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Development of a preliminary scale of counterproductive experiences in supervision: attitudes of interns

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DEVELOPMENT OF A PRELIMINARY SCALE OF COUNTERPRODUCTIVE EXPERIENCES IN SUPERVISION: ATTITUDES OF INTERNS

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by

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TABLE OF CONTENTS

Page

LIST OF TABLES

DEDICATION

To my daughter, one of the most amazing women I have ever had the privilege of knowing: thank you for endlessly inspiring me, for enthusiastically supporting my efforts, and for all your patience during this long journey.

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ABSTRACT

Clinical supervision is now recognized as a distinct professional competency in the field of psychology (APA, 2015). It is a primary method for training new clinicians, providing quality assurance, and ensuring client welfare (Falender & Shafranske, 2004). However, even within the most well-intentioned supervision, counterproductive experiences (CEs) are known to sometimes occur. These can significantly interfere with the supervisory process and often result in a strained supervisory alliance, interfere with clinical training, contribute to a negative training experience, and decrease a supervisor's ability to monitor client welfare and supervisee's ethical behavior. The purpose of this study was to contribute to ongoing research aimed at developing an empirically-validated scale for use in assessing the frequency, effects, and causes of CEs that occur within clinical supervision. A national sample of 188 predoctoral psychology interns anonymously completed an online survey which presented them with 60 CEs (derived from the theoretical and empirical literature) and organized by into 7 supervisory domains (APA, 2015). The interns were asked to rate, and rank order, short lists of CEs based on anticipated negative supervisory impact. Results indicated that all CEs were expected to have at least a minimal adverse impact, consistent with the results of previous studies involving the opinions of supervision experts, doctoral students, and clinical training directors. Further, when the results are viewed by APA supervisory domain, one finds that every domain contains between 2 to 8 of the most highly rated CEs. Many of the most highly-rated CEs related to negative interpersonal interactions (e.g., insensitivity, disrespect, misused power). Areas considered most impactful (e.g., boundary violations) and most potentially harmful (e.g., ethical lapses) are discussed. These results contribute to the development of a preliminary scale of counterproductive experiences in supervision. An argument is made for organizing the final scale by APA

supervisory domain to improve content validity and ensure applicability to future supervision training efforts. Recommended research directions are also explored.

Introduction

Though clinical supervision in the field of psychology has only recently become accepted as a distinct professional activity, it has long been considered a vital component of clinical training (Falender, Burnes, & Ellis, 2013; Falender & Shafranske, 2004; Fouad et al., 2009). In fact, it is considered by some to be the primary method for teaching psychotherapy skills and, as important, provides an important quality assurance function to ensure client welfare (Shafranske & Falender, 2016). Unfortunately, it has become evident that sometimes the supervision process includes experiences that are perceived as "hindering, unhelpful, or harmful in relation to the trainee's growth as a therapist" (Ellis et al., 2014; Ellis, Creaner, Hutman, & Timulak, 2015; Gray, Ladany, Walker, & Ancis, 2001, p. 371; Ladany, 2014). These types of experiences are referred to in this study as counterproductive experiences (CEs). They are known to occur within the context of even the best-intentioned supervision and may result in an inadequate or even harmful supervisory experience (Ellis, 2001; Ellis et al., 2014; Gray et al., 2001; Ladany & Lehrman-Waterman, 1999; Nelson & Friedlander, 2001). When this happens, client welfare is adversely affected, trainee growth may be limited, and the supervisory process itself is experienced as negative (Bang & Goodyear, 2014; Bukard et al., 2006; Gray et al., 2001; Hess et al., 2008; Hutt, Scott, & King, 1983; Kozlowski, Pruitt, DeWalt, & Knox, 2014).

Researchers have investigated and characterized many CEs in supervision but the frequency, effects, causes and even types of CEs commonly experienced by supervisees are still unclear (Gray et al., 2001; Veach, 2001). Considering the importance of clinical supervision, as well as the potential negative impact that CEs can have on important supervisory goals – such as the assurance of client welfare – further investigation of CEs is warranted to further characterize CEs and measure their occurrence. However, no empirically validated instrument exists for

assessing CEs in this manner. The purpose of this study is to continue work aimed toward developing such an instrument and contributes to this effort by obtaining and analyzing the opinions of psychology interns concerning the impacts of a wide range of CEs.

Background

In order to provide context for this study, this section will discuss the definition and functions of clinical supervision (henceforth referred to simply as *supervision*), delineate components of effective supervision, discuss the boundaries of minimally adequate supervision, explore what is known about inadequate and harmful supervision, and summarize the history of scholarly research in the area of counterproductive experiences in supervision.

Supervision defined. Supervision has been defined in the literature many times, and definitions vary widely in their focus and emphasis. For instance, while Milne's (2007) definition emphasizes training and methods, and Bernard and Goodyear's (2014) definition emphasizes the hierarchical nature of the supervisory relationship as well as the important quality control and gatekeeping functions of supervision, Falender and Shafranske (2017) define supervision from a competency-based framework, expanding previous definitions to include not only goals and tasks, but also a description of how effective supervision should be practiced (e.g., with multicultural sensitivity; while promoting integrity through modeling of ethical, legal and professional practices). They define supervision as:

> a distinct professional practice that requires balancing the inherent power differential within a collaborative relationship while utilizing both facilitative and evaluative components. It has the multiple goals of monitoring the quality of services provided to clients; protecting the public and gatekeeping for the profession; and enhancing the professional competence and professionalism of the supervisee, including developing skill in the use of science-informed assessment procedures, empirically-supported treatments and evidence-based practices. Clinical supervision is experiential, and involves observation, evaluation, feedback, facilitation of supervisee self-reflection and self-assessment, use of didactic and experiential learning approaches, and is conducted in a manner

> sensitive to individual differences and multicultural context and in which ethical standards, legal prescriptions, and professional practices are used to promote integrity and welfare of the client and communities. (pp. 4-5)

Recently, the American Psychological Association (APA) adopted *Guidelines for Clinical Supervision in Health Service Psychology* as their policy regarding supervision (APA, 2014, 2015). These guidelines provide a similar definition:

> Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. (2014; p. 5)

Effective supervision. The scholarly literature has recently been filled with efforts to define the construct of clinical supervision as a professional competency built upon a foundation of ethical values, empirical evidence, multicultural awareness, and relational integrity. For instance, this construct has been well-developed by Falender and Shafranske (2004) who delineate three fundamental components, or "pillars," of supervision: the supervisory relationship, upon which the supervisory working alliance is founded; the process of inquiry, which helps trainees to solidify their knowledge about – and personal impact upon – the therapeutic process; and educational praxis, which allows the application of theory to actual practice. They further stress that, not only must the three pillars be present, but they should also be grounded in a foundation of ethical values, empirical evidence, and multicultural awareness, and applied with relational integrity.

Other experts and organizations have developed frameworks defining essential components of supervision. For instance, the Association of State and Provincial Psychology Boards (ASPPB) published its Supervision Guidelines for Education and Training Leading to Licensure as a Health Service Psychologist in 2015. The APA also published its Guidelines the

same year (2015); these delineate seven essential domains of supervisory practice, briefly summarized below:

Domain A: Supervisor Competence

- Supervisor has formal education/training as a supervisor
- Supervisor serves as role model, protects public, and is a gatekeeper for the profession
- Supervisor coordinates with others involved in the supervisee's education/training regarding goals and expectations
- Supervisor strives to be competent in use of any technology used for supervision

Domain B: Diversity

- Supervisor develops diversity competency in self and supervisee; includes ongoing training, modeling client advocacy, promoting change in organizations/ communities, and maintaining familiarity with literature and identified practices related to these issues
- Supervisor is respectful and strives to expand self-awareness
- Supervisor is mindful of diversity factors, including oppression and privilege as they relate to the supervisory relationship and client-SE interactions

Domain C: Supervisory Relationship

- Supervisor is aware of, and works toward maintaining a positive supervisory alliance (e.g., reviewing relational effectiveness, attending to the power differential, and addressing any issues that arise)
- Supervisor works collaboratively with SE to promote competence and identify appropriate responsibilities, expectations, learning goals, and performance standards of both parties

Domain D: Professionalism

- Supervisor teaches and models appropriate comportment, professionalism, and social interactions
- Supervisor provides ongoing evaluation of training progress

Domain E: Assessment/Evaluation/Feedback

- Supervisor provides timely, clear, and developmentally appropriate feedback and evaluations, and does so in a manner that promotes transparency
- Supervisor monitors and guides supervisee's development by reviewing live or recorded sessions, and providing behaviorally-anchored, competency-specific feedback
- Supervisor is responsive to supervisee's reactions to feedback, and is aware of its impact on the supervisory alliance
- Supervisor seeks feedback from supervisee and others regarding supervision effectiveness, as well as the strength of supervisory alliance, and adjusts accordingly
- Supervisor encourages supervisee to develop self-assessment skills

Domain F: Problems with Professional Competence

- Supervisor is mindful of the gatekeeper role, endeavors to quickly identify and directly address potential issues, and develops/implements appropriate remediation

Domain G: Ethics, Legal, and Regulatory Considerations

- Supervisor models appropriate, ethical behavior and decision making
- Supervisor protects client welfare and is a gatekeeper to the profession
- Supervisor provides the supervisee with clear expectations (e.g., written supervision contract) that includes an explanation of the purpose of supervision, training

expectations, clearly defined supervisor/supervisee roles, limits of confidentiality, legal and ethical issues, and procedure for resolving ethical dilemmas

- Supervisor documents supervisee's progress regarding professional development and skill-building across competency areas

Adding to this framework, Falender and Shafranske (2017) developed a list of Components of Supervision Effectiveness that are "essential to the integrity and effectiveness of supervision practice" (p. 22):

- Metacompetence, self-assessment and reflective practice;
- Supervisory relationship and alliance (including identification and management of strains and ruptures);
- Supervision contract (which ensures clarity and transparency in expectations);
- Learning cycle (which systematically facilitates reflective practice, evaluation and feedback, and learning);
- Infusion of consideration of multiculturalism and diversity of all participants anchored in the worldviews of the client(s);
- Attention to personal factors;
- Competence in legal and ethical standards, regulations (including ethical problem solving), and professionalism;
- Evaluation and feedback;
- Managing supervisees who do not meet competence standards; and
- Self-care. (p. 22)

When well executed and effective, clinical supervision serves several vital roles in the field of psychology. It provides quality assurance in terms of considering client welfare and professional gatekeeping, and allows one to monitor client care as well as ensure ethical practice within one's area of competence (Falender & Shafranske, 2004; Watkins & Scaturo, 2013). It also operates as a main component of training geared toward building clinical competence and experiential skill. Further, quality supervision also provides modeling for effective professional behavior, personal functioning, and the process of supervision itself (Falender & Shafranske, 2004). However, only recently have researchers begun to formally study and understand the characteristics that are empirically associated with effective supervision competency.

Minimally adequate supervision. Ellis et al. (2014) compiled a list of components drawn from a wide variety of professional guidelines, requirements, and standards regarding clinical supervision (e.g., ethical and licensure guidelines, accreditation standards); these components are a set of characteristics and behaviors that a supervisor must possess and perform in order to provide the "bare minimum necessary for clinical supervision" (p. 438) to occur. They suggest that, for minimally adequate supervision to occur, the supervisor:

- Has the proper credentials as defined by the supervisor's discipline or profession;
- Has the appropriate knowledge of and skills for clinical supervision and an awareness of his or her limitations;
- Obtains a consent for supervision or uses a supervision contract;
- Provides a minimum of 1 hr [sic] of face-to-face individual supervision per week
- Observes, reviews, or monitors supervisee's therapy/counseling sessions (or parts thereof);
- Provides evaluative feedback to the supervisee that is fair, respectful, honest, ongoing, and formal;
- Promotes and is invested in the supervisee's welfare, professional growth and development;
- Is attentive to multicultural and diversity issues in supervision and in therapy/counseling;
- Maintains supervisee confidentiality (as appropriate); and
- Is aware of and attentive to the power differential (and boundaries) between the supervisee and supervisor and its effects on the supervisory relationship. (Ellis et al., 2014, p. 439)

In other words, supervision lacking any of these components is, by their definition, inadequate. The relationship of these components to the seven supervisory domains of the APA Guidelines (2015) is shown in Appendix C.

Inadequate and harmful supervision. Unfortunately, supervision is not always effective or even minimally adequate; in fact, over the past decade, the theoretical and empirical literature has established that it is sometimes "counterproductive" (Gray et al., 2001, p. 376; Veach, 2001, p. 396), "inadequate" (Ellis, 2010, p. 107), "ineffective" (Ladany, Mori, & Mehr,

2013, p. 42; Watkins, 1997, p. 178), "lousy" (Magnuson, Wilcoxon, & Norem, 2000b, p. 200), "bad" (Cummings & Ballantyne, 2014, p. 230) and even "harmful" (Ellis, 2001, p. 403; 2010, p. 107).

Based on his list of criteria for minimally adequate supervision, Ellis et al. (2014) developed and tested a framework to categorize supervisory experiences or situations as either *inadequate* or *harmful.* Within his framework, inadequate supervision occurs whenever supervisory experiences interfere with the provision of minimally adequate supervision. Harmful supervision occurs when supervisory practices result in actual harm, or, when those practices are generally known to cause harm (even if no harm is reported). Using these definitions in a study exploring supervisory experiences of clinical trainees, they found that most (i.e., 96%) of the 363 participants reportedly received inadequate clinical supervision at some point in their careers (i.e., supervision that did not serve to develop professional performance, that did not adequately monitor the trainee's work, and/or that did not serve a gatekeeping role); over half (51%) reportedly received clinical supervision that was undeniably harmful at some point in their careers (e.g., exploitive, abusive). A summary of the inadequate and harmful supervisory experiences discovered by this study is included in Appendix C; for narrative examples of harmful supervision provided by 11 anonymous supervisees, an interested reader is referred to Ellis' (2017) follow-up study.

These data are consistent with previous findings (e.g., Gray et al., 2001; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Nelson & Friedlander, 2001) and expectations (Ladany, 2004). A list of the experiences Ellis et al. (2014) classified as inadequate and harmful is included in Appendix C, which compares the various aspects of effective and ineffective

supervision that were discussed above, as well as all of the counterproductive experiences in supervision identified below.

Counterproductive experiences in supervision. For the purpose of this study, CEs are defined as supervision-related experiences that interfere in some way with the provision of supervision as outlined in the APA Guidelines (2015) as well as the other sources discussed above. These include supervisory experiences that are present but should not be (e.g., boundary crossings, cultural insensitivity, failure to address the needs of the supervisee), experiences that should be included but are absent (e.g., lack of a supervision contract, not providing the minimally required amount of supervision), and experiences that have the potential to cause harm to the supervisee (e.g., unethical behavior). When CEs occur in supervision, they have the potential to interrupt all important components of supervision. For instance, CEs can adversely impact the development of trainees' skills and competence; they may taint the training experience with negative feelings such as anxiety, powerlessness, and frustration; and, if the supervisory working alliance is weakened, CEs sometimes result in inadequate monitoring of trainees' work such that ethical practice and client welfare can no longer be monitored (Ellis, 2010; Gray et al., 2001; Hess et al., 2008; Hutt et al., 1983; Sweeney & Creaner, 2013).

Ellis et al.'s (2014) model of inadequate and harmful supervision can be applied to most of the supervisory-related counterproductive experiences (CEs) being considered in this study. However, this study is part of a larger research project that is not at this time concerned with categorizing CEs in this way. Rather, this study was aimed toward better understanding how often they occur, how they impact the supervisory process, what causes them, and discovering more of them. Further, this study included some CEs that do not fit into Ellis et al.'s definition of inadequate or harmful supervisory practices but, nonetheless, are still known to interfere with the

effectiveness of the supervisory process (e.g., theoretical orientation mismatch between supervisor and supervisee).

The fact that some supervision experiences are inadequate is truly unfortunate. However, perhaps more disturbing is the fact that some supervision experiences are damaging to the supervisees; an even more alarming fact is that clients – whom psychologists are duty-bound to protect – are also in danger of being harmed by negative supervisory experiences (Gray et al., 2001; Hutt et al., 1983). The competency-based supervision movement has begun to address, and minimize the effects of, CEs in supervision, but much remains to be learned about the factors leading to ineffective and harmful supervision (Ellis, 2001) and researchers have recommended that more studies be conducted regarding the impact of CEs on the supervision process (Veach, 2001). It is imperative that we have a reliable and valid way of identifying, characterizing and quantifying the occurrence of CEs so that efforts to train supervisors and trainees alike can be better informed.

No empirically validated instrument exists for assessing CEs in this manner; however, ongoing collaborative research studies – including this current one – have been working toward completing the steps to develop such an instrument. For example, in Lucas (2013), Kakavand (2014), and Grayson (2014), five directors of clinical training, eight experts in clinical supervision, and 15 doctoral students, respectively, provided their opinions about the potential adverse impact of CEs identified in the theoretical and/or empirical literature. Across all three of these studies, participants rated all CEs as potentially having at least a minimal adverse effect on the supervisory process. It is unknown whether the results would have been different if the samples had been larger. However, the current study was designed to extend this previous work by studying a large number of pre-doctoral psychology interns as participants. Results of this

current study will ultimately be combined with those of the other related studies in order to compare perspectives of the various participant groups and assist with item selection for the emerging scale.

Review of the theoretical and empirical literature. The theoretical literature addresses several types of CEs and the empirical literature contains studies of many of these (Appendix A), such as unclear performance expectations and role conflict within the supervisory relationship; inappropriate self-disclosure by supervisors; problems with the supervisory alliance and relationship; mismatched supervisor-supervisee dyads vis-à-vis style, knowledge, and theoretical approach; cultural insensitivity; failure to address supervisee needs; inadequate attention given to ethical practice; and boundary violations. The negative impact of these experiences on the supervisory relationship and working alliance are also a common theme, as are the general negative effect these experiences have on the training experience and even future career goals (Ladany et al., 2013; Ramos-Sanchez et al., 2002). All of these aspects of CEs are included in the summary of the literature presented here. Note that the literature review below includes all literature identified by Kakavand's (2014) study, in addition to new literature published since then. In order to illustrate continuity between the two studies, the literature review of CEs provided below included essentially the same categories used in Kakavand's study. Each section is followed by a corresponding list of CEs being considered for inclusion in the developing final scale.

Category I – Inadequate understanding of performance expectations for supervisee and supervisor/role conflict. One identified aspect of effective supervision is the ability of the supervisor to facilitate the setting of mutually acceptable, developmentally appropriate training goals, maintain well-defined relational roles, and provide consistent, constructive and clear

feedback to the trainee (Ellis, 2010; Falender & Shafranske, 2004; Ladany et al., 2013). However, at times, a supervisor's expectations and feedback are un-clarified, inconsistent and/or developmentally inappropriate and the roles of the supervisor and supervisee are undefined. This can adversely affect the supervisory relationship, working alliance and general training experience.

Several researchers have studied this CE category. For instance, one study conducted by Magnuson, Wilcoxon, and Norem (2000b) found that 11 experienced counselors, interviewed about their experiences with ineffective supervision, reported that both vague feedback and insensitivity to supervisees' developmental needs were detrimental to the supervisees. In another study, conducted by Nelson, Barnes, Evans, and Triggiano (2008), in which 12 supervisors nominated by peers as outstanding were interviewed, it was found that failure to outline expectations in the supervisory relationship was one major contributing factor to conflict. Nelson and Friedlander (2001) interviewed a national sample of 13 master's and doctoral trainees about their supervisory experiences and found that power struggles and dual relationships were associated with the relationships reported as most harmful by the trainees. Finally, Olk and Friedlander (1992) measured satisfaction of 240 doctoral-level trainees and found that role difficulties and conflicts within the supervisor-supervisee relationship predicted dissatisfaction regarding supervision, clinical work, and work-related anxiety.

The counterproductive experiences in supervision being considered for inclusion in the developing scale from this subset of the literature are:

- Supervisor does not encourage the development of mutually agreed upon goals of supervision.
- Supervisor fails to clearly communicate performance expectations to the supervisee.

- Supervisor's performance expectations are developmentally inappropriate, i.e., too high or too low in light of the supervisee's experience and competence.
- Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations.

In addition, during Kavaland's (2014) study, supervision experts who participated suggested the following additional CE for consideration:

- Supervisor gives the supervisee a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision.

Category II – Inappropriate supervisor self-disclosure. Supervisor self-disclosure occurs when a supervisor shares personal issues, reactions to supervisees or their clients, clinical struggles, or supervisory and other professional experiences during supervision (Falender & Shafranske, 2004; Knox, Burkard, Edwards, Smith, & Schlosser, 2008; Ladany & Lehrman-Waterman, 1999; Ladany & Walker, 2003). It is thought to occur frequently (Ladany & Lehrman-Waterman, 1999) and, according to 16 supervisors interviewed in one study, it is typically used to teach, normalize an experience, or further supervisee development (Knox et al., 2008). Supervisor self-disclosure is considered a powerful supervisory intervention that helps build the supervisory working alliance and contributes to supervision outcome, especially when well timed, appropriate to the trainees' immediate needs (e.g., modeling self-exploration of an issue, normalizing experiences), and when provided within a positive supervisory relationship (Falender & Shafranske, 2004; Hutt et al., 1983; Knox et al., 2008; Kozlowski, Pruitt, DeWalt, & Knox, 2014; Ladany & Walker, 2003; Ladany et al., 2013).

However, there has been some evidence that supervisory self-disclosure is not always used effectively or even appropriately. Ladany and Lehrman-Waterman (1999) found that 73%

of the 105 trainees in their study reported their supervisors made at least one self-disclosure about personal issues and that the frequency of such self-disclosures was negatively related to overall working alliance. Other researchers have also corroborated these finding, noting that supervisor self-disclosures often involve information unrelated to the supervisory work (e.g., supervisor's strong reaction to trainee's clients, experiences as a supervisor, experiences regarding dynamics at a training site, professional struggles), concluding that when these are inappropriate and/or excessive, the trainees' supervisory experience is likely to be negative (Ladany & Walker, 2003; Nelson & Friedlander, 2001).

For instance, when 12 supervisees were interviewed about the effect of supervisor self-disclosure on the supervisory relationship and the supervision experience in general, it was found that some reported feelings of self-consciousness as well as anxiety about boundaries and future supervision experiences when some self-disclosures were made about personal issues (Knox, Edwards, Hess, & Hill, 2011). Researchers studying the effects of supervisory self-disclosure suggest that, before self-disclosing, supervisors should consider if the disclosure is appropriate, how it may affect the trainee, and determine if it is being made in the service of the trainee or the supervisor (Ladany & Lehrman-Waterman, 1999).

The counterproductive experiences in supervision being considered for inclusion in the developing scale under this category heading are:

- Supervisor makes highly personal disclosures about his/her personal life during supervision.
- Supervisor discloses negative opinions about the profession, his/her career, or colleagues/staff/training site.
- Supervisor discloses negative personal opinions about the supervisee's clients.

Category III – Supervisory alliance and relationship problems. According to the experts, the ideal supervisory relationship is interpersonally and culturally sensitive in addition to being positive, empathic, flexible, and supportive (Falender & Shafranske, 2004; Ladany et al., 2013; Shafranske & Falender, 2016). In fact, empirical evidence suggests that a strong supervisory working alliance is a critical component to effective supervision, and has been rated the most influential component of a supervisee's positive training experience (Bordin, 1983; Cheon, Blumer, Shih, Murphy, & Sato, 2009; Inman 2006; Kennard, Stewart, & Gluck, 1987; Ladany et al., 2013; Magnuson, Wilcoxon, & Norem, 2000a; Ramos-Sanchez et al., 2002; Sterner, 2009). Other characteristics include the perception of the supervisor as a trustworthy (Allen, Szollos, & Williams, 1986), attentive (Ladany et al., 2013) expert who provides appropriate self-disclosure (Knox et al., 2008; Ladany & Walker, 2003) as well as ongoing structure to the supervision experience (e.g., goals, tasks, evaluative feedback), but is also open to providing appropriate and well-timed feedback (Ellis, 2010; Knox et al., 2008; Ladany & Walker, 2003; Ladany et al., 2013), resolving relational conflict, and non-defensively receiving feedback regarding his or her supervisory style (Allen et al., 1986). When these factors are present, supervisees report having a stronger emotional bond with their supervisors; greater agreement on supervisory tasks, goals, and feedback; higher levels of work-satisfaction; and lower levels of nondisclosure to supervisors regarding challenging clinical situations (Ladany et al., 2013; Mack, 2012)

Supervisory style has been found to be an important factor in the supervision experience and is also linked to the perception of supervisory working alliance (Ladany, Walker, & Melincoff, 2001). In a study looking at match between supervisor and supervisee pairs, Kennard, Stewart and Gluck (1987) found that trainees characterized supervision as positive when they

perceived their supervisors as more supportive, interpretive and instructional. In a more recent study of 128 supervisees, researchers found that effective supervisors were those who created mutually agreed upon goals, provided task-oriented structure, and were interpersonally attentive and collegial in their supervisory style (Ladany et al., 2013). These results were consistent with earlier work concluding that supervisors who self-identified as having a flexible and supportive style positively related that style to their perception to their supervisory working alliance (Ladany et al., 2001).

