.5
Agree	50	47.6
Strongly Agree	25	23.8
Not reported	6	5.4

14. My supervisor gave me adequate verbal and/or written feedback about my performance throughout the training rotation.

Strongly Disagree	5	4.8
Disagree	12	11.5
Not Sure	8	7.7
Agree	48	46.2
Strongly Agree	31	29.8
Not reported	7	6.3

15. My supervisor communicated any performance concerns in a timely manner (Please leave blank if there were no performance concerns during the rotation).

Strongly Disagree	2	3.9
Disagree	6	11.8
Not Sure	3	5.9
Agree	30	58.8
Strongly Agree	10	19.6
Not reported	60	54.0

16. My supervisor frequently provided formative feedback (i.e., feedback aimed at monitoring ongoing performance).

Strongly Disagree	2	1.9
Disagree	16	15.2
Not Sure	21	20.0
Agree	48	45.7
Strongly Agree	18	17.1
Not reported	6	5.4

17. My supervisor periodically elicited my feedback on the supervisory process.

Strongly Disagree	10	9.4
Disagree	21	19.8
Not Sure	8	7.5
Agree	53	50.0
Strongly Agree	14	13.2
Not reported	5	4.5

18. My supervisor appeared to be aware of recent research, theory, or treatment methods in regard to the presenting problems of my clients.

Strongly Disagree	2	1.9
Disagree	9	8.6
Not Sure	11	10.5
Agree	46	43.8
Strongly Agree	37	35.2
Not reported	6	5.4

19. My supervisor worked with me on a case that involved issues or disorders with which he or she had little or no experience.

Strongly Disagree	18	17.1
Disagree	61	58.1
Not Sure	12	11.4
Agree	13	12.4
Strongly Agree	1	1.0
Not reported	6	5.4

20. My supervisor allowed me to use a treatment approach in which I had been trained, even though (s)he had little knowledge or training in the approach.

Strongly Disagree	9	8.9
Disagree	33	32.7
Not Sure	17	16.8
Agree	38	37.6
Strongly Agree	4	4.0
Not reported	10	9.0

21. My supervisor openly and appropriately discussed ethical issues with me.

Strongly Disagree	1	1.0
Disagree	7	6.7

Not Sure	6	5.7
Agree	54	51.4
Strongly Agree	37	35.2
Not reported	6	5.7

22. I questioned my supervisor's ethical judgment or opinions on at least one occasion.

Strongly Disagree	40	38.1
Disagree	28	26.7
Not Sure	2	1.9
Agree	25	23.8
Strongly Agree	10	9.5
Not reported	6	5.7

23. My supervisor gave me adequate direction about how to handle potentially suicidal or homicidal clients.

Strongly Disagree	0	0.0
Disagree	7	6.7
Not Sure	8	7.7
Agree	46	44.2
Strongly Agree	43	41.3
Not reported	7	6.3

24. My supervisor gave me a clear understanding of how crises or emergencies with clients were to be handled, as well as how he or she could be contacted in the case of an emergency/crisis situation and what I should do if I could not reach him or her.

Strongly Disagree	2	1.9
Disagree	11	10.5
Not Sure	7	6.7
Agree	42	40.0
Strongly Agree	43	41.0
Not reported	6	5.7

25. My supervisor directed me to report disclosures of abuse (e.g., child, elder, etc.) by clients to the appropriate authorities. (Please leave this question blank if you never encountered a case in which abuse reporting was required).

Strongly Disagree	0	0.0
Disagree	5	7.2
Not Sure	3	4.3
Agree	27	39.1
Strongly Agree	34	49.3

Not reported	42	37.8

26. My supervisor instructed me to disclose to my clients that I was a trainee receiving supervision.

Strongly Disagree	0	0.0
Disagree	3	2.9
Not Sure	5	4.8
Agree	41	39.0
Strongly Agree	56	53.3
Not reported	6	5.7

27. My supervisor directed me to inform my clients of the limits of confidentiality related to supervision, (i.e., the supervisor is also privy to information discussed in session).

Strongly Disagree	0	0.0
Disagree	6	5.7
Not Sure	2	1.9
Agree	38	36.2
Strongly Agree	59	56.2
Not reported	6	5.7

28. My supervisor directed me to provide my clients with his or her name should they have concerns about the treatment they were receiving.