However, not all supervisor-supervisee dyads are a good match. In one study, supervisory style and personality issues in supervision were found to account for up to 30% and 50%, respectively, of conflict in the supervisory relationship (Moskowitz & Rupert, 1983). Further, it has been found that when the supervisor is experienced as un-empathic, unsafe, un-invested or unresponsive (Gray et al., 2001; Magnuson et al., 2000b), or when feedback is vague or focused on deficiencies (Ladany et al., 2013; Magnuson et al., 2000b; Watkins, 1997), supervision is experienced as ineffective and the relational bond is experienced as weak. These consequences are further complicated when the conflict in the supervisory relationship goes unaddressed. Gray et al. (2001) found that when their trainee study participants experienced negative interactions with their supervisors, most of them wished their supervisors would have noticed and processed these issues. At least one researcher was able to show that in the majority of cases studied, when conflicts were addressed, supervision improved greatly (Moskowitz & Rupert, 1983).

The counterproductive experiences in supervision being considered for inclusion in the developing scale under this category heading are:

- Supervisor does not attend to the development of the supervisory relationship.

- Supervisee and supervisor do not agree about the means to achieve the supervisory goals, i.e., how the training goals will be met.
- Supervisor is inflexible in his/her approach to supervision, i.e., how supervision is conducted.
- Supervisor does not address strains or conflicts between supervisee and supervisor.
- Supervisor does not appropriately structure the supervision session, i.e., there is either too much or too little structure.
- Supervisor is often insensitive when giving feedback (e.g., provides feedback in a disrespectful manner, makes critical judgments of supervisee without providing constructive feedback).

Category IV – Supervisor/Supervisee style and competence issues. As stated in the above section, supervisor approach and supervisee learning style match are important factors in good supervision. In fact, the idea of style match also extends to the realm of therapeutic approach, skills, and theoretical orientation such that similarities in these areas can lead to a positive supervision experience (Chung, Basking, & Case, 1998; Kennard et al., 1987). However, when there is a *mis*match in any of these areas, conflict in the supervisory relationship can occur. For instance, Ramos-Sanchez et al.'s (2002) study corroborated earlier results (Moskowitz & Rupert, 1983) suggesting that CEs are sometimes related to differences between supervisee and supervisor conceptualization style and theoretical orientation. Other studies have reported negative supervisory experiences when the supervisor is perceived as lacking skills or knowledge, failing to properly instruct the supervisee, disrespecting differences in approach to therapy (Magnuson et al., 2000b; Veach, 2001; Watkins, 1997).

The counterproductive experiences in supervision being considered for inclusion in the developing scale under this category heading are:

- Supervisor lacks knowledge or skill in the competencies required in clinical management and oversight of cases (e.g., lack of knowledge in diagnosis).
- Supervisor and supervisee often differ in their conceptualization of cases.
- Supervisor lacks knowledge of the treatment or assessment procedures that the supervisee has been taught in graduate school.
- Supervisor and supervisee often differ in which therapeutic approach is best suited to achieve the treatment goals.
- Supervisor has limited knowledge about supervisee's theoretical orientation.
- Supervisor unfairly criticizes supervisee's primary theoretical orientation without opportunity for respectful discussion.
- Supervisor and supervisee often differ in which therapeutic approach is best suited to achieve the treatment goals.

Category V – Cultural insensitivity. Psychologists are ethically and professionally required to consider multicultural issues in all areas of practice – including supervision – as it is an essential component of clinical work (APA, 2003, 2015, 2017; Falender et al., 2013; Falender & Shafranske, 2017). Even so, there is still a great need to learn more about diversity and related multicultural issues as they relate to the supervisory process (Falender et al., 2013). In fact, this has been called "one of the most neglected areas in supervision training and research" (Falender & Shafranske, 2004, p. 115), a descriptor that seems appropriate given that researchers have often found supervision to be culturally insensitive (Falender & Shafranske, 2012; Ramos-Sanchez et al., 2002; Veach, 2001; Watkins, 1997).

For instance, several researchers have uncovered culturally insensitive supervisor behaviors including the use of offensive racial or sexist statements (Allen et al., 1986; Ramos-Sanchez et al., 2002; Watkins, 1997), the devaluation of supervisor and/or supervisee cultural identity as it related to the supervisory dyad and to the treatment of clients (Jernigan, Green, Helms, Perez-Gualdron, & Henze, 2010), and the dismissal of important cultural factors when considering case conceptualization and treatment planning (Burkard et al., 2006; Jernigan et al., 2010). Ellis et al. (2014) even lists the making of macro- or micro-aggressions toward a supervisee as one of several examples of harmful supervision. These various types of CEs have been shown to significantly and adversely impact the supervision process, resulting in a weaker supervisory relationship and working alliance (Burkard et al., 2006; Inman, 2006; Ramos-Sanchez et al., 2002; Veach, 2001); more supervisee nondisclosure and negative feelings toward the supervisor (Burkard et al., 2006; Jernigan et al., 2010); decreased satisfaction in the supervision process (Burkard et al., 2006); as well as supervisee reactions of anger, frustration, confusion, invalidation and mistrust (Burkard et al., 2006; Jernigan et al., 2010).

The counterproductive experiences in supervision being considered for inclusion in the developing scale under this category heading are:

- Supervisor does not consider the impact of his/her own and/or supervisee's cultural identities.
- Supervisor does not encourage the use of culturally appropriate interventions.
- Supervisor uses or assumes cultural/racial stereotypes when discussing clients.
- Supervisor does not consider the impact of the client's cultural identities in diagnosing, conceptualizing cases, or treatment planning.

Category VI - Failure to address needs of the supervisee. Another type of CE that has been described in the scholarly literature occurs when the professional and developmental needs of a supervisee are not addressed in supervision. According to some researchers (Allen et al., 1986; Ellis, 2010; Watkins, 1997), where effective supervisors display appropriate professional interest in their supervisees' professional and personal growth and provide developmentally appropriate instruction, negative or ineffective supervisors are often professionally apathetic, unaware of their supervisees' clinical struggles and developmental needs (Magnuson et al., 2000b). Other researchers have found that supervisors sometimes seemed distracted or disinterested during supervision (Allen et al., 1986; Chung et al., 1998) or were unresponsive to their supervisees' difficulties and concerns (Bang & Goodyear, 2014; Watkins, 1997).

The counterproductive experiences in supervision being considered for inclusion in the developing scale under this category heading are:

- Supervisor is unresponsive to supervisee's verbalized training/supervision needs.
- Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his/her professional performance.
- Supervisor appears to be distracted in supervision.
- Supervisor does not consider the developmental needs of the supervisee.

In addition, during Kavaland's (2014) study, supervision experts who participated suggested the following additional CEs for consideration:

- Supervisor not prepared for supervision, e.g., has not reviewed chart notes or has not reviewed tape of therapy session submitted by the supervisee.
- Supervisor has an apathetic attitude toward supervision.

Category VII - Inadequate attention to ethics, ethical lapses, and unethical behavior. A core competency area for supervision involves maintaining legal, ethical and professional standards (Falender & Shafranske, 2017). Unfortunately, researchers have studied the ethical behavior of clinical supervisors and found that various forms of ethical violations have occurred (Falender & Shafranske, 2004; Ramos-Sanchez et al., 2002). For example, Ladany and colleagues (1999) found that of the 151 supervisees studied, over half reported that their supervisors had engaged in at least one ethical violation (the most common related to inadequate performance evaluation, confidentiality issues, or inability to work with alternative perspectives). These supervisees reported that the ethical violations had a mild or moderate negative impact on their clients. Other researchers have also reported related CEs, including inadequate performance evaluation (Ladany et al., 1999), inadequate direct observation of supervisee work (Amerikaner & Rose, 2012), supervisory confidentiality issues (Ladany et al., 1999; Magnuson et al., 2000b), and sexually inappropriate behavior (Allen et al., 1986; Ellis, 2010; Magnuson et al., 2000b). The counterproductive experiences in supervision being considered for inclusion in the developing scale under this category heading are:

- Supervisor does not regularly provide adequate evaluative feedback, i.e., feedback that assists in the supervisee's development.
- Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained.
- Supervisor speaks about clients in a recognizable way, e.g., using their names in public areas.
- Supervisor directs the supervisee not to file a mandated report (e.g., for child abuse) when the supervisee reports clear instances of abuse, intent to harm, etc.

- Supervisor sometimes ignores important agency policies or directs supervisee to do so.
- Supervisor does not consistently review audio/videotapes or provide live supervision of supervisee's clinical work.
- Supervisor does not consistently review charts/progress notes of supervisee.
- Supervisor does not help, is not available to discuss (outside of scheduled supervision), and/or tries to avoid involvement with ethical dilemmas or emergency situations.

In addition, during Kavaland's (2014) study, supervision experts who participated suggested the following additional CEs for consideration:

- Supervisor appears intoxicated in a social situation related to the training rotation, e.g., a holiday party.
- Supervisor unnecessarily discloses supervisee's personal disclosures to other clinical faculty or staff without any ethical or professional justification.

Category VIII – Boundary crossings/violations. As in the provision of psychotherapy, the supervisory process requires that appropriate boundaries be established and upheld in order to build and maintain a positive and effective supervisory relationship (Ellis, 2010; Falender & Shafranske, 2004). Unfortunately, researchers have captured many different types of CEs involving boundary violations. In fact, in one study, the participants reported feeling that supervisory boundaries had been violated – this was a frequent response and often resulted in feelings of confusion and disharmony (Nelson & Friedlander, 2001). Some boundary violations include exploitation such as sexual advances made by supervisors toward supervisees; these types of violations were deemed particularly detrimental to the supervision process (Allen et al., 1986; Magnuson et al., 2000b). Other types of violations include supervisors using supervision time to provide individual therapy to a supervisee (Magnuson et al., 2000b), and the supervisor

engaging in a dual relationship with a supervisee (Allen et al., 1986). The counterproductive experiences in supervision being considered for inclusion in the developing scale under this category heading are:

- Supervisor discusses another supervisees' professional clinical performance or competence.
- Supervisor makes jokes/comments with sexual innuendos.
- Supervisor expresses attraction toward supervisee.
- Supervisor initiates (or attempts to initiate) a dual-relationship with supervisee (e.g., invites supervisee to attend a personal event outside of supervision).
- Supervisor asks supervisee to participate in an activity (e.g., edit an article the supervisor wrote for publication, purchase items from supervisor) for the sole benefit of the supervisor.
- Supervisor makes inquiries about inappropriate areas of the supervisee's personal life (e.g., “Are you dating anyone?”).
- Supervisor attempts to help the supervisee resolve a personal conflict unrelated to his/her professional performance.

In addition, during Kavaland’s (2014) study, supervision experts who participated suggested the following additional CEs for consideration:

- Supervisor has a sexual relationship with supervisee.
- Supervisor misuses power and authority.

Category IX – Additional counterproductive experiences. Some additional CEs were included in Kakavand’s (2014) study. These include un-clarified expectations and unaddressed miscommunications (Magnuson et al., 2000b), administrative constraints, lack of respect for

supervisor/supervisee, motivational issues (Veach, 2001), professionalism issues, inadequate environment/office space for supervision (Magnuson et al., 2000b), inflexibility (Watkins, 1997), lack of demonstrated empathy (Ladany et al., 2013; Ellis, 2010), insensitivity to professional and developmental needs (Magnuson et al., 2000b), and insufficient trainee meeting time (Hatcher, Wise, Grus, Mangione, & Emmons, 2012). These types of CEs caused intense negative feelings in some supervisees, including anxiety, mistrust, and/or disrespect toward the supervisor, and increased nondisclosure as well in some cases (Hutt et al., 1983; Sweeney & Creaner, 2013) and include:

- Supervisor does not demonstrate respect for the supervisee.
- Supervisor is frequently late for supervision.
- Supervisor does not demonstrate empathy for the supervisee.
- Supervisor does not provide guidance about professional development as a psychologist.
- Inadequate environment/office space is provided for supervision (e.g., supervision conducted in a non-confidential location, such as a restaurant).
- Supervisor demonstrates unnecessary inflexibility (e.g., in scheduling, case conceptualization).

Category X – Supplemental items. Five additional CE items were added to the cumulative list of CEs outlined above. The inclusion of these items was based on need identified from several sources unavailable during the Kakavand study, including the APA Guidelines (2015), identified key components of supervision effectiveness (Falender & Shafranske, 2017), and Ellis et al.'s (2014) standards for minimally adequate supervision as well as their lists of inadequate and harmful supervision practices (see Appendix C for a comparison of these). These supplementary CE items include:

- Supervisor does not use a supervision contract.
- Supervisor fails to provide the minimally required amount of supervision.
- Supervisor does not possess adequate skills to supervise a particular case.
- Primary supervisor does not possess current knowledge of, adequate skills regarding, and/or actual experience providing, supervision.
- Supervisor does not appear to address professional competence problems in other trainees.

In summary, of the 60 CEs, 46 were previously studied in Kakavand's (2014) study, seven were added to this study based on suggestions collected during Kakavand's study, two others (one in both of Categories III and IV) were added based on recently published empirical and theoretical literature, and the additional five were added as outlined here in the description of Cluster X. Appendix D includes a comprehensive list of CEs from all Categories I-X, and clearly indicates which 14 CEs were added for this study.

Purpose of this Study

Clinical supervision has been established as an essential component of clinician training and also serves the vital role of monitoring the welfare of clients. However, counterproductive experiences in supervision are known to occur and may negatively impact important supervisory functions and responsibilities. Researchers have recommended that more studies be conducted regarding the impact of CEs on the supervision process (Veach, 2001); further investigation of CEs is warranted to further identify, characterize, and quantify the occurrence of CEs. Since no empirically validated instrument exists for assessing CEs in this manner, the purpose of this study was to build upon previous work aimed at developing such an empirically-validated scale; specifically, the data collected during this study helped to identify which CEs are considered

most significant and important for inclusion in the final scale. Ideally, the final scale will be used in conjunction with other established scales to study factors related to CEs, such as differences in the frequency and impact of CEs according to supervisors and their supervisees. It is believed that this knowledge will also aid future efforts to train supervisors and trainees alike.

Method

This study was one of multiple studies within a single research program aimed toward developing a scale to better identify, characterize, and measure the frequency of CEs. This section discusses the scale development model followed by this study's research program, outlines the parts of this process covered by this particular research study, and also discusses study participants, instrumentation, procedures, as well as possible limitations of this study.

Scale Development

DeVellis (2012) outlines eight steps in scale development:

1. Clearly understand, define, and state the distinct construct to be measured.
2. Generate an inclusive pool of potential scale items that represent the underlying construct being studied.
3. Select the scale's measurement format.
4. Enlist experts to review the potential scale items.
5. Determine if the scale needs to include validation items or subscales (e.g., to detect response pattern bias or impression management).
6. Administer the pool of potential scale items to a large developmental sample.
7. Analyze data collected for each potential scale item to determine appropriate items for inclusion in the final scale.
8. Select the final number of scale items.

Kakavand (2014) began work toward completion of the first four of these steps; the current study built upon that work. The construct being measured (Step 1) was that of counterproductive experiences in supervision, using the definition provided by Gray and colleagues (2001): any experience in clinical supervision that is "hindering, unhelpful, or harmful in relation to the trainee's growth as a therapist" (p. 371). Specifically, we sought to further identify and characterize CEs.

As discussed in the sections above, Kakavand's (2014) study amassed a broad pool of theoretically and empirically identified CEs from the scholarly literature (Step 2). Then a group of doctoral supervisors reviewed the potential scale items for content validity, relevance, clarity and comprehensiveness. These supervisors also offered 6 additional potential scale items. Next, a group of eight clinical supervision experts were recruited to rate the degree of impact each item in the final item pool is thought to have on the supervision process (Step 4). It was found that all items were considered by at least some of the experts to meet the stated definition of CEs. Additional potential scale items were also suggested.

The current study administered essentially the same item pool (edited for clarity and conciseness), along with the additional potential scale items identified by Kakavand's (2014) study and the supplementary items identified above (together, referred to as the *study item pool*, defined below), to a large sample of pre-doctoral interns (Step 6) for rating and rank ordering, as described below. The results were combined with the results of a previous study (i.e., Kakavand 2014) so that further analysis of each potential scale item could be completed (Step 7), the relative importance of each item determined, and a set of potential final scale items selected (Step 8). Note that the results of this current study can be added to the results of the Kakavand (2014) study as well as other related studies (e.g., Grayson, 2014 and Lucas, 2013) to inform

future researchers in determining the scale's measurement format (Step 3). Future researchers may also consider adding validation items or subscales (Step 5).

It should be noted that since the publication of Kakavand's study, the APA published Guidelines for Clinical Supervision in Health Service Psychology (2015) as their policy informing supervision provision. These guidelines outline seven supervisory domains – domains that were used as a framework to reorganize the presentation of CEs in this study. During data collection, participants in this study were asked to compare and rank order CEs related to each of the seven domains (during a rank ordering task) and also to rate the potential adverse impact of each CE individually (during a rating task). Presenting the CEs to participants this way allowed for analysis of the CEs from different perspectives, including by APA supervisory domain. The collected data helped to identify which of the CEs from each APA supervisory domain is/are considered most important for inclusion in the final scale. It is thought that the final scale may have increased content validity if the final pool of included CE items is representative of all seven of these domains.

Participants

The target population for this study included all advanced doctoral students in psychology (clinical, counseling, school, and combined psychology programs) currently completing predoctoral internships at Association of Psychology Postdoctoral and Internship Centers (APPIC) member sites as listed in the APPIC directory for the 2017-2018 year. Further, eligible participants were all currently enrolled in an APA- or Canadian Psychological Association (CPA)-accredited doctoral training program – an application requirement for all APPIC internships. Confirmation of eligibility was made when participants completed an online

demographics questionnaire that included questions about type and accreditation of doctoral program, age range, and internship program accreditation information (discussed below).

Participants (i.e., interns) were recruited indirectly for this study; all potential interns accessed a link to the online study materials through an email forwarded to them by their internship training directors. Over 3,500 APPIC predoctoral internship positions were filled each year during the last three academic years (according to APPIC Match Statistics, 2015, 2016, and 2017); therefore, it was estimated that the same number (i.e., 3,500 qualified participants) would be potentially reached through their internship training directors during the recruitment phase of this study. Though a response rate will not be calculable due to the recruitment method, if 3,500 qualified participants did receive recruitment materials, a sample of 346 intern participants would be needed to provide a 95% confidence interval and 5% margin of error for data collected on a population that size (Krejcie & Morgan, 1970).

Recruitment emails were sent to 787 training directors; seven were returned as undeliverable and no alternate email address was available in the APPIC directory program listings, the provided links to the internship brochures, nor by searching the program's website on the internet. This resulted in a total of 203 interns who accessed the study survey. All indicated their consent to participate. However, six did not complete any study items and therefore generated no data. Of those remaining, nine were ineligible (i.e., they indicated they were not currently interning in an APA-, CPA-, or APPIC-accredited site) and had their data removed. The final number of interns in the sample was 188. Demographic characteristics of the participants are displayed in Table 1.

Table 1

Participant Demographics (*N*=188)

Characteristic	*n*	*%*	APPIC Applicant Survey 2017 for Comparison (%)
Type of program			
Clinical	150	80	77
Counseling	24	13	13
School	8	4	6
Combined	6	3	3
Other	0	0	1
Not reported	--	--	--
Degree sought			
Ph.D.	98	52	59
Psy.D.	90	48	40
Ed.D.	0	0	0
Other	0	0	0
Not reported	--	--	--
APA- or CPA- accredited doctoral program			
Yes	179	95	96%
No	9	5	4%
Not reported	--	--	--
Primary theoretical orientation			
Cognitive-Behavioral	112	60	--
Existential/Humanistic	16	9	--
Family Systems	3	2	--
Psychodynamic	28	14	--
Other	29	15	--
Not reported	--	--	--
Age			
18-30 years	131	70	Mean age = 30 (SD=5.3)
31-40 years	53	28	
41-50 years	3	2	
51-60 years	1	1	
61 years or over	0	0	
Not reported	--	--	
Gender identity			
Female	153	81	78
Male	34	18	21
Other (trans, intersex)	1	1	0
Not reported	--	--	--

(continued)

Characteristic	*n*	*%*	APPIC Applicant Survey 2017 for Comparison (%)
Racial/Ethnic identification*			
African-American/Black	6	3	7
American Indian/Alaskan Native	2	1	1
Asian/Pacific Islander	16	9	10
Hispanic/Latino	16	9	10
White (non-Hispanic)	147	78	72
Bi-racial/Multi-racial	14	7	5
Other	6	3	3
Not reported	--	--	--
Internship accreditation			
APPIC	40	21	--
APA	131	70	--
CPA	17	9	--

Note. *Several interns made more than one selection; therefore, the number of responses is greater than the number of participants.

Most of the participants fell between the ages of 18-30 years (70%). One hundred fifty-three self-identified as female (81%), 34 as male (18%), and one as Other (1%) regarding gender. Most of the interns selected White (non-Hispanic) as their primary ethnic/racial identity (78%); 9% selected Asian/Pacific Islander, 9% selected Hispanic/Latino, 7% selected Bi-racial/Multi-racial, 3% selected Other (e.g., Middle Eastern, Jewish), 3% selected African American/Black, and 1% selected American Indian/Alaskan Native. Approximately half indicated they were enrolled in a Ph.D. program (52%); the others indicated enrollment in a Psy.D. program (48%). Almost all participants indicated their doctoral training programs were APA- or CPA-accredited (79%).

The vast majority of participants were from clinical doctoral programs (80%); 13%, 4%, and 3% were from Counseling, School, and Combined programs, respectively. The majority of the participants selected cognitive-behavioral as their primary theoretical orientation (60%); the rest indicated Other (e.g., relational/cultural, integrative), psychodynamic, existential/humanistic, and family systems as theirs (15%, 14%, 9%, 2%). The majority of interns indicated they were

currently completing an APA-accredited internship (70%), while 21% indicated completing an APPIC-accredited, and 9% a CPA-accredited, internship. The demographic characteristics of this sample are very similar to those of the internship applicants who were registered for the 2017 APPIC Match (APPIC, 2017; see Table 1).

Instrumentation

Two instruments were developed for use in this study: a demographic questionnaire and an instrument containing a rating and rank ordering task. These are both summarized below, followed by a presentation of the associated instructions.

Demographic questionnaire. In order to characterize the sample population of predoctoral interns who participated in this study – as well as compare it to the intended study population (i.e., all predoctoral interns completing APPIC member site internships) – study participants were asked to complete a brief demographics questionnaire consisting of forced-choice items regarding the same type of information collected by the APPIC Match Survey of internship applicants (i.e., age, gender, ethnicity, program type, degree type, and theoretical orientation). The Demographic Questionnaire can be found in Appendix E.

Rating and rank ordering survey. A second instrument was a rating and rank ordering survey created to capture both the individual and relative anticipated adverse impact of the CEs under study. The sample item pool used for data collection with this instrument is outlined below.

Sample item pool. The item pool included the 60 CEs listed under each category (i.e., Categories I-X) in the literature review above. For the purpose of best organizing the survey instrument and collected data resulting from this study, these 60 CEs were reorganized into seven groups corresponding to the seven APA supervisory domains (2015). These seven

groupings of CEs contained between three and 18 items. Because this study included a rank ordering task, and because 18 items is too many for such a task, these seven groupings were further sub-grouped into 21 *clusters* of 1-6 items based on content and according to their original Category (I-X). The relationships between CE categories, domains, and clusters are shown in Table 2.

Table 2

Relationships Between Counterproductive Experience (CE) Categories, Domains, and Clusters

Domain A: Supervisor Competence (3 CEs)	
Cluster 1	Category IV – Supervisor/Supervisee Style and Competence Category X – Supplementary Items (items added to address aspects of the APA supervisory guidelines not yet covered by other categories)
Domain B: Diversity (4 CEs)	
Cluster 2	Category V – Cultural Insensitivity
Domain C: Supervisory Relationship (18 CEs)	
Cluster 3	Category III – Supervisory alliance and Relationship Problems
Cluster 4	Category IV – Supervisor/Supervisee Style and Competence Category VI – Failure to Address Needs of the Supervisee
Cluster 5	Category VIII – Boundary Crossings/Violations
Cluster 6	Category IX – Additional Counterproductive Experiences
Domain D: Professionalism (9 CEs)	
Cluster 7	Category II – Inappropriate Supervisor Self-Disclosure
Cluster 8	Category IV – Supervisor/Supervisee Style and Competence
Cluster 9	Category VI – Failure to Address Needs of the Supervisee
Cluster 10	Category VII – Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior
Cluster 11	Category VIII – Boundary Crossings/Violations
Domain E: Assessment/ Evaluation/Feedback (13 CEs)	
Cluster 12	Category IX – Additional Counterproductive Experiences
Cluster 13	Category I – Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflict
Cluster 14	Category III – Supervisory alliance and Relationship Problems
Cluster 15	Category VI – Failure to Address Needs of the Supervisee
Cluster 16	Category VII – Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior

(continued)

Domain F: Problems of Professional Competence (2 CEs)	
Cluster 17	Category I – Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflict
Cluster 18	Category X – Supplementary Items (items added to address aspects of the APA supervisory guidelines not yet covered by other categories)
Domain G: Ethics, Legal, and Regulatory (11 CEs)	
Cluster 19	Category VII – Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior
Cluster 20	Category VIII – Boundary Crossings/Violations
Cluster 21	Category X – Supplementary Items (items added to address aspects of the APA supervisory guidelines not yet covered by other categories)

The sample item pool can be viewed in Appendices B and C. Appendix C illustrates the relationship of each CE to multiple, specific previously identified aspects of effective and ineffective supervision as discussed above, i.e., the domains contained in the APA Guidelines (APA, 2015); the Components of Supervision Effectiveness (Falender & Shafranske, 2017); and Ellis et al.'s lists of minimally adequate, inadequate, and harmful supervision (2014). It also identifies the 21 CE clusters. Appendix D displays the entire item pool listed by Category (I-X); it also shows the relationship between each CE and the seven APA supervisory domains.

Instructions provided with the study instruments. The study instruments were administered online via web-based software that provided participants with easy access to the study (regardless of geographic location), straightforward instructions, and confidentiality (i.e., anonymity), while allowing the study to accommodate a large number of participants and produce standardized information collection. Participants were given the following general instructions before they began:

> Thank you for sharing your opinions with me making a contribution to our research team. Your participation will contribute to the understanding of clinical supervision and is deeply appreciated. On the following pages, you will first be asked to share general demographic information. Then, you will be shown several short lists to read, rate, and rank. Before you begin, please read the Information Sheet document below, and indicate whether or not you agree to participate in this study.

The survey began only if the participant clicked on the checkbox indicating agreement to participate. Participants were then given the following directions and directed to complete the demographics questionnaire:

> First, we would like to collect some general demographic information from you. For each item, please select the answer choice that is most appropriate for you. If there is not an answer that is appropriate, select Other and type your response in the box provided. If you prefer not to answer any item, you may leave it blank.

Next, participants were provided with the following instructions for completing the remainder of the survey:

> Now, please read through the following short lists of counterproductive experiences (CEs) in clinical supervision that have been identified in the theoretical and empirical literature. You may or may not have experienced these CEs yourself during your clinical training. However, please consider each CE and imagine the impact that each would have – if it were to occur – on the supervisory alliance, your experience of supervision, your professional growth, and the effectiveness of supervision. For each list of CEs, you will be asked to (1) rate each CE regarding the strength of its impact, and then to (2) place the CEs in rank order. At the end of the survey, you will also be given the opportunity to suggest any additional CEs you think should be added to our list. You will also be given instructions about how to enter a drawing for one of four $25 Amazon gift cards.

On each subsequent page of the survey, a cluster of between 1-6 CEs was displayed along with the definitions and instructions shown below.

> Please consider the impact of the following CEs, keeping in mind the following definitions/clarifications:
>
> Adverse Impact
> - Significant/Major Effect – I believe this event/experience will significantly strain or rupture the supervisory alliance, and/or have a major negative impact my experience of supervision, personal growth or the effectiveness of supervision.
> - Moderate Effect – I believe this event/experience will moderately strain or rupture the supervisory alliance, and/or have a moderately negative impact my experience of supervision, personal growth or the effectiveness of supervision.
> - Minimal Effect – I believe this event/experience will minimally strain or rupture the supervisory alliance, and/or have a minimally negative

impact my experience of supervision, personal growth or the effectiveness of supervision.

- No Effect – I believe this event/experience will not strain or rupture the supervisory alliance, and/or will have no negative impact my experience of supervision, personal growth or the effectiveness of supervision.

Rank Order

Assign numbers from most impactful to least:
1 = The most impactful item
2 = The next most impactful item, etc.

These instructions were followed by one or more clusters of CEs from the sample item pool. The instructions were repeated on each new page, and cluster lists were presented sequentially until the last CE cluster had been presented. The last page of the survey contained the following message:

> Thank you for your valuable time and for your contribution to this research study. As a small token of thanks, you are invited to enter a drawing for a chance to win one of four $25 Amazon gift cards. To enter, please close this survey, then send an email to the primary investigator at carey.incledon@pepperdine.edu; write, 'CE Study Drawing' in the subject line. Your email address will be entered into the drawing. Your email address will not be associated with your survey results, though your anonymity as a general participant may be compromised. All emails and email addresses collected will be deleted after winners have received their drawing prizes.

Before recruitment and data collection began, the online survey was piloted using a small number of volunteers to ensure it was functioning as intended, to check for errors, and ensure all pages were readable and understandable. Results of this process suggested that the survey was functioning as intended and that the data was being collected in a useable format. Note that data collected during this piloting process was deleted and not included in the study.

Procedures

Recruitment of study participants occurred through a two-pronged approach involving email requests (see Appendix F) sent to training directors at APA-, CPA-, and APPIC-accredited

doctoral-level internship training sites, and by snowball sampling, as discussed below. Data collection was accomplished through the use of a web-based survey instrument designed specifically for this study and containing the two instruments discussed above: a demographics questionnaire, and a survey instrument used to both rate the adverse impact (i.e., hypothetical severity) of each CE, and rank order similar items presented together. Both the recruitment and data collection procedures are explained in detail below. Lastly, in order to thank participants for supporting this research effort – and in order to possibly increase response rate (Hoonakker & Carayon, 2009) – all participants, and potential participants, were given the opportunity to enter their email addresses into a drawing for four $25 Amazon gift cards. Instructions on how to enter the drawing were included in both the Invitation for Predoctoral Intern Research Participation letter (Appendix G) and again at the end of the online survey. Seventy-five interns chose to participate in the prize drawing; after the study concluded, four winners were chosen randomly and awarded a gift card.

Recruitment. Recruitment for this study began, following final approval from Pepperdine University's Institutional Review Board (IRB), on March 5, 2018. An email invitation (Appendix F) was sent to all current training directors of APPIC member internship sites. At weeks three and five, a reminder email (Appendix H) was sent to the same list of training directors to boost recruitment.

The initial email invitation briefly explained the purpose and importance of the study, advised the training directors that study participants would be anonymously evaluating statements regarding hypothetical supervision situations, and contained a request that the training directors forward an attached Invitation for Predoctoral Research Participation to their current interns (Appendix G). The attached Invitation for Research Participation provided a brief

overview of the study and an Information Sheet (in place of an informed consent document), as well as a link to a website where interested parties could participate. It also requested that the recipient interns forward the invitation to any additional eligible predoctoral interns who may not have received or seen the invitation. This sampling method (i.e., snowball sampling) was intended to recruit additional qualified participants who may not have received the invitation from their training directors. One drawback of using snowball sampling for recruitment is that some interns may have received an invitation to participate more than once; however, the web-based program housing the survey only allowed each computer internet protocol (IP) address to access the survey once.

Protection of human subjects. This study was expected to pose no greater than minimal risk to its participants. All participants were adult, advanced doctoral students, who completed an online survey. The study material involved reading through a list of hypothetical supervision situations that predoctoral internship trainees have already learned about, considered, or experienced during their training. Internet protocol (IP) addresses used by participants to access the online survey were not recorded or stored to protect participant anonymity. In addition, emails and email addresses provided for a prize drawing (discussed below) were not associated with survey results; they were also deleted after the investigator received confirmation that the drawing prizes had been claimed. In accordance with Pepperdine University's Information Security Policies, study data will be stored in electronic format, on a password-protected computer and/or on a USB drive kept in a secure location (either the investigator's locked file or locked combination safe), for five years after the study has been completed; then it will be destroyed. This provides at least two safeguards for protecting the electronic study data. No personally identifiable information was obtained in connection with this anonymous study.

Consent for participation. This study was approved by Pepperdine University's IRB as exempt (under the federal regulations 45 CFR 46.101 governing human subject protection; see Appendix B) since it was expected to pose no greater than minimal risk to its participants, participation was anonymous, participants did not include any vulnerable subjects (e.g., children, prisoners), and because this study's methodology fell into one of the exempt categories defined by federal regulations (i.e., surveys). The study investigator was granted IRB approval to use an Information Sheet (Appendix I) instead of formal informed consent procedures and documentation. This Information Sheet was included in the recruitment materials as well as on the first page of the online survey. It contained information regarding the purpose and importance of the study, the procedures that would be followed, an estimation of participation time, confidentiality protection, the rights of human research subjects (including the fact that participation was voluntary and could be discontinued at any time).

A link to the online survey was placed at the end of the recruitment materials, i.e., at the bottom of the Information Sheet. Participants were informed that by clicking this link, they acknowledged they had read the study information and agreed to participate in the study. Once a participant accessed the online survey, a second copy of the Information Sheet was provided on the opening page; the two data-collecting instruments included on the survey were only accessible after the participant checked a box confirming that he or she has read, understood, and accepted the information provided, and agreed to participate. This process for obtaining consent allowed the participants to remain anonymous while still verifying that all collected data came from informed participants. However, it did not produce any tangible informed consent documentation.

Potential risks and benefits. Though this study was expected to pose no greater than minimal risk to its participants, two potential risks were identified. First, though study participation was made as simple as possible by using a streamlined commercial online survey program, easily accessible from any computer with online access, participants were asked to spend approximately 15 minutes of their time completing the study, which may have been experienced as an inconvenience. Second, participants were asked to read through a list of hypothetical experiences in supervision thought to have negative impact on training; this may have caused distress to any participants who had previously experienced any of them. The participants were provided with the name and contact information of the study investigator as well as the project advisors; if contact had been made, the participants were to have been directed to seek assistance from a trusted advisor, clinician, or to a local psychological association for a psychotherapy referral.

Although participants may not have directly benefited from participation in this study, it is possible that they may have gained a greater awareness of the supervisory process as well as supervision competency standards. They may also have spent time reflecting on their own past and present supervisory relationship during or after the study – a competency benchmark for clinical training in psychology (Fouad et al., 2009). In addition, participants may have felt a sense of satisfaction about contributing to research efforts in this important field, as well as knowledge that the results of this study are intended to aid in future efforts to train supervisors and trainees.

Data collection. An internet-based data collection method was chosen for this study for several reasons. For instance, as Hoonakker and Carayon (2009) have shown, this method provided a more flexible, simple, and fast way to access a nationwide sample of predoctoral

psychology interns than mail-based surveys, and it had the added benefit of reducing cost (Kraut et al., 2004) as well as increasing sample size (Gosling, Vazire, Srivastava, & John, 2004). It also provided convenient access to a wide array of participants. Moreover, this method has been successfully used for protecting participant confidentiality (Gosling et al., 2004) – a factor that may also have contributed to higher response rates and more honest responses (Hoonakker & Carayon, 2009). Collecting raw data online also reduced the error and time-related costs associated with manual data entry during data analysis. Furthermore, there is growing evidence that data collected through internet methods are similar to those collected by more traditional methods (e.g., paper-and-pencil surveys; Gosling, et al., 2004). Finally, online surveys are considered no more risky than similar offline surveys; in fact, they are sometimes considered less risky (Kraut et al., 2004).

Recruitment and data collection began on March 5, 2018 and continued until April 17, 2018. A link to the online survey for this study was included with the emailed recruitment materials. This link directed the participants to an online survey development cloud-based software service (i.e., SurveyMonkey®) where the participants could complete the study survey. Average completion time was 15 minutes. SurveyMonkey® allowed for access to the study's anonymous survey instruments (i.e., the website did not request, record, or track personal information). Therefore, study participation was anonymous – no identifiable information was obtained during study participation. The survey was designed so the internet protocol (IP) addresses used by participants to access the online survey were not recorded or stored, which provided further protection of participant anonymity.

SurveyMonkey® confidentially collected data and reported the results to the investigator as descriptive statistics. These data will also be stored on a password-protected external

computer drive, as well as a USB drive (locked in the investigator's file or safe), for five years, at which time it will be destroyed by the investigator.

Data Analysis

Study data were collected via the SurveyMonkey® software, along with general statistics related to the study (e.g., the number of responses, average completion time, etc.). Before analysis, the investigator downloaded the data, checked it for errors, and excluded nine response sets provided by interns who did not meet the eligibility criteria (i.e., they were not currently completing APPIC-, APA-, or CPA-accredited internships and were not enrolled in APA- or CPA-accredited doctoral programs).

Two types of data were elicited from the interns during the study by requesting two different responses for each of the 60 CEs in the sample item pool. These CEs were presented as a series of 21 clusters, and interns were asked to first rate each individual CE for perceived magnitude of anticipated adverse impact (e.g., No Effect to Significant/Major Effect), then to rank order all the CEs within the cluster based on perceived relative impact. Collecting data this way provided multiple options for data analysis and comparison of the CEs that composed the item pool.

For instance, a mean magnitude of impact was calculated for each CE by assigning a weighted score to each response from the rating task (No Effect = 0, Minimal Effect = 1, Moderate Effect = 2, and Significant/Major Effect =3). The unweighted scores were downloaded into a Microsoft® Excel spreadsheet, weighted, summed, then divided by the number of times the CE was rated, to produce a *mean rating score* (MRS). The equation used to calculate average rankings is illustrated numerically here, where f_1, f_2, and f_3 represent the frequency count for Minimal, Moderate, and Significant/Major Effect responses, respectively, and N represents the

total number of responses: $MRS = (f_1 + 2f_2 + 3f_3)/N$. Sample standard deviation (*SD*) from the mean was also computed for each CE's score using the standard equation within a Microsoft® Excel spreadsheet. The MRSs for each CE were compared with those of all the other CEs in the item pool, as well as with other CEs in the same domain and cluster. This provided multiple options for determining which CEs were considered most salient within these different contexts.

Additionally, the *mean ranking scores* for CEs within the same cluster were calculated by assigning a weighted score to each response from the ranking task. Since the instructions for this task involved rank ordering CEs from most important to least important, weighted scores for each response were assigned in reverse order; in other words, every time a CE was ranked first, it was assigned the highest possible score, every time it was ranked second it was assigned the second highest possible score, and so on. The equation used to calculate average rankings is illustrated numerically below, where *f* represents the frequency count, *w* represents the weighted value of the item's rank, and *n* represents the number CEs in the cluster being analyzed (there were between one and six items within each of the 21 clusters), and *N* represents the total number of responses: $\textit{mean ranking score} = (f_1w_1 + f_2w_2 + f_3w_3 + \ldots f_nw_n)/N$. The average ranking score for each CE was compared to that of others within the same cluster and was used to discern which CEs the interns deemed most impactful relative to the others. Finally, combining both rating and ranking data helped determine which CEs were considered most impactful.

Results

Results of the study are discussed in this section. First, a general overview is provided of the results as a whole (i.e., all 60 CEs). Second, CE results are presented in detail based on their domain and cluster. Third, a brief summary of the results organized by the CE categories used in previous studies (i.e., Grayson, 2014; Kakavand, 2014; and Lucas, 2013) is provided for the sole

purpose of providing comparison data related to the previous studies. Finally, new CEs suggested by the interns during this study are presented.

Data are listed in Table J1 where the CEs are arranged by APA supervisory domain as well as cluster, and Table J2 where the items are arranged by Categories I-X (see Appendix J). On both tables, the counterproductive experiences are listed in order of importance based on score. In other words, CEs with the highest mean rating scores (and ranking scores, where applicable) are listed toward the top of each list, and those with the lowest mean scores are listed toward the bottom.

Overall, the mean rating scores (MRS) for the sample item pool of 60 CEs ranged between Minimal Effect (MRS = 1.21, SD = 0.97) to Significant/Major Effect (MRS = 2.94, SD = 0.32), though well over half of the scores (38 CEs) fell in the Moderate to Significant/Major Effect range (i.e., MRS ≥ 2.0). In other words, this sample of interns expected every CE to have at least a minimal adverse impact on the supervisory process, though most were expected to have at least a moderate or even major impact.

Out of the 60 CEs included in the sample item pool for this study, 46 were previously rated by supervision experts in Kakavand's (2014) study. When the results of the two studies are compared, general agreement was found between the opinions of the supervision experts and interns. The other 14 CEs have not been previously studied so no comparison data exist. These new CEs had MRSs that fell within the same range as the entire CE item pool (Minimal to Significant/Major Effect; MRS = 1.21, SD = 0.97 to MRS = 2.94, 0.32), though the majority (9 out of 14; 64%) fell in the Moderate to Significant/Major Effect range (i.e., MRS ≥ 2.0).

The very highest-rated CEs (i.e., those with scores falling in the upper half of the Moderate-Significant/Major Effect range, or MRS ≥ 2.50), as well as the very lowest-rated CEs

(i.e., those with scores falling in the lower half of the Minimal-Moderate Effect range, or MRS ≤ 1.50), are listed on Table J3 in Appendix J. A review of these CEs' scores indicates there was greater consensus regarding the higher scoring CEs, and greater variability in responses regarding the lower-scoring CEs. It is interesting to note--though perhaps not surprising--that of the highly-rated CEs, most related in some way to negative interpersonal interactions between the supervisor and supervisee (e.g., insensitivity, disrespect, misused power, expressed attraction). Of the three lowest-rated CEs, two related to practices deemed extremely important by experts in the field (e.g., using a supervision contract and monitoring supervisee's work via audio/video or live supervision); this could indicate that interns lack knowledge about the importance of these supervisory practices and/or the potential consequences of their absence.

Counterproductive Experiences – Organized by Domain/Cluster

In this subsection, results regarding CEs grouped within each APA supervisory domain will be presented in detail. All CEs with MRSs falling in the Moderate to Significant/Major Effect (i.e., MRS ≥ 2.0) are highlighted in the text. Each domain contains anywhere from two to nine CEs with MRSs falling in the Moderate to Significant/Major Effect range. Twenty of the 21 CE clusters contained at least one as well (i.e., all but Cluster 7).

Since many CEs within a cluster were, at times, assigned the same rating category (e.g., Significant/Major Effect), it is interesting to consider the combined results from both the rating and ranking tasks. In general, the mean rating scores produced by the rating task paralleled those produced by the rank ordering task. That is, with only two exceptions (i.e., two CEs in Cluster 4), when CEs were listed in order from highest to lowest mean rating score, they fell in the same order as when they were listed in order from highest to lowest mean ranking score. The fact that the items rated higher most frequently during the rating task were also ranked higher during the

rank ordering task may suggest the interns were thoughtful when providing their answers, and it also strengthens the evidence that CEs with higher MRSs were considered more important than the ones lower on the lists.

Domain A: Supervisor competence. This Domain contained three CEs grouped into one cluster (Cluster 1), all related to supervisor competence as outlined in Categories IV and X in the literature review above. The CEs had MRSs ranging between the upper Minimal-Moderate Effect range (MRS = 1.97, SD = 0.77) and the mid-Moderate-Significant/Major Effect range (MRS=2.54, SD= 0.64). The two highest scoring CEs from both the rating and ranking tasks were:

- Supervisor lacks knowledge or skill in the competencies required in clinical management and oversight of cases, e.g., lack of knowledge in diagnosis (MRS = 2.54, SD = 0.64)
- Primary supervisor does not possess current knowledge of, adequate skills regarding, and/or actual experience providing supervision (MRS = 2.24, SD = 0.71).

Based on these data, the interns anticipate that inadequate supervisory competence will negatively impact the supervisory process.

Domain B: Diversity. Domain B contained four CEs, also grouped into a single cluster (Cluster 2). Items in this domain explored potential adverse supervision experiences related to diversity issues as outlined in Category V in the literature review above. All four CEs had MRSs that fell in the Moderate to Significant/Major Effect range (between MRS = 2.05 [SD = 0.75] and 2.69 [SD = 0.58]):

- Supervisor uses or assumes cultural/racial stereotypes when discussing clients (MRS = 2.69, SD = 0.58)

- Supervisor does not consider the impact of the client's cultural identities in diagnosis, case conceptualization, or treatment planning (MRS = 2.43, SD = 0.68)
- Supervisor does not consider the impact of his/her own and SE's cultural identities (MRS = 2.09, SD = 0.75)
- Supervisor does not encourage the use of culturally appropriate interventions (MRS = 2.05, SD = 0.75).

In general, these results indicate the interns believed that problems with supervisor diversity competence can have a significant adverse impact the supervisory process.

Domain C: Supervisory relationship. This domain covered 18 CEs grouped into four clusters (Clusters 3-6). Counterproductive experiences in this domain focused on various aspects of the supervisory alliance, such as those described in Categories III, IV, VI, VIII, and IX in the literature review above. Within each of the four clusters, the highest scoring two or three CEs had an MRS that fell within the Moderate to Significant/Major Effect range. These nine highest-scoring CEs are presented here:

- Supervisor misuses power and authority (MRS = 2.94, SD = 0.32)
- Supervisor does not demonstrate respect for the supervisee (MRS = 2.91, SD = 0.34)
- Supervisor is unresponsive to supervisee's verbalized training/supervision needs (MRS = 2.79, SD = 0.50)
- Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his/her professional performance (MRS = 2.62, SD = 0.65)
- Supervisor does not demonstrate empathy for the supervisee (MRS = 2.61, SD = 0.61)

- Supervisor does not address strains or conflicts between supervisee and supervisee (MRS = 2.56, SD = 0.64)
- Supervisor demonstrates unnecessary inflexibility (e.g., in scheduling, case conceptualization; MRS = 2.35, SD = 0.68)
- Supervisor is inflexible in his/her approach to supervision (i.e., how supervision is conducted (MRS = 2.16, SD = 0.75)
- Supervisor asks supervisee to participate in an activity (e.g., edit an article the supervisor wrote for publication, purchase items from supervisor) for the sole benefit of the supervisor (MRS = 2.04, SD = 0.90)

Overall, these results indicate the interns believe that problems that occur within the supervisory alliance and relationship can have a significant adverse impact the supervisory process.

Domain D: Professionalism. This domain covered nine CEs grouped into five clusters (Clusters 7-12). Counterproductive experiences in this domain explored various problems of supervisor professionalism, such as those discussed in Categories II, IV, VI, VIII, and VIII in the literature review above. Four of the five clusters contained CEs with MRSs falling into the Moderate to Significant/Major Effect range. Those CEs are listed here:

- Supervisor expresses attraction to supervisee (MRS = 2.88, SD = 0.46)
- Supervisor unfairly criticizes supervisee's primary theoretical orientation without opportunity for respectful discussion (MRS = 2.52, SD = 0.67)
- Supervisor has an apathetic attitude toward supervision (MRS = 2.45, SD = 0.72)
- Supervisor sometimes ignores important agency policies or directs the supervisee to do so (MRS = 2.34, SD = 0.74)

- Supervisor appears to be distracted in supervision (MRS = 2.07, SD = 0.72)

These results indicate that interns believe a supervisor's poor professional behavior can have a significant adverse impact the supervisory process.