Strongly Disagree	1	1.0
Disagree	14	13.3
Not Sure	9	8.6
Agree	37	35.2
Strongly Agree	44	41.9
Not reported	6	5.7

29. My supervisor clearly defined his or her role as my supervisor and my role as supervisee when I began the training year.

Strongly Disagree	1	1.0
Disagree	11	10.5
Not Sure	8	7.6
Agree	48	45.7
Strongly Agree	37	35.2
Not reported	6	5.7

30. My supervisor outlined his/her responsibilities and multiple obligations (i.e., primary responsibility to client, followed by responsibility for trainee professional development, followed by gatekeeping duty).

Strongly Disagree	1	1.0

Disagree	29	27.6
Not Sure	20	19.0
Agree	31	29.5
Strongly Agree	24	22.9
Not reported	6	5.7

31. My supervisor asked me to sign a supervisory agreement contract (describing supervisor and supervisee responsibilities and procedures) when I began the training year.

Strongly Disagree	15	14.3
Disagree	28	26.7
Not Sure	8	7.6
Agree	25	23.8
Strongly Agree	29	27.6
Not reported	6	5.7

32. My supervisor stated or implied that what I shared in supervision was confidential and would not be shared as part of the evaluation process.

Strongly Disagree	11	10.5
Disagree	28	26.7
Not Sure	29	27.6
Agree	27	25.7
Strongly Agree	10	9.5
Not reported	6	5.7

33. My supervisor attended to the supervisory relationship (i.e., demonstrated respect, empathy, trust, and integrity).

Strongly Disagree	2	1.9
Disagree	9	8.6
Not Sure	8	7.6
Agree	40	38.1
Strongly Agree	46	43.8
Not reported	6	5.7

APPENDIX E

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 type in your response in the space that is provided.

1. Current doctoral program type:

A. Clinical
B. Counseling
C. School
C. Combined (e.g., clinical-school)
D. Other _____

2. Degree you are seeking:

A. Ph.D.
B. Psy.D.
C. Ed.D.
D. Other (e.g., Respecialization) _____

3. How many separate practicum or externship training experiences (specific year-long training rotations) have you had in your doctoral program?

A. 1
B. 2
C. 3
D. 4
E. 5 or more

4. Which of the following best describes your racial/ethnic identification? (Check all that apply)

A. African-American/Black
B. American Indian/Alaska Native
C. Asian/Pacific Islander
D. Hispanic/Latino
E. White (Non-Hispanic)
F. Biracial/Multiracial
G. Other _____

5. What is your gender?

A. Male
B. Female
C. Other (e.g., trans, intersex)_____

6. What is your sexual orientation?

A. Heterosexual
B. Gay Male
C. Lesbian
D. Bisexual
E. Other _____

7. What is your age?

In the following items Primary Supervisor refers to your Primary Supervisor from your **LAST PRACTICUM ROTATION PRIOR TO INTERNSHIP.**

8. Which of the following best describes your last practicum site prior to internship?

A. Armed Forces Medical Center
B. Child/Adolescent Psychiatric/Pediatrics
C. Community Mental Health Center
D. Consortium
E. Medical School
F. Prison/Other Correctional Facility
G. Private General Hospital
H. Private Outpatient Clinic
I. Private Psychiatric Hospital
J. Psychology Department
K. School District
L. State/County/Other Public Hospital
M. University Counseling Center
N. Veterans Affairs Medical Center
O. Other (please specify):_____

9. What percentage of your client contact hours was devoted to conducting individual psychotherapy in your last practicum rotation prior to internship?

A. 100%
B. 75-99%
C. 50-74%
D. 25-49%
E. Less than 25%

10. Which of the following best describes your primary theoretical orientation?

A. Behavioral
B. Biological
C. Cognitive-Behavioral
D. Eclectic
E. Humanistic/Existential
F. Integrative
G. Interpersonal
H. Psychodynamic/Psychoanalytic
I. Systems
J. Other _____

11. Which of the following best describes your primary supervisor's theoretical orientation (from your last practicum rotation prior to internship)?