Domain E: Assessment/Evaluation/Feedback. This domain covered 13 CEs grouped into five clusters (Clusters 13-16). Counterproductive experiences in this domain focused on problems with evaluating supervisees and providing adequate feedback, such as the related experiences discussed in Categories I, III, VI, VIII, and IX in the literature review above. All five of these clusters contained at least one CE with an MRS in the Moderate to Significant/Major Effect range:

- Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations (MRS = 2.79, SD = 0.42)
- Supervisor is often insensitive when giving feedback (e.g., provides feedback in a disrespectful manner, makes critical judgments of supervisee without providing constructive feedback (MRS = 2.79, SD = 0.49)
- Supervisor fails to clearly communicate performance expectations to the supervisee (MRS = 2.52, SD = 0.64)
- Supervisor's performance expectations are developmentally inappropriate (i.e., too high or too low in light of the SE's experience and competence (MRS = 2.41, SD = 0.64)
- Supervisor does not consider the developmental needs of the supervisee (MRS = 2.37, SD = 0.68)
- Supervisor does not regularly provide adequate evaluative feedback (e.g., feedback that assists in the supervisee's development; MRS = 2.17, SD = 0.72)

- Inadequate environment/office space is provided for supervision (e.g., supervision conducted in non-confidential location, such as a restaurant; MRS = 2.11, SD = 0.85)
- Supervisee and supervisor do not agree about the means to achieve the supervisory goals (i.e., how the training goals will be met; MRS = 2.00, SD = 0.75)

These results provide evidence that the interns believe problems related to assessment, evaluation, and feedback can significantly and negatively impact the supervisor process.

Domain F: Problems of professional competence. This domain covered two CEs grouped into two separate clusters (Clusters 17 and 18). Counterproductive experiences in this domain focused on issues related to professional competence such as those described in Categories I and X in the literature review above. Both CEs had MRSs that fell within the Moderate to Significant/Major Effect range:

- The supervisor gives the supervisee a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision (MRS = 2.92, SD = 0.36)
- Supervisor does not appear to address professional competence problems in other trainees (MRS = 2.12, SD = 0.82)

These results suggest the interns believe inadequate supervisory competence will negatively impact the supervisory process.

Domain G: Ethics, Legal, and Regulatory Considerations. This domain covered 11 CEs grouped into three clusters (Clusters 19-21). Counterproductive experiences in this domain explored various problems related to ethics, legal, and regulatory issues, such as those discussed in Categories VII, VIII, and X in the literature review above. All three clusters contained at least

one CE with an MRS falling in the Moderate to Significant/Major Effect range. These are listed here:

- Supervisor has a sexual relationship with supervisee (MRS = 2.93, SD = 0.42)
- Supervisor directs the supervisee not to file a mandated report (e.g., for child abuse) when the supervisee reports clear instances of abuse, intent to harm, etc. (MRS = 2.85, SD = 0.54)
- Supervisor unnecessarily reveals supervisee's personal disclosures to other clinical faculty or staff without any ethical or professional justification (MRS = 2.73, SD = 0.56)
- Supervisor does not help, is not available to discuss (outside of scheduled supervision), and/or tries to avoid involvement with ethical dilemmas or emergency situations (MRS = 2.73, SD = 0.56)
- Supervisor makes jokes/comments with sexual innuendos (MRS = 2.63, SD = 0.69)
- Supervisor fails to provide the minimally required amount of supervision (MRS = 2.46, SD = 0.72)
- Supervisor discusses another supervisees' professional clinical performance or clinical competence (MRS = 2.37, SD = 0.76)
- Supervisor speaks about clients in a recognizable way (e.g., using their name) in public areas (MRS = 2.32, SD =0.79)

These results may indicate interns anticipate that ethical, legal, and regulatory problems in supervision could have a significant negative impact the supervisory process.

Counterproductive Experiences – Organized by Category

In this subsection, results regarding CEs grouped within each Category I-X (see Table J2) will be briefly summarized. A detailed analysis is not presented since it is hoped that the final

scale will include items representative of all APA supervisory domains (not Categories) to improve content validity and ensure applicability to future supervision training efforts. However, Table J2 was prepared for future researchers who may be interested in these data.

Every category except Category II contained CEs rated in the Moderate to Significant/Effect range). Category VIII contained the highest number of the highest rated CEs, indicating that the interns as group rated supervisory experiences related to boundary crossings and violations as having the most potential to negatively impact supervision (e.g., "Supervisor misuses power and authority", MRS = 2.94, SD = 0.32; "Supervisor has a sexual relationship with a supervisee", MRS = 2.93, SD = 0.42). Other very highly rated categories (e.g., Categories I and VII) contained CEs related to inadequate understanding of performance expectations (e.g., "The supervisor gives the supervisee a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of supervision", MRS = 2.92, SD = 0.36) and inadequate attention to ethical issues (e.g., "Supervisor directs supervisee not to file a mandated report (e.g., for child abuse) when the supervisee reports clear instances of abuse, intent to harm, etc.", MRS = 2.85, SD = 0.54), respectively. Other highly rated items include: "Supervisor does not demonstrate respect for the supervisee" (MRS = 2.91, SD = 0.34) and "Supervisor expresses attraction to the supervisee" (MRS = 2.88, SD = 0.46). These results are consistent those of previous studies (i.e., Grayson, 2014; Kakavand, 2014; Lucas, 2013) using a similar sample item pool.

Counterproductive Experiences Suggested by Interns

Following completion of the study survey, interns were provided an opportunity to suggest additional CEs for future consideration. Twenty-five interns provided suggestions. These covered a wide variety of supervisory experiences; however, no novel CEs were suggested. That

is, it was possible to classify each suggested experience as a subset, or specific instance, of at least one of the existing 60 CEs used in this study. A representative sample of these suggestions is included here (shown with corresponding CEs from this study):

- Providing only positive feedback without indication of areas for growth; Supervisor does not provide opportunity or encourage development of supervisee's clinical style
    - CE #36: Supervisor does not provide guidance about professional development as a psychologist
- Supervisor is absent from work for extended periods of time (illness or other) without finding suitable fill-in; Inadequate amount of supervision; Supervisor frequently reschedules or cancels supervision
    - CE #59: Supervisor fails to provide the minimally required amount of supervision
- Supervisor flaunting their money/salary or their lifestyle
    - CE #4: Supervisor does not consider the impact of his/her own and supervisee's cultural identities
- Supervisor does not deal with ruptures in a timely manner; Is there an appropriate chain of command, related to supervision, so that one may feel generally supported even when the primary supervisor may strain the relationship?
    - CE #9: Supervisor does not address strains or conflicts between supervisee and supervisor
- Supervisor is critical of trainee in front of other staff/undermines them; Supervisor responds to evaluation feedback defensively; Supervisor becomes punishing (rude, sarcastic, or abusive)

    - CE #23: Supervisor does not demonstrate respect for the supervisee
    - CE #24: Supervisor does not demonstrate empathy for the supervisee
- Supervisor provides positive feedback in-person, but negative feedback in written evaluation
    - CE# 45 Supervisor does not regularly provide adequate evaluative feedback (e.g., feedback that assists in the supervisee's development)
- Supervisor does not make it clear how soon an assignment must be completed
    - CE #40 Supervisor fails to clearly communicate performance expectations to the supervisee
- Supervisor relies on threats and the use of power to get his/her way
    - CE #22 Supervisor misuses power and authority
- Supervisor expects supervisee to complete tasks unrelated to internship, simply for the supervisor's convenience (i.e. treats them like a personal assistant)
    - CE #19: Supervisor asks supervisee to participate in an activity (e.g., edit an article the supervisor wrote for publication, purchase items from supervisor) for the sole benefit of the supervisor

Discussion

This study was designed to build upon previous, preliminary work aimed at developing an empirically-validated scale to better identify, characterize, and quantify the counterproductive experiences in supervision that are known to frequently occur in – and negatively impact – clinical supervision processes. Specifically, its purpose was to collect opinions about the negative impact of counterproductive experiences in supervision from a national sample of predoctoral interns. In order to do this, interns were recruited to complete a survey that involved

both rating and rank ordering a list of 60 theoretically- and empirically-derived CEs based on their anticipated adverse impact on the supervisory process. The pool of CEs used in this study spanned multiple functions of the supervisory process, with some focused on the process of protecting public welfare, others related to gatekeeping for the profession, and many directly addressing clinical training.

The 60 CEs were divided into groups that corresponded to the seven APA supervisory domains, and then each domain was subdivided into clusters based on CE type. Forty-six of the CEs were previously studied and rated by supervision experts (defined as psychologists who professionally supervise and have contributed to the theoretical and/or empirical literature in the area of clinical supervision; see Kakavand, 2014). The remaining 14 CEs were added based on suggestions from these supervision experts and on need identified by several recently published major publications regarding clinical supervision (e.g., the APA Guidelines; 2015).

The resulting data suggest that the sample of interns who participated in this study believe all 60 of the CEs – spanning all seven APA domains, and including the additional 14 CEs – will adversely impact the supervisory process to at least to a minimal degree (and a majority of them to a moderate or significant/major degree). Further, the general results of this study (i.e., that all CEs are expected to negatively impact supervision) corroborate those of three related studies involving doctoral students, supervision experts, and directors of clinical training (Grayson, 2014; Kakavand, 2014; and Lucas, 2013, respectively). The fact that interns, doctoral students, supervision experts, and clinical training directors agree that all proposed CEs could potentially interfere with the supervisory process reinforces the argument that further study of these CEs is warranted, and, therefore, that this developing scale could be beneficial.

The following section discusses implications for supervision training, recommendations for further scale development, future research directions, and limitations of this study.

Implications for Supervision Training

Even though the theoretical literature is steadily growing to include new articles, books, and guidelines outlining the components of effective clinical supervision, adequate clinical supervision is not always provided to supervisees. In fact, as previously discussed, the empirical literature is filled with studies reporting the occurrence and negative impact of CEs experienced within even the best-intentioned supervision. The results of this study strengthen existing evidence that a wide variety of CEs have the potential to negatively impact or even derail the supervisory process. This information can be incorporated into training efforts and used to help determine which supervisory knowledge, skills and attitudes to emphasize. The following recommendations are suggested.

First, it is recommended that clinical supervision training curricula focus on teaching both effective and ineffective supervision practices because it is essential to teach clinicians how to recognize when the supervisory process has gone awry. Clinicians (supervisors and supervisees) could also benefit from information regarding how the frequency and severity of CEs may play a factor regarding the impact of a CE on the supervisory process.

Second, both veteran and novice supervisors, as well as supervisors in training (i.e., students), would likely benefit from a better understanding of the different types of CEs studied thus far, as well as other characteristics, such as how frequently they occur, and the extent of their potential to cause harm (e.g., supervisor-supervisee sexual relationship versus supervisor having limited knowledge of supervisee's theoretical orientation). This knowledge could aid supervisors as they navigate tricky issues in supervision such as discussions of cultural

differences or professional boundaries. It could also raise awareness among supervisees who may not realize the importance of some supervisory practices such as the use of a supervision contract.

Third, it may be helpful to place special emphasis on areas considered most potentially impactful (e.g., boundary violations) and most potentially harmful (e.g., ethical lapses). It is hoped that the results of this study will help shape a final scale of CEs that will be used to systematically study CE characteristics as well other factors (e.g., the differences between supervisor and supervisee perceptions of CEs frequency and magnitude of their impact). This type of data could inform efforts to design supervision training programs, both for current supervisors and future ones, and may help determine which supervisory skills to emphasize in various workshops, course curricula, supervision textbooks, or supervision manuals that may become essential to many psychologists aiming to maintain supervisory competence throughout their careers.

Recommendations for Further Scale Development

It is hoped that the data collected during this study will aid efforts to determine which items to include in a final scale of CEs. Since the study item pool was developed by combining the results of an extensive literature search with current major works defining supervision competencies (e.g., the APA Guidelines; 2015), and since all items were deemed potentially impactful by supervision experts and/or interns, any and all CEs could essentially be included in the final scale. One may consider including only the most highly-rated CEs in the final scale; however, this might be a mistake for three reasons.

First, including only the highest-rated CEs would result in a list of CEs that do not represent every domain and cluster studied. Including at least some CEs from each of the seven

domains and 21 clusters would provide the most comprehensive coverage of the CEs under consideration and would aid in improving content validity of the final scale as well. Second, the 60 CEs may span all seven APA supervisory domains, but not all the domains are represented evenly. Choosing only the highest rated CEs would result in a list of CEs that over-represents some domains and underrepresents others. It is recommended that each domain be evenly represented on the final scale.

Finally, seven CEs were added to this study specifically to represent unaddressed topics outlined in the recently published APA Guidelines (2015). However, these new CEs are not evenly distributed across domains. If only the highest rated CEs are retained on the final scale, some of these important topics would no longer be represented by the scale. For instance, the lowest rated CE overall was "Supervisor does not use a supervision contract". This low rating may reflect limited familiarity with current literature supporting the use of supervision contracts, or it may indicate that the supervision contracts currently in use are generally not considered very useful by the interns in this study's sample. In either case, this item would be excluded from any final list based on mean rating score alone, even though the use of a supervision contract is specifically listed as a necessary component of supervision by many experts and organizations (e.g., Ellis et al., 2014; Falender & Shafranske, 2017; APA, 2015). Since one potential use of the finalized scale will be to focus future supervision training efforts, these important (though lower-rated) CEs must be retained.

In summary, these recommendations will provide comprehensive coverage of both CEs and aspects of effective supervision that have been studied in the literature; they will also help improve content validity and potential usefulness of the final scale.

Future Research Directions

The results of this study suggest particular considerations for future research. First, this study included 14 CEs that have not been previously studied. The data collected provide strong evidence that these new CEs are important; however, these results need to be replicated. Second, the other 46 CEs in this study have now been presented to supervision experts, doctoral students, clinical training directors, and pre-doctoral interns for their evaluation, but the opinions of these samples do not necessarily represent those of the entire population of mental health clinicians. Therefore, it is recommended that a future researcher elicit the opinions of a large sample of psychologists to improve the generalizability of the overall pattern of results. Third, this is the first time the CEs have been analyzed based on APA supervisory domain. Another study using the same 60 CEs and analyzed by APA domain would confirm the usefulness of using the domains as a framework for organizing the CEs.

The results of future studies will hopefully be combined with data already collected to inform future researchers in determining which CEs to include in a final scale. With this information, it would then be possible to design the final scale's measurement format, determine whether or not validation items or subscales should be incorporated, and edit some CEs so they can be reverse-scored. Instructions for the final scale also need to be developed, and future researchers may consider including a statement regarding the fact that, though CEs have the potential to interfere with the supervisory process, not all CEs do so in every case (e.g., if the frequency is low, the supervisory alliance is strong, if a relational rupture is repaired, etc.). Finally, a pilot study is recommended to test the ability of the final scale to collect the intended information.

Limitations of this Study

Perhaps the most significant limitation of this study is that the perspectives collected cannot be not generalize to those of all clinicians, for several reasons. First, participants in this study were predoctoral psychology interns; as a group, interns represent only a small subset of all clinicians. Second, this study included participants from within the United States and Canada only; perspectives about counterproductive supervision experiences may vary across different countries. Third, this study limited participants to psychology trainees currently completing predoctoral internships accredited by APA, CPA, or APPIC – each of which require applicants to be enrolled APA- or CPA-accredited training programs. Trainees who were clinically trained through unaccredited (or other-accredited) graduate programs and are completing unaccredited (or other-accredited) internships may perceive supervisory experiences differently and/or may have responded differently to the study items.

Another limitation of this study is that those who chose to participate may have different perspectives about supervision than those who chose not to participate. For instance, the interns who chose to participate may have been motivated to do so by factors unknowable to the investigators (e.g., because of a history of particularly bad or particularly good supervision experiences) and these factors may have influenced their responses and led to bias in the data. It is hoped that when the study results are combined with other data sets (i.e., from future studies) that the combined results will provide a more representative characterization of the CEs.

Another potential limitation involves the fact that, since the study involved using an indirect recruitment method via email, it is not possible to ensure that all members of the targeted population received an invitation to participate, or to determine the response rate.

Conclusion

Though clinical supervision in psychology has been distinguished as a distinct professional activity and a vital component of clinical training, there is abundant evidence that even the most well-intentioned supervision may include counterproductive experiences. These experiences (e.g., boundary crossings, cultural insensitivity, failure to address the needs of the supervisee) are thought to occur at an alarming frequency and are known to disrupt the supervisory process. When this happens, client welfare is adversely affected, trainee growth may be limited, and the supervisory process is experienced as negative.

Though many researchers have investigated and characterized various types of counterproductive experiences known to occur during clinical supervision, so far, no empirically-validated scale has been developed for assessing their frequency, effects, or causes. The purpose of this study was to build upon previous research aimed at developing such a scale. One hundred and eighty-eight interns were asked for opinions regarding how negatively impactful they believed various CEs might be. This sample of interns anticipated that the majority of these experiences would have a moderate to significant/major adverse impact (and that all would have at least a minimal adverse impact). The fact that these results are consistent with those of previous studies involving the same sample item pool (with doctoral students, supervision experts, and clinical training directors as participants) reinforces the argument that CEs have the potential to significantly disrupt the supervisory process and that further study of these CEs is warranted.

These findings will be used in subsequent research within the same research center to finalize the development, validation, and piloting of a scale for future use. It is hoped that the data collected with this developing scale will allow the study of various factors related to CEs,

such as differences in the frequency and impact of CEs based on perspective of supervisors and their supervisees. It is believed that this information will contribute meaningfully to the field of psychology – particularly in the growing area of competency-based supervision – and guide future efforts to train supervisors and trainees.

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APPENDIX A

Counterproductive Experiences Identified in the Theoretical and Empirical Literature

Counterproductive Experiences Identified in the Theoretical and Empirical Literature

Study/ Publication	Purpose	Design/Method	Major Findings
Category I: Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflict			
Theoretical			
Ellis, 2010	To extend the literature related to supervision experiences; "to examine the relationship between effective and ineffective supervisor behaviors and supervision process and outcome" (p. 30); to determine differences between the best and worst supervisors.	N/A	Discusses various topics related to supervision: --Supervisors are not protecting clients/supervisees from harm --There is not enough cross-cultural attention --The need for accurate theories describing supervision --The need to monitor/video supervisee sessions --The relationship is the most important aspect Suggests "Do's" of Clinical Supervision: --Be the gatekeeper but remember the power differential --Use basic group therapy skills in group sup (let go of control) --Establish a strong working alliance --Use basic therapy skills (communication, listening, empathy, empowerment, respect, boundaries) and foster professional development --Use informed consent --Monitor in-session behaviors --Attend to diversity issues/micro-aggressions --Document supervision (problems, competencies/deficiencies, remediation plans) --Use supervision and consultation --Work to bridge science and practice --Learn supervision skills --Participate in research Suggests "Don'ts" of Clinical Supervision: --Don't neglect diversity --Don't avoid the gatekeeping/evaluative roles --Don't provide inadequate/harmful supervision
Empirical			
Olk & Friedlander, 1992	Scale construction and validation	Study 1: 6 supervisors and 9 trainees Semistructured interview regarding role conflict and ambiguity experienced; used content analysis and expert ratings to narrow down to 29 items	Characterized role ambiguity and role conflict. Role ambiguity was more common in newer trainees whereas role conflict was found to be more common in advanced trainees. Note that role conflict was found to negatively affect the supervisory relationship. Role difficulties predicted dissatisfaction with supervision, increased work-related anxiety and decreased work satisfaction.

(continued)

Study/ Publication	Purpose	Design/Method	Major Findings
		Study 2: 240 respondents (doctoral-level trainees) Measured satisfaction with supervision, work satisfaction, work-related anxiety, and collected demographics	
Nelson & Friedlander, 2001	To increase knowledge about supervision, regarding causes and consequences of nonproductive conflict.	Qualitative National sample, N=13 (9 women, 4 men) Semistructured 60-minute interview regarding nonproductive conflict that was experienced as harmful, negatively impacting training within the last 6 months-3 years Instruments: --Supervisory Styles Inventory --Role Conflict/Role Ambiguity Inventory	Two themes emerged: --Supervisory relationships perceived as harmful involved power struggles; this was thought to reflect role conflict. --Dual relationships were associated with confusion and disharmony. Categorical structure of supervisee experiences of negative impact: -Initiation of relationship (remote/uncommitted/too busy/too familiar) -Impasse characteristics (power struggle/role conflict/sexual attraction/supervisor defensive) -Supervisee perception of supervisor's reactions (anger, threatened, non-flexible) -Supervisee reactions (hurt/confused; lost trust, felt unsafe, guarded, powerless) -Supervisee coping strategies (directly confronted, sought support from peers/training director; perspective taking, self-reflection) -Positive outcomes (increased sense of self, grateful for support from home school/site administrators at internship; proud of standing up for self) -Negative outcomes (anxiety/avoidance of supervisor in future; cynical about the profession; distrustful of supervisors; considering change of career) -Contributing factors: power struggles and dual relationships were associated with most harmful supervisory relationships (closely related to the concepts of role conflict and ambiguity) -"Most supervisees in this study did not experience enough attention, warmth, or understanding to maintain a sense of trust in their supervisors." (p. 391)

(continued)

Study/ Publication	Purpose	Design/Method	Major Findings
Magnuson et al., 2000b	This qualitative research examined the qualities and behaviors detrimental to supervisees.	Qualitative N= 11 counselors with a minimum of 5 years of experience with diverse geographic location, work setting, professional experiences, and cultural backgrounds (African American, Hispanic, European American); 8 men, 3 women. Measures: individual interviews from 45-75 minutes (5 by telephone).	Identified two categories of 'lousy supervision:' Overarching Principles: --Unbalanced (overemphasizing some elements of supervision experiences and excluding others) --Developmentally inappropriate --Intolerant of differences --Poor model of professional/ personal attributes (e.g., sex with supervisee; disclosing confidential information about supervisee) --Professionally apathetic General Spheres: --Organizational/administrative (failure to establish parameters to conduct supervision e.g., expectations not clarified; neglecting initial assessment of supervisees' needs; fail to recognize where they were developmentally) --Technical/cognitive (unskilled, unreliable professional resources); vague/global/abstract feedback; relying on a single primary model, disregarding supervisee's approach to counseling --Relational/affective (not providing safe environment); insensitive to supervisees' professional and developmental needs Two discreet aspects of "lousy supervision": 1) the absence of factors previously associated with effective supervision, 2) the presence of factors suspected but not yet demonstrated to be counterproductive; lousy supervision derives from a combination of both factors.
Ladany et al., 2013	Looked at effective and ineffective supervision, including behaviors, techniques, skills, and their effect on many aspects of supervision, including outcome, supervisory working alliance, and supervisory nondisclosure.	Mixed-method design; Qualitative and quantitative N=128, primarily doctoral trainees Supervisee evaluation of supervisor from --Working Alliance Inventory/Supervision – Short Form --Supervisory Styles Inventory	Supervisees associated the best supervisors with a stronger emotional bond, greater agreement on tasks and goals; they were also reported as having more attractive, interpersonally sensitive and task-oriented style. Supervisees reported less nondisclosure, more effective goal-setting and feedback processes with these supervisors. Bond weakening and lower supervisee disclosure was associated with negative supervisee perception of the bond, tasks, goals, and alliance. Conclusions: --The supervisory relationship seems to be a critical and foundational component of supervision; when perceived as weak by supervisees, it was characterized as problematic. --General therapeutic skills (e.g., empathy, reflection, interpersonal attentiveness, encouragement) used in supervision enhances efficacy of supervision. --Supervisees valued supervision that empowered them.

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Study/ Publication	Purpose	Design/Method	Major Findings
		--Supervisor Self-Disclosure Index --Trainee Disclosure Scale --Evaluation Process w/in Supervision Inventory	--Effective supervision builds a strong supervisory alliance by collaboratively developing goals and tasks, employs basic therapeutic skills, employs self-disclosure sparingly and appropriately, and provides both formative and summative feedback.
Nelson et al., 2008	Worked toward describing and developing strategies for teaching supervisors to effectively work with conflict within the supervisory relationship.	Consensual qualitative research 12 supervisors nominated by peers as "outstanding" Semistructured interview (1-2 hours by telephone) focusing on theoretical approach to supervision and various aspects of conflict in supervision.	A core themes that emerged were openness to conflict, commitment to resolving conflictual situations, and regular attention to the general clinical processes involved in supervision. Factors that contributed to conflict included working within a challenging agency context, relational factors such as personality differences and power differential, supervisory factors such as not establishing clear expectations or fear about gatekeeping responsibilities, and supervisee factors which included resistance and a dismissive attitude about the need for supervision.
Kakavand, 2014	To contribute to the understanding of counterproductive experiences in supervision, and to begin developing an empirically validated scale to better characterize these experiences.	8 experts in clinical supervision Q-sort technique was used to better characterize a Q-set of 50 items.	Experts rated all the counterproductive experiences studied as potentially having a negative impact on supervision. Those rated most impactful involved ethical lapse (i.e., not filing a mandated child abuse report) and boundary violations (i.e., the supervisor expressing sexual attraction toward supervisee or using sexual innuendo). Other notably significant items involved insensitive evaluative feedback (e.g., providing critical judgments without any constructive feedback, or inadequate understanding of performance expectations) and inattention to the supervisory relationship (e.g., not addressing strains or conflicts). Higher severity ratings were assigned to items that involved intentionality, frequency and timing issues.

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Study/ Publication	Purpose	Design/Method	Major Findings
Category II: Inappropriate Supervisor Self-Disclosure			
Theoretical			
Ladany & Walker, 2003	To provide a better understanding of the effective use of supervisor self-disclosure.	Theoretical discussion with case examples	Outlined 5 categories of supervisory self-disclosure: a) Personal material -- mostly unrelated to supervision; this was deemed mostly harmless if kept to a minimum b) Therapy experiences -- often used for modeling c) Professional experiences -- often regarding administrative or interpersonal dynamics of an agency d) Reactions to Trainee's clients -- can be used to model appropriate self-disclosure e) Supervision experiences -- these can be powerful when pertaining to previous struggles supervisor had and has overcome Conclusions: --Well-timed self-disclosure can be powerful. --Self-disclosures that are mostly focus on the needs of the supervisee and that are made in order to foster supervisee growth were found to be the most meaningful as compared to those provided for the sole purpose of serving the needs of the supervisor. --The outcomes most affected by self-disclosures are the supervisory alliance (e.g., self-disclosure may deepen the emotional bond), trainee self-disclosure (e.g., modeling may encourage supervisee self-disclosure), and trainee edification (e.g., disclosing similar personal struggles may serve as didactic mentoring).
Empirical			
Knox et al., 2008	To better understand the effects of supervisor self-disclosure (e.g., antecedents, events and consequences) from the supervisor's point of view.	Consensual qualitative research (CQR) Semistructured phone interviews 16 licensed psychologist supervisors and 2 doctoral-level counselor educators with credentials	--Supervisors believed their self-disclosures were generally beneficial and resulted in positive effects. --Supervisors reported using the intervention for the purposes of teaching or fostering supervisee development. --Supervisors reported that self-disclosure was typically offered at times when they sensed the supervisee was struggling.
Knox et al., 2011	Explored how supervisees experience supervisor self-disclosure and its effects on clinical work	Consensual qualitative research (CQR) Semistructured phone interviews	For most supervisees, the supervisor self-disclosures were experienced as positive and as an element of a strong relationship (e.g., their worries were alleviated, their supervisory working alliance strengthened, they felt comfortable disclosing more themselves, and these positive effects extended into future supervisory relationships).

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Study/ Publication	Purpose	Design/Method	Major Findings
	and the supervision process.	12 supervisees (11 doctoral and 1 masters level trainees; 10 women, 2 men)	For a minority, the self-disclosure resulted in them feeling self-conscious, worried about boundaries in supervision, and fearful regarding future disclosures
Kozlowski et al., 2014	Looked at better characterizing positive boundary crossings in clinical supervision, with attention to whether crossings were viewed as entirely positive or, instead, had some negative elements. Also studied how these crossings were handled (e.g., whether they were addressed) within the supervisory relationship.	Consensual Qualitative Research (CQR) Semi-structured phone interviews regarding positive boundary crossings in supervision 11 trainees (9 practicum students, 2 pre-doctoral interns)	Many trainees with positive supervisory relationships felt that boundary crossings done for the benefit of the supervisee (not the supervisor) strengthened the supervisory relationship and enhanced training; however, some trainees found the crossings caused role confusion. Researchers suggested that boundary crossings be discussed more regularly in supervision to help clear up role confusion issues.
Ladany & Lehrman-Waterman, 1999	Examined the content and frequency of supervisory self-disclosure from the trainee perspective in order to determine its relationship with supervisory style and its effect on the supervisory relationship.	Qualitative study using a discovery-oriented exploratory approach. -105 trainees (82 women, 23 men; 84 White, 12 African American, 3 Asian American, 5 Hispanic, 1 unspecified)	The most frequent types of supervisor self-disclosures were: --Personal issues were reported by 73% of participants – the authors caution supervisors from using these types of disclosures too frequently as they can indicate role-reversal, and they detract from supervision and are in the service of trainee development. --Neutral counseling experiences were reported by 55%. --Counseling struggles were reported by 51%. Supervisor self-disclosures were related to supervisor style and the supervisory relationship.

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Study/ Publication	Purpose	Design/Method	Major Findings
		Supervisory Self-Disclosure Questionnaire; Supervisor Self-Disclosure Index; Supervisory Styles Inventory; Working Alliance Inventory – Trainee Version, Demographic Questionnaire.	
Hutt et al., 1983	To study subjective supervision experiences.	Qualitative, phenomenological research study. 3 post-masters level trainees (1 each from education, social work and clinical psychology), selected by faculty and professional colleague's recom-mendation. Used open-ended interviews and audio recordings of the following question: "Try to recall a positive (or negative) experience you have had in supervision and describe it in as much detail as you can."	--Supervisors must attend to both relational aspects and other supervisory tasks; general relational dimensions (e.g., warmth, trust, respect) are important in supervisory relationships as in all helping relationships. --Self-disclosure links the supervisory relationship and better supervisee self-exploration regarding clinical issues. --Negative dynamics chiefly involve a supervisee's ongoing resistance as well as unresolved impasses in the supervisory relationship; they evoke negative feelings (e.g., anxiety, frustration) and fail to accomplish training goals. --Discussed the need for more research regarding supervision experience from a supervisee phenomenological standpoint before a useful measure (for future research) can be developed

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Study/ Publication	Purpose	Design/Method	Major Findings
		Data analysis followed a procedure outlined by Colaizzi, 1978.	
Ladany et al., 2013	Looked at effective and ineffective supervision, including behaviors, techniques, skills, and their effect on many aspects of supervision, including outcome, supervisory working alliance, and supervisory nondisclosure.	Mixed-method design; Qualitative and quantitative N=128, primarily doctoral trainees Supervisee evaluation of supervisor from --Working Alliance Inventory/Supervision – Short Form --Supervisory Styles Inventory --Supervisor Self-Disclosure Index --Trainee Disclosure Scale --Evaluation Process w/in Supervision Inventory	Supervisees associated the best supervisors with a stronger emotional bond, greater agreement on tasks and goals; they were also reported as having more attractive, interpersonally sensitive and task-oriented style. Supervisees reported less nondisclosure, more effective goal-setting and feedback processes with these supervisors. Bond weakening and lower supervisee disclosure was associated with negative supervisee perception of the bond, tasks, goals, and alliance. Conclusions: --The supervisory relationship seems to be a critical and foundational component of supervision; when perceived as weak by supervisees, it was characterized as problematic. --General therapeutic skills (e.g., empathy, reflection, interpersonal attentiveness, encouragement) used in supervision enhances efficacy of supervision. --Supervisees valued supervision that empowered them. --Effective supervision builds a strong supervisory alliance by collaboratively developing goals and tasks, employs basic therapeutic skills, employs self-disclosure sparingly and appropriately, and provides both formative and summative feedback.
Nelson & Friedlander, 2001	To increase knowledge about supervision, regarding causes and consequences of nonproductive conflict.	Qualitative National sample, N=13 masters/ doctoral trainees (9 women, 4 men) Semistructured 60-minute interview regarding nonproductive conflict that was	Two themes emerged: --Supervisory relationships perceived as harmful involved power struggles; this was thought to reflect role conflict. --Dual relationships were associated with confusion and disharmony. Categorical structure of supervisee experiences of negative impact: -Initiation of relationship (remote/uncommitted/too busy/too familiar) -Impasse characteristics (power struggle/role conflict/sexual attraction/supervisor defensive) -Supervisee perception of supervisor's reactions (anger, threatened, non-flexible)

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Study/ Publication	Purpose	Design/Method	Major Findings
		experienced as harmful, negatively impacting training within the last 6 months-3 years Instruments: --Supervisory Styles Inventory --Role Conflict/Role Ambiguity Inventory	-Supervisee reactions (hurt/confused; lost trust, felt unsafe, guarded, powerless)-Supervisee coping strategies (directly confronted, sought support from peers/training director; perspective taking, self-reflection) -Positive outcomes (increased sense of self, grateful for support from home school/site administrators at internship; proud of standing up for self) -Negative outcomes (anxiety/avoidance of supervisor in future; cynical about the profession; distrustful of supervisors; considering change of career) -Contributing factors: power struggles and dual relationships were associated with most harmful sup relationships (closely related to the concepts of role conflict and ambiguity) -"Most supervisees in this study did not experience enough attention, warmth, or understanding to maintain a sense of trust in their supervisors." (p. 391)
Category III: Supervisory Alliance and Relationship Problems			
Theoretical			
Watkins, 1997	Purpose was to consider bad, poor, and/or ineffective supervision behaviors in terms of what is known about them, how they have been characterized, and how they develop and persist.	Literature review and theoretical discussion; summarizes some of the findings in the literature to date -Reviewed 5 studies of bad supervision (psychiatry, psychology and social work).	A good supervisor was characterized as "empathic, supportive, flexible, instructive, knowledgeable, interested in supervision, specific, tracks supervisee well, interpretive, respectful, focused and practical." Bad, poor or ineffective supervisors were characterized as having the following traits: "rigidity, low empathy, low support, failure to consistently track SE concerns, failure to teach or instruct, being indirect and intolerant, being closed, lacking respect for differences, being non-collegial, lacking in praise and encouragement, being sexist, and emphasizing evaluation, weakness and deficiencies."
Empirical			
Kennard et al., 1987	Purpose was to study the match between supervisor and supervisee to determine which supervisee characteristics, supervisory styles, or similarities within the dyad (e.g., theoretical orientation)	68 trainee-supervisor pairs Survey; collected self-description, description of dyad's therapeutic or supervisory behavioral style, and had participants rate frequency of supportive, directive,	Concluded that trainees rated their supervision experience as positive in dyads where corresponding supervisors rated the trainees as seeming interested in receiving feedback. Trainees reported more positive experiences with supervisors who were seen as "more supportive, instructional and interpretive." (p. 174) Other similarities between trainee and supervisor (e.g., behavioral style or theoretical orientation) were also found to be important.

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Study/ Publication	Purpose	Design/Method	Major Findings
	correspond to positive and negative experiences in supervision.	instructional, interpretive and confrontational behaviors used.	
Ladany et al., 2001	The purpose of this study was to examine the relationship between supervisor perception of their supervisory style, working alliance, and self-disclosure.	N= 137 counselor supervisors (80 women, 55 men, 2 unspecified) averaging 45 years of age; 119 white, 6 African American, 4 Asian, 3 Latina, 1 "other"; 110 doctorate degrees, 27 master's degrees; counselor education and counseling psychology (68%) clinical psychology (18%). Supervisory Styles Inventory: a 33-item self-report questionnaire about style of supervision.	Supervisors' perception of their own style was directly related to the way they viewed their supervisory relationships. "Supervisors who believed themselves to be warm, friendly, and supportive were likely to view the supervisory relationship as mutually trusting and perceived an agreement with trainees on goals and tasks of supervision. Furthermore, when supervisors believed they approached trainees from a counselor-like or task-oriented orientation, they perceived a higher agreement on the tasks of supervision." "Also, supervisors who saw themselves approach trainees in a didactic or teacher-like fashion were also likely to perceive that the tasks of supervision were mutually agreed upon." (p. 271) It is thought that all three of these style components affect the supervisory working alliance differently.
Gray et al., 2001	Analyzed various aspects surrounding the occurrence of counterproductive events in supervision (e.g., trainee experience, factors that perpetuate the experiences, and relational	13 (10 women, 3 men) trainee students in counseling psychology graduate programs (4 masters, 9 doctoral) Qualitative Semi-structured interview	-Defines counterproductive event in supervision as, "any experience that was hindering, unhelpful, or harmful in relationship to the trainee's growth as a therapist" (p. 371). -CEs identified in this study include supervisor dismissing supervisees' thoughts and feelings, lacking empathy, arriving to supervision session unprepared, pushing supervisor's own agenda, challenging the supervisee, inappropriately self-disclosing, misinterpreting supervisee, and not listening or responding to supervisee. -CEs were typically seen as negatively influencing supervision progress and outcome. -Negative reactions to CEs included negative thoughts about supervisor or supervisory relationship; feeling their work was not valued; crying or feeling unsafe; and feeling confusion,

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Study/ Publication	Purpose	Design/Method	Major Findings
	dynamics), including how these events affect alliance, training dynamics, the therapeutic process, and outcome. Also examined trainee disclosure of these events.	Supervision Satisfaction Questionnaire	frustration, anger, anxiety, uncomfortable, upset or defensive, -Most supervisees reported not disclosing the CE to their supervisor; of those who did, only half also processed with supervisors how the event influenced the trainee or the supervisory relationship. -All trainees reported experiencing negative supervisory interactions following the experience of a CE, and that this led to their changing the way they interacted with the supervisor (e.g., telling the supervisor what she wanted to hear, being on guard, withdrawing). -Generally, though CEs negatively influenced the self-efficacy of the majority of supervisees, some participants reported that CEs fostered their professional development in some ways (e.g., improved self-efficacy, better appreciation for the purpose of effective supervision). Most trainees reported that CEs negatively affected their clients.
Magnuson et al., 2000b	This qualitative research examined the qualities and behaviors detrimental to supervisees.	Qualitative N= 11 counselors with a minimum of 5 years of experience with diverse geographic location, work setting, professional experiences, and cultural backgrounds (African American, Hispanic, European American); 8 men, 3 women. Measures: individual interviews from 45-75 minutes (5 by telephone).	Identified two categories of 'lousy supervision:' Overarching Principles: --Unbalanced (overemphasizing some elements of supervision experiences and excluding others) --Developmentally inappropriate --Intolerant of differences --Poor model of professional/ personal attributes (e.g., sex with supervisee; disclosing confidential information about supervisee) --Professionally apathetic General Spheres: --Organizational/administrative (failure to establish parameters to conduct supervision e.g., expectations not clarified; neglecting initial assessment of supervisees' needs; fail to recognize where they were developmentally) --Technical/cognitive (unskilled, unreliable professional resources); vague/global/abstract feedback; relying on a single primary model, disregarding supervisee's approach to counseling --Relational/affective (not providing safe environment); insensitive to supervisees' professional and developmental needs Two discreet aspects of "lousy supervision": 1) the absence of factors previously associated with effective supervision, 2) the presence of factors suspected but not yet demonstrated to be counterproductive; lousy supervision derives from a combination of both factors.
Moskowitz & Rupert, 1983	Studied conflict in the supervisory relationship, from the supervisees' perspective.	Survey 150 graduate students in clinical psychology from APA-	-38.8% of the respondents reported experiencing a major conflict with a supervisor that interfered with supervision goals. Types of conflict identified: -20% of the conflicts revolved around differences in theoretical orientation or therapeutic approach (e.g., differing

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Study/ Publication	Purpose	Design/Method	Major Findings
		approved PhD programs in Illinois, or interns in APA-approved sites within the Chicago area.	opinions regarding clinical focus or appropriate interventions). -30% related to supervisory style (e.g., too directive, not directive enough). -50% involved personality issues. --Supervisees indicated they wanted supervisors to notice and initiate conversations about conflict 76.9% of supervisees with conflict discussed the issue with their supervisors. Of these, 83.8% initiated the conversations. Discussion resolution of conflicts depended partly on type of conflict (e.g., personality issues were harder to resolve than those involving supervision style). In 25% of cases, supervision after discussion became "excellent;" in 32.5% of cases, supervision became "adequate or workable;" in 37.5%, no improvement in situation (and sometimes became worse – especially when personality issues were involved).
Ladany et al., 2013	Looked at effective and ineffective supervision, including behaviors, techniques, skills, and their effect on many aspects of supervision, including outcome, supervisory working alliance, and supervisory nondisclosure.	Mixed-method design; Qualitative and quantitative N=128, primarily doctoral trainees Supervisee evaluation of supervisor from --Working Alliance Inventory/Supervision – Short Form --Supervisory Styles Inventory --Supervisor Self-Disclosure Index --Trainee Disclosure Scale --Evaluation Process w/in Supervision Inventory	Supervisees associated the best supervisors with a stronger emotional bond, greater agreement on tasks and goals; they were also reported as having more attractive, interpersonally sensitive and task-oriented style. Supervisees reported less nondisclosure, more effective goal-setting and feedback processes with these supervisors. Bond weakening and lower supervisee disclosure was associated with negative supervisee perception of the bond, tasks, goals, and alliance. Conclusions: --The supervisory relationship seems to be a critical and foundational component of supervision; when perceived as weak by supervisees, it was characterized as problematic. --General therapeutic skills (e.g., empathy, reflection, interpersonal attentiveness, encouragement) used in supervision enhances efficacy of supervision. --Supervisees valued supervision that empowered them. --Effective supervision builds a strong supervisory alliance by collaboratively developing goals and tasks, employs basic therapeutic skills, employs self-disclosure sparingly and appropriately, and provides both formative and summative feedback.

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Study/ Publication	Purpose	Design/Method	Major Findings
Mack, 2012	Investigated the role of alliance on counter-transference disclosure within the peer supervisory relationship and compared these to the same within the supervisee and supervisor of record.	Online survey 52 doctoral students (42 female, 9 male) in APA-accredited clinical and counseling programs who were engaged in both peer supervision and clinical supervision. Working Alliance Inventory (Supervisee and Peer Supervisee Forms); Reaction Disclosure Questionnaire (Supervisee and Peer Supervisee); Demographic Questionnaire	Supervisory working alliance was positively correlated with the degree of comfort supervisees felt regarding sharing countertransference with both their peer supervisors and primary supervisors. Supervisees were more likely to make personal disclosures about countertransference regarding clients when they perceived their peer supervisors to have traits generally considered "ideal" by experts in the field of supervision (e.g., supervisors who are supportive, nonjudgmental, etc.). This is more support that these supervisor characteristics (even in peer supervisors) build a safe relational foundation with the supervisee.
Category IV: Supervisor/Supervisee Style and Competence			
Theoretical			
Veach, 2001	Discussed and commented on the findings of two studies (Nelson & Friedlander, 2001; Gray et al., 2001)	Comment paper	Calls for further exploration of conflicts and counterproductive supervision events, including: -Immediate versus long-term impact of CEs. -whether conflictual supervisory relationships are due to single or multiple CEs. -Causes of CEs and conflictual relationships. -Differences of CEs that occur in group supervision versus in individual. Practice recommendations: -Individuals should receive more training in supervision before becoming supervisors. -Suggests supervisors would benefit from monitoring provided by peer group supervision. -Endorses the use of informed consent in supervision.

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Study/ Publication	Purpose	Design/Method	Major Findings
			Author summarizes possible reasons conflict has occurred in supervision include supervisor's lack of knowledge, lack of skills, motivation al issues, personal distress-impairment, and transference/countertransference, as well as individual and cultural differences and administrative constraints.
Watkins, 1997	Purpose was to consider bad, poor, and/or ineffective supervision behaviors in terms of what is known about them, how they have been characterized, and how they develop and persist.	Literature review and theoretical discussion; summarizes some of the findings in the literature to date -Reviewed 5 studies of bad supervision (psychiatry, psychology and social work).	A good supervisor was characterized as "empathic, supportive, flexible, instructive, knowledgeable, interested in supervision, specific, tracks supervisee well, interpretive, respectful, focused and practical." Bad, poor or ineffective supervisors were characterized as having the following traits: "rigidity, low empathy, low support, failure to consistently track supervisee concerns, failure to teach or instruct, being indirect and intolerant, being closed, lacking respect for differences, being non-collegial, lacking in praise and encouragement, being sexist, and emphasizing evaluation, weakness and deficiencies."
			Empirical
Kennard et al., 1987	Purpose was to study the match between supervisor and supervisee to determine which supervisee characteristics, supervisory styles, or similarities within the dyad (e.g., theoretical orientation) correspond to positive and negative experiences in supervision.	68 trainee-supervisor pairs Survey; collected self-description, description of dyad's therapeutic or supervisory behavioral style, and had participants rate frequency of supportive, directive, instructional, interpretive and confrontational behaviors used.	Concluded that trainees rated their supervision experience as positive in dyads where corresponding supervisors rated the trainees as seeming interested in receiving feedback. Trainees reported more positive experiences with supervisors who were seen as "more supportive, instructional and interpretive." (p. 174) Other similarities between trainee and supervisor (e.g., behavioral style or theoretical orientation) were also found to be important.
Magnuson et al., 2000b	This qualitative research examined the qualities and behaviors	Qualitative N= 11 counselors with a minimum of 5 years of experience with diverse	Identified two categories of 'lousy supervision:' Overarching Principles: --Unbalanced (overemphasizing some elements of supervision experiences and excluding others) --Developmentally inappropriate --Intolerant of differences

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Study/ Publication	Purpose	Design/Method	Major Findings
	detrimental to supervisees.	geographic location, work setting, professional experiences, and cultural backgrounds (African American, Hispanic, European American); 8 men, 3 women. Measures: individual interviews from 45-75 minutes (5 by telephone).	--Poor model of professional/ personal attributes (e.g., sex with supervisee; disclosing confidential information about supervisee) --Professionally apathetic General Spheres: --Organizational/administrative (failure to establish parameters to conduct supervision e.g., expectations not clarified; neglecting initial assessment of supervisees' needs; fail to recognize where they were developmentally) --Technical/cognitive (unskilled, unreliable professional resources); vague/global/abstract feedback; relying on a single primary model, disregarding supervisee's approach to counseling --Relational/affective (not providing safe environment); insensitive to supervisees' professional and developmental needs Two discreet aspects of "lousy supervision": 1) the absence of factors previously associated with effective supervision, 2) the presence of factors suspected but not yet demonstrated to be counterproductive; lousy supervision derives from a combination of both factors.
Ramos-Sánchez et al., 2002	"This investigation attempted to assess the relationship between supervisee developmental level, working alliance, attachment, and negative experiences in supervision" (p. 198).	Exploratory National Survey Study 126 respondents	-27% of respondents indicated having a negative event in supervision; these were coded into 4 categories: -Interpersonal relationship and style -Supervision tasks and responsibilities -Conceptualization and theoretical orientation -Ethics, legal, and multicultural issues -Negative experiences correlated with weaker supervisory alliances -Responses indicated that negative events negatively affected their current training, general training, and current supervision experience, and adversely affected future career goals. -Supervisory relationship was one of the most influential factors in how the trainee rated satisfaction with training.
Moskowitz & Rupert, 1983	Studied conflict in the supervisory relationship, from the supervisees' perspective.	Survey 150 graduate students in clinical psychology from APA-approved PhD programs in Illinois, or interns in APA-approved sites within the Chicago area.	-38.8% of the respondents reported experiencing a major conflict with a supervisor that interfered with supervision goals. Types of conflict identified: -20% of the conflicts revolved around differences in theoretical orientation or therapeutic approach (e.g., differing opinions regarding clinical focus or appropriate interventions). -30% related to supervisory style (e.g., too directive, not directive enough). -50% involved personality issues.