A. Behavioral
B. Biological
C. Cognitive-Behavioral
D. Eclectic
E. Humanistic/Existential
F. Integrative
G. Interpersonal
H. Psychodynamic/Psychoanalytic
I. Systems
J. Other _____

12. Which of the following best describes your primary supervisor's gender (from your last practicum rotation prior to internship)?

A. Male
B. Female
C. Other (e.g., trans, intersex)_____
D. I don't know

13. What was your primary supervisor's sexual orientation (if known)?

A. Heterosexual
B. Gay Male
C. Lesbian
D. Bisexual
E. Other
F. I don't know

14. Which of the following best describes your primary supervisor's racial/ethnic identification? (Check all that apply)

A. African-American/Black
B. American Indian/Alaska Native
C. Asian/Pacific Islander
D. Hispanic/Latino
E. White (Non-Hispanic)
F. Biracial/Multiracial
G. Other _____

APPENDIX F

Ethical Practices in Supervision Scale - Revised

For the following questions, please consider your primary individual supervisor from your LAST PRACTICUM ROTATION PRIOR TO INTERNSHIP. Your primary individual supervisor is the person who provided the majority of your supervision during the rotation.

Please indicate if the person who primarily supervised you was:

a) a licensed psychologist
b) an unlicensed psychologist (e.g., a postdoctoral fellow)
c) a licensed professional in another discipline (e.g., a psychiatrist or social worker)
d) other: _____

In items 1 - 32, indicate whether your primary individual supervisor performed the behaviors described in the statement.

Monitored supervisee performance and professional activities.

1. My supervisor made sure that I was using appropriate treatment interventions or assessment procedures with all of my clinical cases.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

2. My supervisor met with me on an "as needed" basis (i.e., supervision times were not regularly scheduled OR if they were regularly scheduled, supervision time was cut short by the supervisor when there were no pressing clinical issues to be discussed.)

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

3. My supervisor encouraged me to attempt interventions or treatments for which I felt unprepared.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

4. My supervisor systematically monitored patient progress, e.g., thorough review of outcome measures.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Observed supervisee performance and professional activities.

5. My supervisor regularly reviewed video or audiotapes of my sessions.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

6. My supervisor reviewed my charts/progress notes with me on a regular basis.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

7. My supervisor at times conducted some form of live supervision (e.g., participated in a session with me or observed and commented with the use of a one-way mirror or video system).

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Practiced multicultural sensitivity toward clients and supervisees.

8. My supervisor's conduct and input in supervision suggested that he or she is multiculturally competent, possessing a good understanding of gender, sexual orientation, race, culture, religion, or disability status, etc.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

9. My supervisor encouraged me to discuss any thoughts or feelings I had about gender, sexual orientation, race, culture, religion, or disability status.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Maintained appropriate boundaries and carefully monitored dual roles.

10. My supervisor and I discussed personal issues that did not seem to be appropriately related to my work with clients. ("Personal issues" would not include simple disclosure of personal information such as whether either party is married, has children, etc. UNLESS significant supervision time is spent DISCUSSING one's relationship, family, etc.)

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

11. My supervisor appropriately acted as my supervisor and did not try to act in the role of my counselor/therapist.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

12. My supervisor behaved toward me in a way that seemed to me to be seductive or sexually provocative.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Discussed the process of evaluation, provided regular feedback about supervisee performance and competence, and documented strengths and areas for improvement.

13. My supervisor discussed with me at the beginning of the training year how I would be evaluated.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

14. My supervisor gave me adequate verbal and/or written feedback about my performance throughout the training rotation.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

15. I was made aware of any concerns my supervisor had regarding my performance. (Please leave blank if this question does not apply to you).

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

16. My supervisor frequently provided formative feedback.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

17. My supervisor periodically elicited my feedback on the supervisory process.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Supervised only therapist-client relationships in which (s)he was competent.

18. My supervisor appeared to be aware of recent research, theory, or treatment methods in regard to the presenting problems of my clients.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

19. My supervisor worked with me on a case that involved issues or disorders with which he or she had little or no experience.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

20. My supervisor allowed me to use a treatment approach in which I had been trained, even though the supervisor had little knowledge or training in the approach.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Modeled professional principles, values, and ethics.

21. My supervisor openly and appropriately discussed ethical issues with me.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

22. I questioned my supervisor's ethical judgment or opinions on at least one occasion.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Legal Issues.