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Study/ Publication	Purpose	Design/Method	Major Findings
			--Supervisees indicated they wanted supervisors to notice and initiate conversations about conflict 76.9% of supervisees with conflict discussed the issue with their supervisors. Of these, 83.8% initiated the conversations. Discussion resolution of conflicts depended partly on type of conflict (e.g., personality issues were harder to resolve than those involving supervision style). In 25% of cases, supervision after discussion became "excellent;" in 32.5% of cases, supervision became "adequate or workable;" in 37.5%, no improvement in situation (and sometimes became worse – especially when personality issues were involved).
Chung et al., 1998	Investigated factors that contribute to the positive and negative experiences of counseling trainees during supervision" (p. 762).	Semistructured interviews; review of audiotapes 6 practicum students	Themes that emerged related to issues in clinical training, the therapeutic relationship, and the supervisory relationship. For positive supervision experiences, themes related mostly to clinical training, and included: "modeling appropriate skills, teaching new ideas and techniques, and providing feedback, resources, information" (p. 762). For negative supervision experiences, themes related mostly to supervisory relationship, and included: "supervisory being impersonal or distracted during supervision" (p. 762). Authors recommended supervisors attend to the supervisory relationship in addition to clinical training.
Category V: Cultural Insensitivity			
Theoretical			
Falender et al., 2013	Purpose is to "provide background knowledge and context for competency-based clinical supervision and to showcase a diversity of methodologically sound empirical approaches to study effective supervision" (p. 10).	Major Contribution	Reviews literature discussing the lack of formal clinical supervision training in the field of psychology; especially highlights the lack of attention given to multicultural factors in supervision and how this is related to documented significant negative supervisory experiences.
Watkins, 1997	Purpose was to consider bad, poor, and/or ineffective supervision behaviors in	Literature review and theoretical discussion; summarizes some of the	A good supervisor was characterized as "empathic, supportive, flexible, instructive, knowledgeable, interested in supervision, specific, tracks supervisee well, interpretive, respectful, focused and practical." Bad, poor or ineffective supervisors were characterized as having the following traits: "rigidity, low empathy, low

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Study/ Publication	Purpose	Design/Method	Major Findings
	terms of what is known about them, how they have been characterized, and how they develop and persist.	findings in the literature to date -Reviewed 5 studies of bad supervision (psychiatry, psychology and social work).	support, failure to consistently track supervisee concerns, failure to teach or instruct, being indirect and intolerant, being closed, lacking respect for differences, being non-collegial, lacking in praise and encouragement, being sexist, and emphasizing evaluation, weakness and deficiencies."
Veach, 2001	Discussed and commented on the findings of two studies (Nelson & Friedlander, 2001; Gray et al., 2001)	Comment paper	Calls for further exploration of conflicts and counterproductive supervision events, including: -Immediate versus long-term impact of CEs. -whether conflictual supervisory relationships are due to single or multiple CEs. -Causes of CEs and conflictual relationships. -Differences of CEs that occur in group supervision versus in individual. Practice recommendations: -Individuals should receive more training in supervision before becoming supervisors. -Suggests supervisors would benefit from monitoring provided by peer group supervision. -Endorses the use of informed consent in supervision. Author summarizes possible reasons conflict has occurred in supervision include supervisor's lack of knowledge, lack of skills, motivation al issues, personal distress-impairment, and transference/countertransference, as well as individual and cultural differences and administrative constraints.
APA, 2003	Presents guidelines on multicultural education, training, research, practice, and organizational change.	Published guidelines	"Guideline #1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (p. 17). "Guideline #2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals" (p. 25). "Guideline #3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education" (p. 30). Guideline # 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds" (p. 36). Guideline #5: Psychologists strive to apply culturally-appropriate skills in clinical and other applied psychological practices" (p. 43).

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Study/ Publication	Purpose	Design/Method	Major Findings
			Guideline #6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices" (p. 50).
			Empirical
Ramos-Sánchez et al., 2002	"This investigation attempted to assess the relationship between supervisee developmental level, working alliance, attachment, and negative experiences in supervision" (p. 198).	Exploratory National Survey Study 126 respondents	-27% of respondents indicated having a negative event in supervision; these were coded into 4 categories: -Interpersonal relationship and style -Supervision tasks and responsibilities -Conceptualization and theoretical orientation -Ethics, legal, and multicultural issues -Negative experiences correlated with weaker supervisory alliances -Responses indicated that negative events negatively affected their current training, general training, and current supervision experience, and adversely affected future career goals. -Supervisory relationship was one of the most influential factors in how the trainee rated satisfaction with training.
Inman, 2006	Looked at supervisee's perspective regarding how supervisor multicultural competence affected supervisory working alliance, trainees' multicultural competence, and perceived supervision satisfaction	Path-analysis Modeling 147 students at master's, postgraduate or doctoral level Questionnaires: Supervisor Multicultural Competence Inventory; Working Alliance – Trainee Version; Multicultural Case Conceptualiza-tion Ability; Supervision Satisfaction Questionnaire; Demographic Form	Found that supervisory working alliance "is a significant mediator in the relationship between supervisor multicultural competence and supervision satisfaction" (p. 80); however, supervisor multicultural competence did not translate into increased trainee multicultural competence.
Burkard et al., 2006	Looked at cross-cultural supervision events	Semistructured interview; Consensual qualitative	Culturally unresponsive events (e.g., not discussing culture regarding client's treatment) were reported by 8 of 13 EASEs and all SECs.

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Study/ Publication	Purpose	Design/Method	Major Findings
	(responsive versus nonresponsive)	research; Demographics form 26 doctoral students [clinical and counseling psychology; 13 European American supervisees (EASEs) and 13 supervisees of color (SECs)]	Culturally-unresponsive events generally elicited general negative emotional reactions, caused negative feelings toward supervisor and the supervisory relationship (e.g., distrust, decreased disclosure, emotionality in supervision, decreased supervision satisfaction).
Jernigan et al., 2010	Looked at racial identity in the management of people of Color supervision dyads.	Qualitative Semistructured survey 6 respondents who identified self and supervisor as persons of Color	Across the dyads, the conflictual responses varied based on the disparity in racial development between the supervisee and supervisor; positive outcomes were more likely when the supervisor's racial identity was better developed. Supervisees reported that they were more likely to bring up the topic of race than the supervisor; they reported they generally perceived their supervisors as unsupportive regarding this topic, resulting in negative supervisee reactions (e.g., anger, frustration, resentment, internalized self-doubt). This negatively impacted the supervisory relationship.
Allen et al., 1986	Looked at factors differentiating supervisee perceptions of best and worst supervisors	Survey of 142 doctoral students in clinical and counseling programs Used a questionnaire regarding the context of supervision, supervisory personal attributes, and interactional aspects of supervisory relationship regarding best and worst experiences	Found that the "best discriminators of quality were perceived expertise and trustworthiness of supervisor, duration of training, and an emphasis on personal growth issues over the teaching of technical skills" (p. 91). The best supervisors provided a supportive relationship, clearly communicated expectations and feedback, an managed their conflicting roles (e.g., mentor and evaluator). They modeled respect for differences in values, experience and privacy; employed useful conceptualization frameworks; were tolerant of mistakes; confronted resistance in supervisees; invested time in the supervision process; directly monitored supervisee work; and were open to feedback regarding the supervision process. Worse supervisors were perceived as disinterested, inept, authoritarian, and exploitative (e.g., sexually); these experiences were noted as particularly detrimental to quality of supervision. Sexual intimacy between supervisee and supervisor was reported by 8% of the female and 2% of male students studied. Authors recommended that more attention be given to training the next gen of supervisors.

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Study/ Publication	Purpose	Design/Method	Major Findings
Category VI: Failure to Address Needs of the Supervisee			
Theoretical			
Watkins, 1997	Purpose was to consider bad, poor, and/or ineffective supervision behaviors in terms of what is known about them, how they have been characterized, and how they develop and persist.	Literature review and theoretical discussion; summarizes some of the findings in the literature to date -Reviewed 5 studies of bad supervision (psychiatry, psychology and social work).	A good supervisor was characterized as "empathic, supportive, flexible, instructive, knowledgeable, interested in supervision, specific, tracks supervisee well, interpretive, respectful, focused and practical." Bad, poor or ineffective supervisors were characterized as having the following traits: "rigidity, low empathy, low support, failure to consistently track supervisee concerns, failure to teach or instruct, being indirect and intolerant, being closed, lacking respect for differences, being non-collegial, lacking in praise and encouragement, being sexist, and emphasizing evaluation, weakness and deficiencies."
Veach, 2001	Discussed and commented on the findings of two studies (Nelson & Friedlander, 2001; Gray et al., 2001)	Comment paper	Calls for further exploration of conflicts and counterproductive supervision events, including: -Immediate versus long-term impact of CEs. -whether conflictual supervisory relationships are due to single or multiple CEs. -Causes of CEs and conflictual relationships. -Differences of CEs that occur in group supervision versus in individual. Practice recommendations: -Individuals should receive more training in supervision before becoming supervisors. -Suggests supervisors would benefit from monitoring provided by peer group supervision. -Endorses the use of informed consent in supervision. Author summarizes possible reasons conflict has occurred in supervision include supervisor's lack of knowledge, lack of skills, motivation al issues, personal distress-impairment, and transference/countertransference, as well as individual and cultural differences and administrative constraints.
Empirical			
Allen et al., 1986	Looked at factors differentiating supervisee perceptions of best and worst supervisors	Survey of 142 doctoral students in clinical and counseling programs Used a questionnaire regarding the context of	Found that the "best discriminators of quality were perceived expertise and trustworthiness of supervisor, duration of training, and an emphasis on personal growth issues over the teaching of technical skills" (p. 91). The best supervisors provided a supportive relationship, clearly communicated expectations and feedback, and managed their conflicting roles (e.g., mentor and evaluator). They modeled respect for differences in values, experience and privacy; employed useful conceptualization frameworks; were tolerant of mistakes; confronted resistance in

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Study/ Publication	Purpose	Design/Method	Major Findings
		supervision, supervisory personal attributes, and interactional aspects of supervisory relationship regarding best and worst experiences	supervisees; invested time in the supervision process; directly monitored supervisee work; and were open to feedback regarding the supervision process. Worse supervisors were perceived as disinterested, inept, authoritarian, and exploitative (e.g., sexually); these experiences were noted as particularly detrimental to quality of supervision. Sexual intimacy between supervisee and supervisor was reported by 8% of the female and 2% of male students studied. Authors recommended that more attention be given to training the next gen of supervisors.
Chung et al., 1998	Investigated factors that contribute to the positive and negative experiences of counseling trainees during supervision" (p. 762).	Semistructured interviews; review of audiotapes 6 practicum students	Themes that emerged related to issues in clinical training, the therapeutic relationship, and the supervisory relationship. For positive supervision experiences, themes related mostly to clinical training, and included: "modeling appropriate skills, teaching new ideas and techniques, and providing feedback, resources, information" (p. 762). For negative supervision experiences, themes related mostly to supervisory relationship, and included: "supervisory being impersonal or distracted during supervision" (p. 762). Authors recommended supervisors attend to the supervisory relationship in addition to clinical training.
Magnuson et al., 2000b	This qualitative research examined the qualities and behaviors detrimental to supervisees.	Qualitative N= 11 counselors with a minimum of 5 years of experience with diverse geographic location, work setting, professional experiences, and cultural backgrounds (African American, Hispanic, European American); 8 men, 3 women. Measures: individual interviews from	Identified two categories of 'lousy supervision:' Overarching Principles: --Unbalanced (overemphasizing some elements of supervision experiences and excluding others) --Developmentally inappropriate --Intolerant of differences --Poor model of professional/ personal attributes (e.g., sex with supervisee; disclosing confidential information about supervisee) --Professionally apathetic General Spheres: --Organizational/administrative (failure to establish parameters to conduct supervision e.g., expectations not clarified; neglecting initial assessment of supervisees' needs; fail to recognize where they were developmentally) --Technical/cognitive (unskilled, unreliable professional resources); vague/global/abstract feedback; relying on a single primary model, disregarding supervisee's approach to counseling --Relational/affective (not providing safe environment); insensitive to supervisees' professional and developmental needs

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Study/ Publication	Purpose	Design/Method	Major Findings
		45-75 minutes (5 by telephone).	Two discreet aspects of "lousy supervision": 1) the absence of factors previously associated with effective supervision, 2) the presence of factors suspected but not yet demonstrated to be counterproductive; lousy supervision derives from a combination of both factors.
Hutt et al., 1983	To study subjective supervision experiences.	Qualitative, phenomenological research study. 3 post-masters level trainees (1 each from education, social work and clinical psychology), selected by faculty and professional colleague's recommenda-tion. Used open-ended interviews and audio recordings of the following question: "Try to recall a positive (or negative) experience you have had in supervision and describe it in as much detail as you can." Data analysis followed a procedure outlined by Colaizzi, 1978.	--Supervisors must attend to both relational aspects and other supervisory tasks; general relational dimensions (e.g., warmth, trust, respect) are important in supervisory relationships as in all helping relationships. --Self-disclosure links the supervisory relationship and better supervisee self-exploration regarding clinical issues. --Negative dynamics chiefly involve a supervisee's ongoing resistance as well as unresolved impasses in the supervisory relationship; they evoke negative feelings (e.g., anxiety, frustration) and fail to accomplish training goals. --Discussed the need for more research regarding supervision experience from a supervisee phenomenological standpoint before a useful measure (for future research) can be developed
Sweeney & Creaner, 2013	Study partly-replicated a previous study characterizing nondisclosure	Qualitative; semi-structured interviews 6 counseling	Found that 5 out of 6 participants' nondisclosures concerned clinical concerns, though these nondisclosures were related to (or led to) problems with the supervisory relationship. Developmental level of trainee also influenced non-disclosure in all participants.

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Study/ Publication	Purpose	Design/Method	Major Findings
	in supervision, and further, aimed to identify factors leading to nondisclosure in a supervisory relationship.	psychology graduates, 2 years post-training	Participants with problematic relationship typically felt that their negative supervisory relationship interfered with their ability to discuss various things with supervisor (e.g., supervisory relationship, client difficulties, clinical errors); it was suggested that the emotional bond component of the supervisory relationship may have been missing in these relationships. Authors suggest interpersonal processing would have been helpful in problematic relationships; also, that role induction or supervision contracting at the start of training to help supervisees know how better to use supervision effectively.
Bang & Goodyear, 2014	Looked at negative supervisory experiences in Korea and compared these with those seen in studies focused on Western cultures.	Qualitative; unstructured 1-hour interviews 12 supervisees with master's degree in counseling (5 had assigned supervisors; 7 selected their own supervisors)	Negative supervisory experiences concerned disagreement with supervisors (e.g., over case conceptualization, relevance of personal issues on clinical cases, performance evaluations), and lack of input from supervisors (e.g., no empathy, suggested interventions). Common reactions included cognitive blocking or confusion; feeling disappointment, shame, depressed; and becoming less involved in supervision. Note that disappointment was directed toward supervisors not fulfilling expectations. These resulted in the supervisee feeling they were less effective with clients and forming negative views of supervision, but also resulted in increased supervisee awareness of self and supervisor.
Kakavand, 2014	To contribute to the understanding of counterproductive experiences in supervision, and to begin developing an empirically validated scale to better characterize these experiences.	8 experts in clinical supervision Q-sort technique was used to better characterize a Q-set of 50 items.	Experts rated all the counterproductive experiences studied as potentially having a negative impact on supervision. Those rated most impactful involved ethical lapse (i.e., not filing a mandated child abuse report) and boundary violations (i.e., the supervisor expressing sexual attraction toward supervisee or using sexual innuendo). Other notably significant items involved insensitive evaluative feedback (e.g., providing critical judgments without any constructive feedback, or inadequate understanding of performance expectations) and inattention to the supervisory relationship (e.g., not addressing strains or conflicts). Higher severity ratings were assigned to items that involved intentionality, frequency and timing issues.
Category VII: Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior			
Empirical			
Ramos-Sánchez et al., 2002	"This investigation attempted to assess the relationship	Exploratory National Survey Study	-27% of respondents indicated having a negative event in supervision; these were coded into 4 categories: -Interpersonal relationship and style -Supervision tasks and responsibilities

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Study/ Publication	Purpose	Design/Method	Major Findings
	between supervisee developmental level, working alliance, attachment, and negative experiences in supervision" (p. 198).	126 respondents	-Conceptualization and theoretical orientation -Ethics, legal, and multicultural issues -Negative experiences correlated with weaker supervisory alliances -Responses indicated that adverse events negatively affected their current training, general training, and current supervision experience, and adversely affected future career goals. -Supervisory relationship was one of the most influential factors in how the trainee rated satisfaction with training.
Ladany et al., 1999	Explored supervisees' experience of and reaction to supervisors following (or not following) ethical practices and determined how this impacted supervisor working alliance and supervisee satisfaction with supervision.	151 counseling or clinical psychology trainees (114 women, 36 men, 1 unspecified) Qualitative and quantitative (semi-structured interview, surveys and demographic questionnaire)	-51% of 151 supervisees reported at least 1 ethical violation for supervisor. The most common violations related to inadequate performance evaluation, confidentiality issues, and the ability to work with alternative perspectives. Supervisory alliance and supervisee satisfaction decreased with increasing amounts of supervisor ethical non-adherence. According to supervisees, ethical violations had mild to moderate negative impact on clients.
Amerikaner, 2012	Investigated the frequency of direct observation of supervisee work	Online survey 150 master/doctoral supervisees	Found that supervisors "very infrequently" directly observe supervisee work. Author noted that this practice may increase ethical vulnerability of the supervisors.
Magnuson et al., 2000b	This qualitative research examined the qualities and behaviors detrimental to supervisees.	Qualitative N= 11 counselors with a minimum of 5 years of experience with diverse geographic location, work setting, professional experiences, and cultural backgrounds (African	Identified two categories of 'lousy supervision:' Overarching Principles: --Unbalanced (overemphasizing some elements of supervision experiences and excluding others) --Developmentally inappropriate --Intolerant of differences --Poor model of professional/ personal attributes (e.g., sex with supervisee; disclosing confidential information about supervisee) --Professionally apathetic General Spheres: --Organizational/administrative (failure to establish parameters to conduct supervision e.g., expectations not clarified; neglecting initial assessment of supervisees' needs;

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Study/ Publication	Purpose	Design/Method	Major Findings
		American, Hispanic, European American); 8 men, 3 women. Measures: individual interviews from 45-75 minutes (5 by telephone).	fail to recognize where they were developmentally) --Technical/cognitive (unskilled, unreliable professional resources); vague/global/abstract feedback; relying on a single primary model, disregarding supervisee's approach to counseling --Relational/affective (not providing safe environment); insensitive to supervisees' professional and developmental needs Two discreet aspects of "lousy supervision": 1) the absence of factors previously associated with effective supervision, 2) the presence of factors suspected but not yet demonstrated to be counterproductive; lousy supervision derives from a combination of both factors.
Allen et al., 1986	Looked at factors differentiating supervisee perceptions of best and worst supervisors	Survey of 142 doctoral students in clinical and counseling programs Used a questionnaire regarding the context of supervision, supervisory personal attributes, and interactional aspects of supervisory relationship regarding best and worst experiences	Found that the "best discriminators of quality were perceived expertise and trustworthiness of supervisor, duration of training, and an emphasis on personal growth issues over the teaching of technical skills" (p. 91). The best supervisors provided a supportive relationship, clearly communicated expectations and feedback, an managed their conflicting roles (e.g., mentor and evaluator). They modeled respect for differences in values, experience and privacy; employed useful conceptualization frameworks; were tolerant of mistakes; confronted resistance in supervisees; invested time in the supervision process; directly monitored supervisee work; and were open to feedback regarding the supervision process. Worse supervisors were perceived as disinterested, inept, authoritarian, and exploitative (e.g., sexually); these experiences were noted as particularly detrimental to quality of supervision. Sexual intimacy between supervisee and supervisor was reported by 8% of the female and 2% of male students studied. Authors recommended that more attention be given to training the next gen of supervisors.
Ellis et al., 2014	STUDY 1: "to develop operational definitions of inadequate and harmful clinical supervision that are grounded in theory and consider multiple	STUDY 1: Consensus validation approach 34 clinical supervision experts STUDY 2: Survey of 363 supervisees (81.8% female;	-Defined minimally adequate supervision. -Empirically and theoretically derived a framework and taxonomy of 16 inadequate and 21 harmful supervision experiences that can be used to identify de-facto inadequate/harmful supervision experiences independent of supervisee self-report. All experiences deemed "harmful" were also, by default, determined to be inadequate. -96.3% experienced inadequate supervision either currently or in a previous supervision experience. -50.9% experienced supervision experiences that were deemed "harmful."

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Study/ Publication	Purpose	Design/Method	Major Findings
	perspectives" p. 437 STUDY 2: "to obtain initial data regarding the occurrence of inadequate and harmful clinical supervision from a diverse sample of supervisees in mental health fields" p. 453	79.9% non-Hispanic White; 56.7% master's degree/7% doctorate) from various MH fields (e.g., clinical psych, counseling, social work, SA, school psych);	-Examples of harmful supervision may include violating supervisee's boundaries (e.g., emotional intimacy forced on the supervisee, sexual contact); acting physically, emotionally, or psychologically aggressive and abusive toward supervisee; misusing the power differential, making macro- or micro-aggressions toward supervisee; demeaning, critical, vindictive attitude toward supervisee. -Effects of harmful supervision on the supervisee may last from days to years, may harm clients as well, and include psychological trauma (e.g., sense of mistrust, shame), loss of self-confidence, and significant decline in the supervisee's general health.
Kakavand, 2014	To contribute to the understanding of counterproductive experiences in supervision, and to begin developing an empirically validated scale to better characterize these experiences.	8 experts in clinical supervision Q-sort technique was used to better characterize a Q-set of 50 items.	Experts rated all the counterproductive experiences studied as potentially having a negative impact on supervision. Those rated most impactful involved ethical lapse (i.e., not filing a mandated child abuse report) and boundary violations (i.e., the supervisor expressing sexual attraction toward supervisee or using sexual innuendo). Other notably significant items involved insensitive evaluative feedback (e.g., providing critical judgments without any constructive feedback, or inadequate understanding of performance expectations) and inattention to the supervisory relationship (e.g., not addressing strains or conflicts). Higher severity ratings were assigned to items that involved intentionality, frequency and timing issues.
Category VIII: Boundary Crossings/Violations			
Empirical			
Nelson & Friedlander, 2001	To increase knowledge about supervision, regarding causes and consequences of nonproductive conflict.	Qualitative National sample, N=13 (9 women, 4 men) Semistructured 60-minute interview regarding nonproductive conflict that was experienced as harmful, negatively	Two themes emerged: --Supervisory relationships perceived as harmful involved power struggles; this was thought to reflect role conflict. --Dual relationships were associated with confusion and disharmony. Categorical structure of supervisee experiences of negative impact: -Initiation of relationship (remote/uncommitted/too busy/too familiar) -Impasse characteristics (power struggle/role conflict/sexual attraction/supervisor defensive) -Supervisee perception of supervisor's reactions (anger, threatened, non-flexible)

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Study/ Publication	Purpose	Design/Method	Major Findings
		impacting training within the last 6 months-3 years Instruments: --Supervisory Styles Inventory --Role Conflict/Role Ambiguity Inventory	-Supervisee reactions (hurt/confused; lost trust, felt unsafe, guarded, powerless) -Supervisee coping strategies (directly confronted, sought support from peers/training director; perspective taking, self-reflection) -Positive outcomes (increased sense of self, grateful for support from home school/site administrators at internship; proud of standing up for self) -Negative outcomes (anxiety/avoidance of supervisor in future; cynical about the profession; distrustful of supervisors; considering change of career) -Contributing factors: power struggles and dual relationships were associated with most harmful supervisory relationships (closely related to the concepts of role conflict and ambiguity) -"Most supervisees in this study did not experience enough attention, warmth, or understanding to maintain a sense of trust in their supervisors." (p. 391)
Magnuson et al., 2000b	This qualitative research examined the qualities and behaviors detrimental to supervisees.	Qualitative N= 11 counselors with a minimum of 5 years of experience with diverse geographic location, work setting, professional experiences, and cultural backgrounds (African American, Hispanic, European American); 8 men, 3 women. Measures: individual interviews from 45-75 minutes (5 by telephone).	Identified two categories of 'lousy supervision:' Overarching Principles: --Unbalanced (overemphasizing some elements of supervision experiences and excluding others) --Developmentally inappropriate --Intolerant of differences --Poor model of professional/ personal attributes (e.g., sex with supervisee; disclosing confidential information about supervisee) --Professionally apathetic General Spheres: --Organizational/administrative (failure to establish parameters to conduct supervision e.g., expectations not clarified; neglecting initial assessment of supervisees' needs; fail to recognize where they were developmentally) --Technical/cognitive (unskilled, unreliable professional resources); vague/global/abstract feedback; relying on a single primary model, disregarding supervisee's approach to counseling --Relational/affective (not providing safe environment); insensitive to supervisees' professional and developmental needs Two discreet aspects of "lousy supervision": 1) the absence of factors previously associated with effective supervision, 2) the presence of factors suspected but not yet demonstrated to be counterproductive; lousy supervision derives from a combination of both factors.
Allen et al., 1986	Looked at factors differentiating supervisee perceptions of	Survey of 142 doctoral students in clinical and counseling	Found that the "best discriminators of quality were perceived expertise and trustworthiness of supervisor, duration of training, and an emphasis on personal growth issues over the teaching of technical skills" (p. 91).

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Study/ Publication	Purpose	Design/Method	Major Findings
	best and worst supervisors	programs Used a questionnaire regarding the context of supervision, supervisory personal attributes, and interactional aspects of supervisory relationship regarding best and worst experiences	The best supervisors provided a supportive relationship, clearly communicated expectations and feedback, an managed their conflicting roles (e.g., mentor and evaluator). They modeled respect for differences in values, experience and privacy; employed useful conceptualization frameworks; were tolerant of mistakes; confronted resistance in supervisees; invested time in the supervision process; directly monitored supervisee work; and were open to feedback regarding the supervision process. Worse supervisors were perceived as disinterested, inept, authoritarian, and exploitative (e.g., sexually); these experiences were noted as particularly detrimental to quality of supervision. Sexual intimacy between supervisee and supervisor was reported by 8% of the female and 2% of male students studied. Authors recommended that more attention be given to training the next gen of supervisors.
Kakavand, 2014	To contribute to the understanding of counterproductive experiences in supervision, and to begin developing an empirically validated scale to better characterize these experiences.	8 experts in clinical supervision Q-sort technique was used to better characterize a Q-set of 50 items.	Experts rated all the counterproductive experiences studied as potentially having a negative impact on supervision. Those rated most impactful involved ethical lapse (i.e., not filing a mandated child abuse report) and boundary violations (i.e., the supervisor expressing sexual attraction toward supervisee or using sexual innuendo). Other notably significant items involved insensitive evaluative feedback (e.g., providing critical judgments without any constructive feedback, or inadequate understanding of performance expectations) and inattention to the supervisory relationship (e.g., not addressing strains or conflicts). Higher severity ratings were assigned to items that involved intentionality, frequency and timing issues.
Category IX: Additional Counterproductive Experiences			
Theoretical			
Ellis, 2010	To extend the literature related to supervision experiences; "to examine the relationship between effective and ineffective supervisor behaviors and supervision	N/A	Discusses various topics related to supervision: --Supervisors are not protecting clients/supervisees from harm --There is not enough cross-cultural attention --The need for accurate theories describing supervision --The need to monitor/video supervisee sessions --The relationship is the most important aspect Suggests "Do's" of Clinical Supervision: --Be the gatekeeper but remember the power differential --Use basic group therapy skills in group sup (let go of control) --Establish a strong working alliance

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Study/ Publication	Purpose	Design/Method	Major Findings
	process and outcome" (p. 30); to determine differences between the best and worst supervisors.		--Use basic therapy skills (communication, listening, empathy, empowerment, respect, boundaries) and foster professional development --Use informed consent --Monitor in-session behaviors --Attend to diversity issues/micro-aggressions --Document supervision (problems, competencies/deficiencies, remediation plans) --Use supervision and consultation --Work to bridge science and practice --Learn supervision skills --Participate in research Suggests "Don'ts" of Clinical Supervision: --Don't neglect diversity --Don't avoid the gatekeeping/evaluative roles --Don't provide inadequate/harmful supervision
Watkins, 1997	Purpose was to consider bad, poor, and/or ineffective supervision behaviors in terms of what is known about them, how they have been characterized, and how they develop and persist.	Literature review and theoretical discussion; summarizes some of the findings in the literature to date -Reviewed 5 studies of bad supervision (psychiatry, psychology and social work).	A good supervisor was characterized as "empathic, supportive, flexible, instructive, knowledgeable, interested in supervision, specific, tracks supervisee well, interpretive, respectful, focused and practical." Bad, poor or ineffective supervisors were characterized as having the following traits: "rigidity, low empathy, low support, failure to consistently track supervisee concerns, failure to teach or instruct, being indirect and intolerant, being closed, lacking respect for differences, being non-collegial, lacking in praise and encouragement, being sexist, and emphasizing evaluation, weakness and deficiencies."
Veach, 2001	Discussed and commented on the findings of two studies (Nelson & Friedlander, 2001; Gray et al., 2001)	Comment paper	Calls for further exploration of conflicts and counterproductive supervision events, including: -Immediate versus long-term impact of CEs. -whether conflictual supervisory relationships are due to single or multiple CEs. -Causes of CEs and conflictual relationships. -Differences of CEs that occur in group supervision versus in individual. Practice recommendations: -Individuals should receive more training in supervision before becoming supervisors. -Suggests supervisors would benefit from monitoring provided by peer group supervision. -Endorses the use of informed consent in supervision.

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Study/ Publication	Purpose	Design/Method	Major Findings
			Author summarizes possible reasons conflict has occurred in supervision include supervisor's lack of knowledge, lack of skills, motivation al issues, personal distress-impairment, and transference/countertransference, as well as individual and cultural differences and administrative constraints.
			Empirical
Ladany et al., 2013	Looked at effective and ineffective supervision, including behaviors, techniques, skills, and their effect on many aspects of supervision, including outcome, supervisory working alliance, and supervisory nondisclosure.	Mixed-method design; Qualitative and quantitative N=128, primarily doctoral trainees Supervisee evaluation of supervisor from --Working Alliance Inventory/Supervision – Short Form --Supervisory Styles Inventory --Supervisor Self-Disclosure Index --Trainee Disclosure Scale --Evaluation Process w/in Supervision Inventory	Supervisees associated the best supervisors with a stronger emotional bond, greater agreement on tasks and goals; they were also reported as having more attractive, interpersonally sensitive and task-oriented style. Supervisees reported less nondisclosure, more effective goal-setting and feedback processes with these supervisors. Bond weakening and lower supervisee disclosure was associated with negative supervisee perception of the bond, tasks, goals, and alliance. Conclusions: --The supervisory relationship seems to be a critical and foundational component of supervision; when perceived as weak by supervisees, it was characterized as problematic. --General therapeutic skills (e.g., empathy, reflection, interpersonal attentiveness, encouragement) used in supervision enhances efficacy of supervision. --Supervisees valued supervision that empowered them. --Effective supervision builds a strong supervisory alliance by collaboratively developing goals and tasks, employs basic therapeutic skills, employs self-disclosure sparingly and appropriately, and provides both formative and summative feedback.
Magnuson et al., 2000b	This qualitative research examined the qualities and behaviors detrimental to supervisees.	Qualitative N= 11 counselors with a minimum of 5 years of experience with diverse geographic location, work setting, professional experiences, and cultural backgrounds	Identified two categories of 'lousy supervision:' Overarching Principles: --Unbalanced (overemphasizing some elements of supervision experiences and excluding others) --Developmentally inappropriate --Intolerant of differences --Poor model of professional/ personal attributes (e.g., sex with supervisee; disclosing confidential information about supervisee) --Professionally apathetic General Spheres: --Organizational/administrative (failure to establish parameters to conduct supervision e.g., expectations not clarified; neglecting initial assessment of supervisees' needs;

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Study/ Publication	Purpose	Design/Method	Major Findings
		(African American, Hispanic, European American); 8 men, 3 women. Measures: individual interviews from 45-75 minutes (5 by telephone).	fail to recognize where they were developmentally) --Technical/cognitive (unskilled, unreliable professional resources); vague/global/abstract feedback; relying on a single primary model, disregarding supervisee's approach to counseling --Relational/affective (not providing safe environment); insensitive to supervisees' professional and developmental needs Two discreet aspects of "lousy supervision": 1) the absence of factors previously associated with effective supervision, 2) the presence of factors suspected but not yet demonstrated to be counterproductive; lousy supervision derives from a combination of both factors.
Hatcher et al., 2012	To better characterize many aspects of practicum-level training in professional psychology.	Survey 129 training directors of practicum training programs	Most training programs offered solid training experiences. Some sites had a limited number of licensed psychologists available for supervision. Training programs placed less emphasis on the use of scientific literature-informed service provision than graduate programs. One troubling result was that only 19% of sites studied reported using direct observation (e.g., audio or video recordings) as a supervision modality.
Hutt et al., 1983	To study subjective supervision experiences.	Qualitative, phenomenological research study. 3 post-masters level trainees (1 each from education, social work and clinical psychology), selected by faculty and professional colleague's recom-mendation. Used open-ended interviews and audio recordings of the following question: "Try to recall a positive (or	--Supervisors must attend to both relational aspects and other supervisory tasks; general relational dimensions (e.g., warmth, trust, respect) are important in supervisory relationships as in all helping relationships. --Self-disclosure links the supervisory relationship and better supervisee self-exploration regarding clinical issues. --Negative dynamics chiefly involve a supervisee's ongoing resistance as well as unresolved impasses in the supervisory relationship; they evoke negative feelings (e.g., anxiety, frustration) and fail to accomplish training goals. --Discussed the need for more research regarding supervision experience from a supervisee phenomenological standpoint before a useful measure (for future research) can be developed

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Study/ Publication	Purpose	Design/Method	Major Findings
		negative) experience you have had in supervision and describe it in as much detail as you can." Data analysis followed a procedure outlined by Colaizzi, 1978.	
Bang & Goodyear, 2014	Looked at negative supervisory experiences in Korea and compared these with those seen in studies focused on Western cultures.	Qualitative; unstructured 1-hour interviews 12 supervisees with master's degree in counseling (5 had assigned supervisors; 7 selected their own supervisors)	Negative supervisory experiences concerned disagreement with supervisors (e.g., over case conceptualization, relevance of personal issues on clinical cases, performance evaluations), and lack of input from supervisors (e.g., no empathy, suggested interventions). Common reactions included cognitive blocking or confusion; feeling disappointment, shame, depressed; and becoming less involved in supervision. Note that disappointment was directed toward supervisors not fulfilling expectations. These resulted in the supervisee feeling they were less effective with clients and forming negative views of supervision, but also resulted in increased supervisee awareness of self and supervisor.
Sweeney & Creaner, 2013	Study partly-replicated a previous study characterizing nondisclosure in supervision, and further, aimed to identify factors leading to nondisclosure in a supervisory relationship.	Qualitative; semi-structured interviews 6 counseling psychology graduates, 2 years post-training	Found that 5 out of 6 participants' nondisclosures concerned clinical concerns, though these nondisclosures were related to (or led to) problems with the supervisory relationship. Developmental level of trainee also influenced non-disclosure in all participants. Participants with problematic relationship typically felt that their negative supervisory relationship interfered with their ability to discuss various things with supervisor (e.g., supervisory relationship, client difficulties, clinical errors); it was suggested that the emotional bond component of the supervisory relationship may have been missing in these relationships. Authors suggest interpersonal processing would have been helpful in problematic relationships; also, that role induction or supervision contracting at the start of training to help supervisees know how better to use supervision effectively.
Hatcher et al., 2012	To better characterize many aspects of practicum-level training	Survey 129 training directors of practicum	Most training programs offered solid training experiences. Some sites had a limited number of licensed psychologists available for supervision. Training programs placed less emphasis on the use of scientific literature-informed service provision than graduate programs.

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Study/ Publication	Purpose	Design/Method	Major Findings
	in professional psychology.	training programs	One troubling result was that only 19% of sites studied reported using direct observation (e.g., audio or video recordings) as a supervision modality.
Category X: Supplemental Items			
Theoretical			
APA, 2015	To provide guidelines for clinical supervision	Professional guidelines	Domain A: Supervisor Competence - Supervisor (SR) has formal education/training as a SR - SR serves as role model, protects public, and is a gatekeeper for the profession - SR coordinates with others involved in the SE's education/training regarding goals and expectations - SR strives to be competent in use of any technology used for supervision Domain B: Diversity - SR develops diversity competency in self and SE; includes ongoing training, modeling client advocacy, promoting change in organizations/ communities, and maintaining familiarity with literature and identified practices related to these issues - SR is respectful and strives to expand self-awareness - SR is mindful of diversity factors, including oppression and privilege as they relate to the supervisory relationship and client-SE interactions Domain C: Supervisory Relationship - SR is aware of, and works toward maintaining a positive supervisory alliance (e.g., reviewing relational effectiveness, attending to the power differential, and addressing any issues that arise) - SR works collaboratively with SE to promote competence and identify appropriate responsibilities, expectations, learning goals, and performance standards of both parties Domain D: Professionalism - SR teaches and models appropriate comportment, professionalism, and social interactions - SR provides ongoing evaluation of training progress Domain E: Assessment/Evaluation/Feedback - SR provides timely, clear, and developmentally appropriate feedback and evaluations, and does so in a manner that promotes transparency - SR monitors and guides SE's development by reviewing live or recorded sessions, and providing behaviorally-anchored, competency-specific feedback - SR is responsive to SE's reactions to feedback, and is aware of its impact on the supervisory alliance - SR seeks feedback from SE and others regarding supervision effectiveness, as well as the strength of supervisory alliance, and adjusts accordingly - SR encourages SE to develop self-assessment skills Domain F: Problems of Professional Competence - SR is mindful of the gatekeeper role, endeavors to quickly

(continued)

Study/ Publication	Purpose	Design/Method	Major Findings
			- identify and directly address potential issues, and develops/implements appropriate remediation Domain G: Ethics, Legal, and Regulatory Considerations - SR models appropriate, ethical behavior and decision making - SR protects client welfare and is a gatekeeper to the profession - SR provides the SE with clear expectations (e.g., written supervision contract) that includes an explanation of the purpose of supervision, training expectations, clearly defined SR/SE roles, limits of confidentiality, legal and ethical issues, and procedure for resolving ethical dilemmas SR documents SE's progress regarding professional development and skill-building across competency areas
Ellis et al., 2014	STUDY 1: "to develop operational definitions of inadequate and harmful clinical supervision that are grounded in theory and consider multiple perspectives" p. 437 STUDY 2: "to obtain initial data regarding the occurrence of inadequate and harmful clinical supervision from a diverse sample of supervisees in mental health fields" p. 453	STUDY 1: Consensus validation approach 34 clinical supervision experts STUDY 2: Survey of 363 supervisees (81.8% female; 79.9% non-Hispanic White; 56.7% master's degree/7% doctorate) from various MH fields (e.g., clinical psych, counseling, social work, SA, school psych);	-Defined minimally adequate supervision. -Empirically and theoretically derived a framework and taxonomy of 16 inadequate and 21 harmful supervision experiences that can be used to identify de-facto inadequate/harmful supervision experiences independent of supervisee self-report. All experiences deemed "harmful" were also, by default, determined to be inadequate. -96.3% experienced inadequate supervision either currently or in a previous supervision experience. -50.9% experienced supervision experiences that were deemed "harmful." -Examples of harmful supervision may include violating supervisee's boundaries (e.g., emotional intimacy forced on the supervisee, sexual contact); acting physically, emotionally, or psychologically aggressive and abusive toward supervisee; misusing the power differential, making macro- or micro-aggressions toward supervisee; demeaning, critical, vindictive attitude toward supervisee. -Effects of harmful supervision on the supervisee may last from days to years, may harm clients as well, and include psychological trauma (e.g., sense of mistrust, shame), loss of self-confidence, and significant decline in the supervisee's general health.
Falender & Shafranske, 2017 (pp. 22-45)	To define and explain critical components of competency-based clinical supervision	Theoretical discussion	Necessary components include: -Meta-competence, Self-Assessment and Reflective Practice -The Supervisory Relationship: Alliance Formation and Repair -The Supervision Contract -The Learning Cycle

(continued)

Study/ Publication	Purpose	Design/Method	Major Findings
			-Multiculturalism and Diversity -Personal Factors -Legal and Ethical Competencies and Professionalism -Evaluation and Feedback -Self-Care

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APPENDIX B

Institutional Review Board Exemption Notice

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

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: March 05, 2018

Protocol Investigator Name: Sherilyn Incledon

Protocol #: 17-12-694

Project Title: Development of a Preliminary Scale of Counterproductive Experiences in Supervision: Attitudes of Interns

School: Graduate School of Education and Psychology

Dear Sherilyn Incledon:

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

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

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist

APPENDIX C

Comparison of Various Aspects of Effective and Ineffective Supervision and Counterproductive Experiences being Investigated in this Study

Comparison of Various Aspects of Effective and Ineffective Supervision and

Counterproductive Experiences being Investigated in this Study

Guidelines for Clinical Supervision in Health Service Psychology (APA, 2015)	**Components of Supervision Effectiveness** (Falender & Shafranske, 2017, pp. 22-45)	**Minimally Adequate Supervision** (Ellis et al., 2014, p. 439)	**Inadequate Supervision** **(R=reverse scored)** (Ellis et al., 2014, p. 445)	**Inadequate *and* Harmful Supervision** **(R=reverse scored)** (Ellis et al., 2014, pp. 445-446)	**Counterproductive Experiences (CEs)[a]**
Domain A: Supervisor Competence - Supervisor (SR) has formal education/training as a SR - SR serves as role model, protects public, and is a gatekeeper for the profession - SR coordinates with others involved in the SE's education/training regarding goals and expectations - SR strives to be competent in use of any technology used for supervision	-Self-Care	-"Has the proper credentials as defined by the supervisor's discipline or profession" -"Has the appropriate knowledge of and skills for clinical supervision" -"Awareness of his or her limitations"			<u>Cluster 1</u> 1. Supervisor does not possess adequate skills to supervise a particular case (X) 2. Primary supervisor does not possess current knowledge of, adequate skills regarding, and/or actual experience providing, supervision (X) 3. Supervisor lacks knowledge or skill in the competencies required in clinical management and oversight of cases, e.g., lack of knowledge in diagnosis (IV)
Domain B: Diversity - SR develops diversity competency in self and SE; includes ongoing training, modeling client advocacy, promoting change in organizations/ communities, and maintaining familiarity with literature and identified practices related to these issues - SR is respectful and strives to expand self-awareness - SR is mindful of diversity factors, including oppression and privilege as they relate to the supervisory relationship and client-SE interactions	-Multiculturalism and Diversity -Personal Factors	-"Is attentive to multicultural and diversity issues in supervision and in therapy/ counseling"	-"Oblivious to cultural background" -"No interest in cultural background" -"Treats me with respect[R]"		<u>Cluster 2</u> 4. Supervisor does not consider the impact of his/her own and supervisee's cultural identities (V) 5. Supervisor does not encourage the use of culturally appropriate interventions (V) 6. Supervisor uses or assumes cultural/racial stereotypes when discussing clients (V) 7. Supervisor does not consider the impact of the client's cultural identities in diagnosis, case conceptualization, or treatment planning (V)

(continued)

Guidelines for Clinical Supervision in Health Service Psychology (APA, 2015)	**Components of Supervision Effectiveness** (Falender & Shafranske, 2017, pp. 22-45)	**Minimally Adequate Supervision** (Ellis et al., 2014, p. 439)	**Inadequate Supervision** **(R=reverse scored)** (Ellis et al., 2014, p. 445)	**Inadequate *and* Harmful Supervision** **(R=reverse scored)** (Ellis et al., 2014, pp. 445-446)	**Counterproductive Experiences (CEs)[a]**
Domain C: Supervisory Relationship - SR is aware of, and works toward maintaining a positive supervisory alliance (e.g., reviewing relational effectiveness, attending to the power differential, and addressing any issues that arise) - SR works collaboratively with SE to promote competence and identify appropriate responsibilities, expectations, learning goals, and performance standards of both parties	-The Supervisory Relationship: Alliance Formation and Repair	-"Is aware of and attentive to the power differential (and boundaries) between the supervisee and supervisor and its effects on the supervisory relationship" -"Promotes and is invested in the supervisee's welfare, professional growth and development"	-"Supervising my supervisor" -"Locked in conflict" -"Refuses to address issues" -"Relationship is cold and distant" -"Oblivious to interpersonal process" -"Frequently distracted -Supervision is waste of time" -"Not committed" -"Does not listen" -"Never spend time improving skills" -"Does not discuss difficulties with clients" -"Focus only on diagnoses"		<u>Cluster 3</u> 8. Supervisor does not attend to the development of the supervisory relationship (III) 9. Supervisor does not address strains or conflicts between supervisee and supervisor (III) 10. Supervisor does not appropriately structure the supervision session (i.e., there is either too much or too little structure; III) 11. Supervisor is inflexible in his/her approach to supervision (i.e., how supervision is conducted; III) <u>Cluster 4</u> 12. Supervisor and supervisee often differ in which therapeutic approach is best suited to achieve the treatment goals (IV) 13. Supervisor and supervisee often differ in their conceptualization of cases (IV) 14. Supervisor lacks knowledge of the treatment or assessment procedures that the supervisee has been taught in graduate school (IV) 15. Supervisor has limited knowledge about supervisee's theoretical orientation (IV) 16. Supervisor is unresponsive to supervisee's verbalized training/supervision needs (VI) 17. Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his/her professional performance (VI) <u>Cluster 5</u> 18. Supervisor initiates (or attempts to initiate) a dual-relationship with supervisee (e.g., invites supervisee to attend a personal event outside of supervision; VIII) 19. Supervisor asks supervisee to participate in an activity (e.g., edit an article the supervisor wrote for publication, purchase items from supervisor) for the sole benefit of the supervisor (VIII)

(continued)

Guidelines for Clinical Supervision in Health Service Psychology (APA, 2015)	**Components of Supervision Effectiveness** (Falender & Shafranske, 2017, pp. 22-45)	**Minimally Adequate Supervision** (Ellis et al., 2014, p. 439)	**Inadequate Supervision** **(R=reverse scored)** (Ellis et al., 2014, p. 445)	**Inadequate *and* Harmful Supervision** **(R=reverse scored)** (Ellis et al., 2014, pp. 445-446)	**Counterproductive Experiences (CEs)[a]**
Domain C: Supervisory Relationship (continued)					20. Supervisor makes inquiries about inappropriate areas of the supervisee's personal life (e.g., "Are you dating anyone?"; VIII) 21. Supervisor attempts to help the supervisee resolve a personal conflict unrelated to his/her professional performance (VIII) 22. Supervisor misuses power and authority (VIII) <u>Cluster 6</u> 23. Supervisor does not demonstrate respect for the supervisee (IX) 24. Supervisor does not demonstrate empathy for the supervisee (IX) 25. Supervisor demonstrates unnecessary inflexibility (e.g., in scheduling, case conceptualization; IX)
Domain D: Professionalism - SR teaches and models appropriate comportment, professionalism, and social interactions - SR provides ongoing evaluation of training progress		-"Provides a minimum of 1 hr [sic] of face-to-face individual supervision per week"			<u>Cluster 7</u> 26. Supervisor often makes highly personal disclosures about his/her personal life during supervision (II) 27. Supervisor discloses negative opinions about the profession, his/her career, or colleagues/staff/the training site (II) 28. Supervisor discloses negative personal opinions about the supervisee's clients (II) <u>Cluster 8</u> 29. Supervisor unfairly criticizes supervisee's primary theoretical orientation without opportunity for respectful discussion (IV) <u>Cluster 9</u> 30. Supervisor not prepared for supervision (e.g., has not reviewed chart notes or has not reviewed tape of therapy session submitted by supervisee; VI) 31. Supervisor appears to be distracted in supervision (VI) 32. Supervisor has an apathetic attitude toward supervision (VI)

(continued)

Guidelines for Clinical Supervision in Health Service Psychology (APA, 2015)	**Components of Supervision Effectiveness** (Falender & Shafranske, 2017, pp. 22-45)	**Minimally Adequate Supervision** (Ellis et al., 2014, p. 439)	**Inadequate Supervision** **(R=reverse scored)** (Ellis et al., 2014, p. 445)	**Inadequate *and* Harmful Supervision** **(R=reverse scored)** (Ellis et al., 2014, pp. 445-446)	**Counterproductive Experiences (CEs)[a]**
Domain D: Professionalism (continued)					Cluster 10 33. Supervisor sometimes ignores important agency policies or directs the supervisee to do so (VII) Cluster 11 34. Supervisor expresses attraction to supervisee (VIII) Cluster 12 35. Supervisor is frequently late for supervision (IX) 36. Supervisor does not provide guidance about professional development as a psychologist (IX) 37. Inadequate environment/office space is provided for supervision (e.g., supervision conducted in non-confidential location, such as a restaurant; IX)
Domain E: Assessment/Evaluation/ Feedback - SR provides timely, clear, and developmentally appropriate feedback and evaluations, and does so in a manner that promotes transparency - SR monitors and guides SE's development by reviewing live or recorded sessions, and providing behaviorally-anchored, competency-specific feedback - SR is responsive to SE's reactions to feedback, and is aware of its impact on the supervisory alliance - SR encourages SE to develop self-assessment skills	-Meta-competence, Self-Assessment and Reflective Practice -The Learning Cycle -Evaluation and Feedback	-"Provides evaluative feedback to the supervisee that is fair, respectful, honest, ongoing, and formal"	-"No evaluative feedback" -"Discusses strengths^{R}" -"Never discusses professional development"		Cluster 13 38. Supervisor does not encourage the development of mutually agreed upon goals of supervision (I) 39. Supervisor's performance expectations are developmentally inappropriate (i.e., too high or too low in light of the supervisee's experience and competence; I) 40. Supervisor fails to clearly communicate performance expectations to the supervisee (I) 41. Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations (I) Cluster 14 42. Supervisor is often insensitive when giving feedback (e.g., provides feedback in a disrespectful manner, makes critical judgments of supervisee without providing constructive feedback; III) 43. Supervisee and supervisor do not agree about the means to achieve the supervisory goals (i.e., how the training goals will be met; III)