23. My supervisor gave me adequate direction about how to handle potentially suicidal or homicidal clients. (Please leave blank if this question does not apply to you).

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

24. My supervisor gave me a clear understanding of how crises or emergencies with clients were to be handled, as well as how he or she could be contacted in the case of an emergency/crisis situation and what I should do if I could not reach him or her.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

25. My supervisor directed me to report disclosures of abuse (e.g., child, elder, etc.) by clients to the appropriate authorities. (Please leave this question blank if you never encountered a case in which abuse reporting was required).

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Ensured adequate disclosure to client.

26. My supervisor instructed me to disclose to my clients that I was receiving supervision.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

27. My supervisor directed me to inform my clients of the limits of confidentiality (such as the supervisor is also privy to information discussed in the counseling session).

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

28. My supervisor directed me to provide my clients with his or her name, should they have concerns about the treatment they were receiving.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

Identified parameters of supervision.

29. My supervisor clearly defined his or her role as my supervisor and my role as supervisee when I began the training year.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

30. My supervisor outlined his/her responsibilities and multiple obligations (i.e., primary responsibility to client, followed by responsibility for trainee professional development, followed by gatekeeping duty).

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

31. My supervisor asked me to sign a supervisory agreement contract (describing supervisor and supervisee responsibilities and procedures) when I began the training year.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

32. My supervisor stated or implied that what I shared in supervision was confidential and would not be shared as part of the evaluation process.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

33. My supervisor attended to the supervisory relationship (i.e., demonstrated respect, empathy, trust, and integrity).

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	2	3	4	5

34. If you experienced your supervisor's behavior at times as unethical or unprofessional, please check the areas that were impacted by his/her behavior.

___ negatively affected the supervisory alliance
___ negatively affected my trust in the supervisor
___ negatively affected my willingness to disclose information
___ negatively affected my motivation to be in this field
___ negatively affected the quality of my client care
___ negatively affected me emotionally

APPENDIX G

Working Alliance Inventory-Supervision (Bond Scale)

Instructions: On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her supervisor. As you read the sentences, mentally insert the name of your individual primary supervisor from your **LAST PRACTICUM ROTATION PRIOR TO INTERNSHIP** in place of _____ in the text. Please use the following seven-point scale:

1 2 3 4 5 6 7

Never Rarely Occasionally Sometimes Often Very Often Always

Please work quickly. Your first impressions are the most important to record.

1. I felt uncomfortable with _____. **Rating: _____**

2. _____ and I understood each other. **Rating: _____**

3. I believe _____ liked me. **Rating: _____**

4. I believe _____ was genuinely concerned for my welfare. **Rating: _____**

5._____ and I respected each other. **Rating: _____**

6. I felt that _____ was not totally honest about his or her feelings towards me. **Rating: _____**

7. I was confident in _____'s ability to supervise me. **Rating: _____**

8. I felt that _____ appreciated me. **Rating: _____**

9. _____ and I trusted one another. **Rating: _____**

10. My relationship with _____ was very important to me. **Rating: _____**

11. I had the feeling that it was important that I said or did the "right" things in supervision with _____. **Rating: _____**

12. I believe _____ cared about me even when I did things that he or she didn't approve of. **Rating: _____**

APPENDIX H

Recruitment Letter to Clinical Training Directors

Dear Director of Clinical Training:

I am a doctoral student in the Psy.D. program at Pepperdine University. As part of my clinical dissertation, I am collecting data on pre-doctoral interns' attitudes regarding the experiences they have had in their **previous supervisory relationship prior to internship**. I hope to use the knowledge gained to inform the framework for clinical supervision as a distinct competency. This is particularly relevant in light of new guidelines published by the American Psychological Association in early 2015.

Your training program has been selected from the APPIC directory for participation in the study. I am asking clinical training directors to forward this email to current interns in the program. The study is voluntary and involves completion of a brief demographics questionnaire followed by a questionnaire in which participants utilize a Likert scale to rate their level of agreement with statements regarding techniques utilized in supervision, legal and ethical issues, and styles of interpersonal communication. Both questionnaires will take less than 15 minutes to complete.