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Guidelines for Clinical Supervision in Health Service Psychology (APA, 2015)	**Components of Supervision Effectiveness** (Falender & Shafranske, 2017, pp. 22-45)	**Minimally Adequate Supervision** (Ellis et al., 2014, p. 439)	**Inadequate Supervision** **(R=reverse scored)** (Ellis et al., 2014, p. 445)	**Inadequate *and* Harmful Supervision** **(R=reverse scored)** (Ellis et al., 2014, pp. 445-446)	**Counterproductive Experiences (CEs)[a]**
Domain E: Assessment/Evaluation/ Feedback (continued) - SR seeks feedback from SE and others regarding supervision effectiveness, as well as the strength of supervisory alliance, and adjusts accordingly					Cluster 15 44. Supervisor does not consider the developmental needs of the supervisee (VI) Cluster 16 45. Supervisor does not regularly provide adequate evaluative feedback (e.g., feedback that assists in the supervisee's development; VII) 46. Supervisor does not consistently review audio/videotapes or provide live supervision of supervisee's clinical work (VII) 47. Supervisor does not consistently review charts/progress notes of supervisee (VII)
Domain F: Problems of Professional Competence - SR is mindful of the gatekeeper role, endeavors to quickly identify and directly address potential issues, and develops/implements appropriate remediation					Cluster 17 48. The supervisor gives the supervisee a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision (I) Cluster 18 49. Supervisor does not appear to address professional competence problems in other trainees (X)
Domain G: Ethics, Legal, and Regulatory Considerations - SR models appropriate, ethical behavior and decision making - SR protects client welfare and is a gatekeeper to the profession - SR provides the SE with clear expectations (e.g., written supervision contract) that includes an explanation of the purpose of supervision, training expectations, clearly defined SR/SE roles, limits of confidentiality, legal and	-The Supervision Contract -Legal and Ethical Competencies and Professionalism	-"Obtains a consent for supervision or uses a supervision contract" -"Observes, reviews, or monitors supervisee's therapy/counseling sessions (or parts thereof)" -"Maintains supervisee confidentiality (as appropriate)"	-"[Does] not use consent or contract" -"Behaves unethically" -"Never observed sessions" -"Clients suffered emotional trauma because of supervision" -"Does not meet for 1 hour per week" -"Not provided adequate supervision for clients" -"Unclear what to do" -"Does not know what to do" -"Highly skilled[R]"	-"Avoids exploitative dual roles[R]" -"Drunk together" -Used drugs together" -"Harmed by supervisor's actions" -"Harmed by inactions" -"Supervision is harmful" -"Traumatized by supervision" -"Have a sexual relationship " -"Have been sexually intimate" -"Supervisor sexually inappropriate"	Cluster 19 50. Supervisor does not help, is not available to discuss (outside of scheduled supervision), and/or tries to avoid involvement with ethical dilemmas or emergency situations (VII) 51. Supervisor directs the supervisee not to file a mandated report (e.g., for child abuse) when the supervisee reports clear instances of abuse, intent to harm, etc. (VII) 52. Supervisor appears intoxicated in a social situation related to the training rotation (e.g., holiday party; VII) 53. Supervisor speaks about clients in a recognizable way (e.g., using their name) in public areas; VII)

(continued)

Guidelines for Clinical Supervision in Health Service Psychology (APA, 2015)	**Components of Supervision Effectiveness** (Falender & Shafranske, 2017, pp. 22-45)	**Minimally Adequate Supervision** (Ellis et al., 2014, p. 439)	**Inadequate Supervision** **(R=reverse scored)** (Ellis et al., 2014, p. 445)	**Inadequate *and* Harmful Supervision** **(R=reverse scored)** (Ellis et al., 2014, pp. 445-446)	**Counterproductive Experiences (CEs)[a]**
Domain G: Ethics, Legal, and Regulatory Considerations (continued) ethical issues, and procedure for resolving ethical dilemmas - SR documents SE's progress regarding professional development and skill-building across competency areas				-"Threatened me physically -"Safe from exploitation[R] -"Is aggressive and abusive" -"Dual relationship was harmful" -"Feel exploited" -"Discriminating toward me" -"Is cruel" -"Feel guilt, embarrassment, shame, or blame" -"Feel safe with supervisor[R]" -"Violated sense of safety" -"Publicly humiliated " -"Pathologizes me" -"Evaluations are victimizing"	54. Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained (VII)55. Supervisor unnecessarily reveals supervisee's personal disclosures to other clinical faculty or staff without any ethical or professional justification (VII) <u>Cluster 20</u> 56. Supervisor has a sexual relationship with supervisee (VIII) 57. Supervisor makes jokes/comments with sexual innuendos (VIII) 58. Supervisor discusses another supervisees' professional clinical performance or clinical competence (VIII) <u>Cluster 21</u> 59. Supervisor fails to provide the minimally required amount of supervision (X) 60. Supervisor does not use a supervision contract (X)

Note. [a]Counterproductive Experiences Categories are indicated in parentheses.

APPENDIX D

Counterproductive Experiences being Investigated in this Study and Corresponding APA Supervisory Domains

Counterproductive Experiences being Investigated in this Study and Corresponding APA Supervisory Domains

Counterproductive Experiences[a]	Corresponding APA Supervisory Domain (APA, 2015)
Category I – Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflict	
38. Supervisor does not encourage the development of mutually agreed upon goals of supervision	Domain E: Assessment/ Evaluation/Feedback
40. Supervisor fails to clearly communicate performance expectations to the supervisee	
39. Supervisor's performance expectations are developmentally inappropriate, i.e., too high or too low in light of the supervisee's experience and competence	
41. Supervisor has changing performance expectations of the supervisee, i.e., inconsistent expectations	
48. The supervisor gives the supervisee a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision	Domain F: Problems of Professional Competence
Category II – Inappropriate Supervisor Self-Disclosure	
26. Supervisor makes highly personal disclosures about his/her personal life during supervision	Domain D: Professionalism
27. Supervisor discloses negative opinions about the profession, his/her career, or colleagues/staff/training site	
28. Supervisor discloses negative personal opinions about the supervisee's clients	
Category III – Supervisory Alliance and Relationship Problems	
*8. Supervisor does not attend to the development of the supervisory relationship	Domain C: Supervisory Relationship
9. Supervisor does not address strains or conflicts between supervisee and supervisor	
10. Supervisor does not appropriately structure the supervision session (i.e., there is either too much or too little structure)	
11. Supervisor is inflexible in his/her approach to supervision, i.e., how supervision is conducted	
43. Supervisee and supervisor do not agree about the means to achieve the supervisory goals, i.e., how the training goals will be met	Domain E: Assessment/ Evaluation/Feedback
42. Supervisor is often insensitive when giving feedback (e.g., provides feedback in a disrespectful manner, makes critical judgments of supervisee without providing constructive feedback)	

(continued)

Counterproductive Experiences[a]	Corresponding APA Supervisory Domain (APA, 2015)
Category IV – Supervisor/Supervisee Style and Competence Issues	
*3. Supervisor lacks knowledge or skill in the competencies required in clinical management and oversight of cases, e.g., lack of knowledge in diagnosis	Domain A: Supervisor Competence
13. Supervisor and supervisee often differ in their conceptualization of cases 14. Supervisor lacks knowledge of the treatment or assessment procedures that the supervisee has been taught in graduate school 15. Supervisor has limited knowledge about supervisee's theoretical orientation 12. Supervisor and supervisee often differ in which therapeutic approach is best suited to achieve the treatment goals	Domain C: Supervisory Relationship
29. Supervisor unfairly criticizes supervisee's primary theoretical orientation without opportunity for respectful discussion	Domain D: Professionalism
Category V – Cultural Insensitivity	
4. Supervisor does not consider the impact of his/her own and/or supervisee's cultural identities 5. Supervisor does not encourage the use of culturally appropriate interventions 6. Supervisor uses or assumes cultural/racial stereotypes when discussing clients 7. Supervisor does not consider the impact of the client's cultural identities in diagnosis, case conceptualization, or treatment planning	Domain B: Diversity
Category VI – Failure to Address Needs of the Supervisee	
16. Supervisor is unresponsive to supervisee's verbalized training/supervision needs 17. Supervisor is unresponsive to supervisee's disclosures about personal difficulties affecting his/her professional performance	Domain C: Supervisory Relationship
31. Supervisor appears to be distracted in supervision *30. Supervisor not prepared for supervision (e.g., has not reviewed chart notes or has not reviewed tape of therapy session submitted by supervisee)* *32. Supervisor has an apathetic attitude toward supervision*	Domain D: Professionalism
44. Supervisor does not consider the developmental needs of the supervisee	Domain E: Assessment/ Evaluation/Feedback

(continued)

Counterproductive Experiences[a]	Corresponding APA Supervisory Domain (APA, 2015)
Category VII – Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior	
45. Supervisor does not regularly provide adequate evaluative feedback, i.e., feedback that assists in the supervisee's development)	Domain E: Assessment/ Evaluation/Feedback
46. Supervisor does not consistently review audio/videotapes or provide live supervision of supervisee's clinical work	
47. Supervisor does not consistently review charts/progress notes of supervisee	
33 Supervisor sometimes ignores important agency policies or directs the supervisee to do so	Domain D: Professionalism
54. Supervisor directs the supervisee to use a therapeutic approach in which the supervisee has not been adequately trained	Domain G: Ethics, Legal, and Regulatory Considerations
52. Supervisor appears intoxicated in a social situation related to the training rotation (e.g., holiday party)	
53. Supervisor speaks about clients in a recognizable way, e.g., using their names, in public areas	
51. Supervisor directs the supervisee not to file a mandated report (e.g. for child abuse) when the supervisee reports clear instances of abuse, intent to harm, etc.	
50. Supervisor does not help, is not available to discuss (outside of scheduled supervision), and/or tries to avoid involvement with ethical dilemmas or emergency situations	
55. Supervisor unnecessarily discloses supervisee's personal disclosures to other clinical faculty or staff without any ethical or professional justification	
Category VIII – Boundary Crossings/Violations	
18. Supervisor initiates (or attempts to initiate) a dual-relationship with supervisee (e.g., invites supervisee to attend a personal event outside of supervision)	Domain C: Supervisory Relationship
19. Supervisor asks supervisee to participate in an activity (e.g., edit an article the supervisor wrote for publication, purchase items from supervisor) for the sole benefit of the supervisor	
20. Supervisor makes inquiries about inappropriate areas of the supervisee's personal life (e.g., "Are you dating anyone?")	
21. Supervisor attempts to help the supervisee resolve a personal conflict unrelated to his/her professional performance	
22. Supervisor misuses power and authority	
34. Supervisor expresses attraction to supervisee	Domain D: Professionalism
58. Supervisor discusses another supervisee's professional clinical performance or clinical competence	Domain G: Ethics, Legal, and Regulatory Considerations
56. Supervisor has a sexual relationship with supervisee	
57. Supervisor makes jokes/comments with sexual innuendos	

(continued)

Counterproductive Experiences[a]	Corresponding APA Supervisory Domain (APA, 2015)
Category IX – Additional Counterproductive Experiences	
23. Supervisor does not demonstrate respect for the supervisee	Domain C: Supervisory Relationship
24. Supervisor does not demonstrate empathy for the supervisee	
25. Supervisor demonstrates unnecessary inflexibility (e.g., in scheduling, case conceptualization	
35. Supervisor is frequently late for supervision	Domain D: Professionalism
36. Supervisor does not provide guidance about professional development as a psychologist	
37. Inadequate environment/office space is provided for supervision (e.g., supervision conducted in a non-confidential location, such as a restaurant)	
Category X – Supplemental Items	
*1. Supervisor does not possess adequate skills to supervise a particular case	Domain A: Supervisor Competence
*2. Primary supervisor does not possess current knowledge of, adequate skills regarding, and/or actual experience providing, supervision	
*49. Supervisor does not appear to address professional competence problems in other trainees	Domain F: Problems of Professional Competence
*60. Supervisor does not use a supervision contract	Domain G: Ethics, Legal, and Regulatory Considerations
*59. Supervisor fails to provide the minimally required amount of supervision	

Note. [a]Counterproductive experiences added to this study based on suggestions collected from supervision experts during Kakavand's (2014) study are italicized.
*Counterproductive experiences added to this study based on theoretical and empirical literature.

APPENDIX E

Demographic Questionnaire

Demographic Questionnaire

Instructions: For each item, please select the answer choice that is most appropriate for you. If there is not an answer that is appropriate, select "other" and type your response in the box provided. If you prefer not to answer any item, you may leave it blank.

1. Type of doctoral program:
A. Clinical
B. Counseling
C. School
D. Combined
E. Other _____

2. Degree sought:
A. Ph.D.
B. Psy.D.
C. Ed.D.
D. Other _____

3. Is your doctoral program APA or CPA accredited?
A. Yes
B. No

4. Which of the following best describes your primary theoretical orientation?
A. Cognitive-Behavioral (including cognitive and behavioral)
B. Existential/Humanistic
C. Family Systems
D. Psychodynamic
E. Other _____

5. What is your age?
A. 18-30 years
B. 31-40 years
C. 41-50 years
D. 51-60 years
E. 61 years or over

6. With which gender do you identify?
A. Female
B. Male
C. Other (trans, intersex) _____

7. Which of the following best describes your racial/ethnic identification? Check all that apply.
A. African-American/Black
B. American Indian/Alaskan Native
C. Asian/Pacific Islander
D. Hispanic/Latino
E. White (non-Hispanic)
F. Bi-racial/Multi-racial
G. Other _____

9. My current predoctoral internship program is accredited by:
A. APPIC
B. APA
C. CPA
D. CAPIC
E. It is not accredited
F. Other _____

APPENDIX F

Recruitment Email to Training Directors

Subject: Invitation for Pre-Doctoral Intern Research Participation

Dear Training Director:

My name is Carey Incledon and I am a doctoral candidate in the Graduate School of Education and Psychology program at Pepperdine University, working on a dissertation under the supervision of Edward Shafranske, Ph.D., ABPP, in the Clinical Supervision, Training, and Professional Development Research Center. I am conducting a research study examining the opinions of psychology trainees currently completing predoctoral internships at Association of Psychology Postdoctoral and Internship Centers (APPIC) member sites as listed in the APPIC directory for the 2017-2018 year. These interns will be asked to go online to rate and rank the expected impact of a list of *hypothetical supervision experiences.* They will not be asked to disclose any information about their experiences of supervision during internship nor identifying information regarding their academic and training programs as part of this study. These opinions are greatly needed to aid future efforts to train supervisors and trainees.

Participation is this study poses no greater than *minimal risk* to participants since the probability **and** magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. Participants will be asked their opinions about the impact of hypothetical supervision experiences. Should they feel any discomfort, participants are advised to seek consultation from a trusted professional, colleague, or Drs. Shafranske or Falender, who have broad experience in supervision. This study has been approved by the Institutional Review Board at Pepperdine University.

I am contacting all APPIC-member internship sites and requesting their assistance with this study. **It would be very much appreciated if you would kindly forward this email, along with the attached Invitation for Research Participation document, to your interns.**

If you have any questions or comments, please do not hesitate to contact me, at carey.incledon@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, at edward.shafranske@pepperdine.edu; Dr. Carol Falender, Committee Member at Carol.Falender@pepperdine.edu, or Dr. Judy Ho, Chairperson of the Pepperdine University Graduate and Professional Schools Institutional Review Board, at gpsirb@pepperdine.edu.

Thank you very much for your support of this study.

Sincerely,

Carey Incledon, M.A.
Clinical Psychology Doctoral Candidate
Graduate School of Education and Psychology
Pepperdine University

(Attach Appendix G: Invitation for Predoctoral Intern Research Participation letter)

APPENDIX G

Invitation for Pre-Doctoral Intern Research Participation

Dear Psychology Intern:

My name is Carey Incledon and I am a doctoral candidate in the Graduate School of Education and Psychology program at Pepperdine University, working on a dissertation under the supervision of Edward Shafranske, Ph.D., ABPP, in the Clinical Supervision, Training, and Professional Development Research Center. I am conducting a research study examining the opinions of psychology interns regarding the expected impact of hypothetical supervision experiences, and you are invited to participate in the study.

As a predoctoral intern, you have navigated multiple supervisory experiences and undoubtedly have opinions about which you feel were effective (and not so effective). **I believe you are in the unique position of offering invaluable insights about the impact of the particular supervision experiences being studied.** Your opinions are greatly needed to aid future efforts to train supervisors and trainees. If you agree, you will be asked to complete a brief (i.e., 15-20 minute) online survey that will record your opinions about the impact of hypothetical supervision experiences.

Participation in this study is voluntary and poses no greater than *minimal risk* to participants since the probability **and** magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. Furthermore, no identifying information will be collected so your identity will remain anonymous during and after the study. Should you feel any discomfort during or after your participation in the study, you are advised to seek consultation from a trusted professional, colleague, or Drs. Shafranske or Falender, who have broad experience in supervision. This study has been approved by the Institutional Review Board at Pepperdine University.

Participation is open to all current psychology interns completing predoctoral internships accredited by either APPIC, APA, or CPA. **If you would like to participate, please follow the link at the bottom of this letter.** Upon completion of this study, you will be given instructions about how to enter a drawing for one of four $25 gift certificates to Amazon. If you choose not to participate, you can still enter the drawing by sending an email to carey.incledon@pepperdine.edu with "CE Study Drawing" in the subject line. *Please feel free to forward this invitation to any psychology interns you know.*

If you have any questions or comments, please do not hesitate to contact me, at carey.incledon@pepperdine.edu. You may also contact Dr. Edward Shafranske, Dissertation Chairperson, at edward.shafranske@pepperdine.edu; Dr. Carol Falender, Committee Member at Carol.Falender@pepperdine.edu, or Dr. Judy Ho, Chairperson of the Pepperdine University Graduate and Professional Schools Institutional Review Board, at gpsirb@pepperdine.edu.

Thank you very much for your support of this study.

Sincerely,

Carey Incledon, M.A.
Clinical Psychology Doctoral Candidate
Graduate School of Education and Psychology
Pepperdine University

(Insert Appendix I – the Information Sheet – here, with a link to the study website.)

APPENDIX H

Follow-up Email to Training Directors

Subject: Thank you -- Invitation for Pre-Doctoral Intern Research Participation

Dear Training Director:

A few weeks ago, I sent you a request to forward an Invitation for Predoctoral Intern Research Participation to your current interns. I wanted to sincerely thank you for supporting this research and allowing your interns to play an important role in informing future supervision and training practices. If you have not yet had a chance to forward the Invitation to your interns, I would appreciate it if you would please consider doing so now so your interns can participate; the Invitation letter is attached below for your convenience. Thank you very much.

Sincerely,

Carey Incledon, M.A.
Clinical Psychology Doctoral Candidate
Graduate School of Education and Psychology
Pepperdine University

(Attach Appendix G: Invitation for Predoctoral Intern Research Participation letter)

APPENDIX I

Information/Fact Sheet for Exempt Research

PEPPERDINE UNIVERSITY

Graduate School of Education and Psychology

INFORMATION/FACTS SHEET FOR EXEMPT RESEARCH

DEVELOPMENT OF A PRELIMINARY SCALE OF COUNTERPRODUCTIVE EXPERIENCES IN SUPERVISION: ATTITUDES OF INTERNS

You are invited to participate in a research study conducted by Carey Incledon, M.A., and Edward Shafranske, Ph.D., ABPP at Pepperdine University, because you are a predoctoral intern currently completing an APPIC-, APA-, or CPA-accredited internship. Your participation is voluntary. You should read the information below and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends.

PURPOSE OF THE STUDY

The purpose of the study is to continue work aimed toward developing an empirically validated instrument to aid researchers in studying the frequency, effects, causes and types of counterproductive experiences that occur within the context of clinical supervision. The results of this study are intended to aid future efforts to train supervisors and trainees.

PARTICIPANT INVOLVEMENT

If you agree to voluntarily take part in this study, you will be asked to complete an online survey which is anticipated to take about 15-20 minutes. You do not have to answer any questions you don't want to, click "next" or "N/A" in the survey to move to the next question.

PAYMENT/COMPENSATION FOR PARTICIPATION

Upon completion of this study, you will have the option to participate in a drawing for one of four $25 gift certificates to Amazon. This drawing will be held following the study's data collection period and winners will receive the gift certificate via email. If you choose not to participate, you can still enter the drawing (see the Invitation for Predoctoral Intern Research Participation for instructions). If you choose to participate in this drawing, you will be asked to provide an email address, though this email address will not be associated with your study data in any way and any record of your email address will be destroyed once the gift certificates have been awarded. However, it is possible that your anonymity as a general participant in this study could be compromised since the primary researcher may learn your identity through your email address. The primary investigator will randomly select and then contact drawing winners via the provided email address; winners will also receive an email from Amazon.com with a claim code for the gift certificate.

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 not waiving any legal claims, rights, or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items which you feel comfortable.

CONFIDENTIALITY

I will keep your records for this study anonymous as far as permitted by law. However, if I am required to do so by law, I may be required to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me about instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

Study data will be stored on a password-protected computer in the researcher's office for five years after the study has been completed and then destroyed. There will be no identifiable information obtained in connection with this study. Your name, address or other identifiable information will not be collected. However, as noted above, it is possible that your anonymity as a *general* participant in this study could be compromised if you provide your email address for the post-study drawing (though your email address will not be associated with your study data in any way).

INVESTIGATOR'S CONTACT INFORMATION

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Carey Incledon, M.A. at carey.incledon@pepperdine.edu or Dr. Edward Shafranske, Dissertation Chairperson, at edward.shafrasnke@pepperdine.edu if I have any other questions or concerns about this research.

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 any time, for any reason without penalty.

You Agree to Participate *(Insert link to study here)*

You Do Not Wish to Participate

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

APPENDIX J

Rating and Ranking Survey Results

Table J1

Rating and Ranking Survey Results – Domains/Clusters

Counterproductive Experiences (Category)[a]	Adverse Impact Rating *N*	SigE =3	ModE =2	MinE =1	NoE =0	MRS[b] *(SD)*	Rank Order *N*	1	2	3	4	5	6	*M*[c] *(SD)*
Domain A: Supervisor Competence														
Cluster 1														
•3. SR lacks knowledge or skill in the competencies required in clinical management and oversight of cases, e.g., lack of knowledge in diagnosis (IV)	182	113	56	12	1	**2.54** (0.64)	180	101	56	23	--	--	--	2.43 (0.71)
•2. Primary SR does not possess current knowledge of, adequate skills regarding, and/or actual experience providing, supervision (X)	182	72	83	26	1	**2.24** (0.71)	179	48	74	57	--	--	--	1.95 (0.77)
•1. SR does not possess adequate skills to supervise a particular case (X)	182	48	83	48	3	1.97 (0.77)	180	32	50	98	--	--	--	1.63 (0.77)
Domain B: Diversity														
Cluster 2														
6. *SR uses or assumes cultural/racial stereotypes when discussing clients* (V)	176	132	35	8	1	**2.69** (0.58)	174	103	34	27	10	--	--	3.32 (0.90)
7. SR does not consider the impact of the client's cultural identities in diagnosis, case conceptualization, or treatment planning (V)	176	92	71	10	3	**2.43** (0.68)	174	51	78	30	15	--	--	2.95 (0.90)
4. SR does not consider the impact of his/her own and SE's cultural identities (V)	176	56	80	39	1	**2.09** (0.75)	173	17	32	46	78	--	--	1.93 (1.01)
5. SR does not encourage the use of culturally appropriate interventions (V)	176	51	85	37	3	**2.05** (0.75)	173	5	28	69	71	--	--	1.81 (0.81)

(continued)

Counterproductive Experiences (Category)[a]	Adverse Impact Rating						Rank Order							
	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS[b] *(SD)*	*N*	1	2	3	4	5	6	*M*[c] *(SD)*
Domain C: Supervisory Relationship														
Cluster 3														
9. SR *does not address strains or conflicts between SE and SR (III)*	165	104	50	10	1	**2.56** (0.64)	165	91	40	24	10	--	--	3.28 (0.93)
11. SR is inflexible in his/her approach to supervision (i.e., how supervision is conducted; III)	165	58	78	26	3	**2.16** (0.75)	165	41	52	45	27	--	--	2.65 (1.03)
•8. SR does not attend to the development of the supervisory relationship (III)	165	37	82	44	2	1.93 (0.73)	164	26	52	53	33	--	--	2.43 