There is no direct benefit to study participants beyond the opportunity to anonymously share details of previous supervisory relationships. Risk of harm is assessed to be minimal, and includes the possibility of experiencing discomfort or negative emotions in reflecting upon specific past experiences. I recommend that participants who experience negative emotional reactions contact a colleague, professor, or supervisor with whom they can discuss these issues.

Please feel free to contact me via email if you have questions regarding this study or would like to obtain an abstract of study results. I can be reached at: lydiahansell@gmail.com. You may also contact my dissertation advisor, Dr. Edward Shafranske, at 310-568-5600 or the IRB administrator Dr. Judy Ho at 310-568-5600 with any questions.

Thank you again for your willingness to share this email and the attached recruitment letter with your current interns. I am looking forward to examining the results of the study and I hope that the knowledge gained will benefit the larger training community.

Sincerely,

Lydia Hansell, M.A.
Doctoral Student
Pepperdine University

APPENDIX I

Recruitment Letter/Informed Consent to Participants

Dear Psychology Intern,

You are invited to participate in a research study conducted by **Lydia Hansell, M.A.** and **Edward Shafranske, Ph.D.** of Pepperdine University because you are **a current pre-doctoral psychology intern**. Your participation is voluntary and you have the right to refuse participation or to withdraw participation at any time.

PURPOSE OF THE STUDY

The purpose of the study is to collect data on pre-doctoral interns' attitudes regarding the experiences they have had in their **previous supervisory relationship prior to internship**. The knowledge gained will help to inform the framework for clinical supervision as a distinct competency. This is particularly relevant in light of new guidelines for supervision published by the American Psychological Association in early 2015.

PARTICIPANT INVOLVEMENT

If you agree to voluntarily take part in this study, you will be asked to complete a questionnaire that includes a few brief demographics questions followed by questions about your **previous supervisory relationship prior to internship**. Questions include topics related to supervisory alliance, supervisor behaviors, and working alliance. The time to complete the survey is less than 15 minutes.

PAYMENT/COMPENSATION FOR PARTICIPATION

There is no payment/compensation offered for participation in the study.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are also free to not answer any questions you do not want to answer. You are not waiving any legal claims, rights, or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The only alternative to participation in the study is to not participate.

CONFIDENTIALITY

No identifying information will be collected from study participants; accordingly, all survey results will be **anonymous**. Survey data will be stored on a password protected computer in the principal investigator's place of residence. The data will be stored for a minimum of three years. Data will be collected anonymously and aggregated prior to analysis. Study results will be documented in aggregate form, with no identifying data available.

RISKS

Participation in this study involves no more than minimal risk. It is possible you may experience negative emotions upon reflecting about prior supervisory experiences. You may wish to seek consultation from a colleague, professor, or supervisor should you experience any negative reactions to participation in this study. If you experience negative reactions to participation in the study and would like to have a pro bono consultation from one of two professionals who have expertise in the field of clinical supervision, please contact me.

INVESTIGATOR'S CONTACT INFORMATION

As the principal investigator, I am willing to answer any inquiries you may have concerning the research herein described. You may contact me at: lydiahansell@gmail.com or you may contact my dissertation chair, Dr. Edward Shafranske, Ph.D., at 310-568-5600 if you have questions or concerns about this research.

Please feel free to print this information sheet if you would like a copy of it for your records. Finally, you may request an abstract of the survey results by emailing Lydia Hansell, M.A. at: lydiahansell@gmail.com.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University, 6100 Center Drive Suite 500, Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

By clicking on the link to the survey questions, you are acknowledging you have read the study information. You also understand that you may end your participation at end time, for any reason without penalty.

Please click the link to begin: https://www.surveymonkey.com/r/57W7GDD

If you would like documentation of your participation in this research you may print a copy of this form.

Thank you again for your participation!

Sincerely,

Lydia Hansell, M.A.
Pepperdine University

APPENDIX J

Pepperdine University IRB Notice of Approval for Human Research

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 24, 2017

Protocol Investigator Name: Erin Hansell

Protocol #: 16-12-456

Project Title: Perceptions of Supervisor Ethical Behavior by Psychology Interns

School: Graduate School of Education and Psychology

Dear Erin Hansell:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your 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 46.101 that govern the protections of human subjects.

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 an amendment to the IRB. Since 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 IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the 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 IRB as soon as possible. We will ask for a complete written explanation of the event and your written 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 IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair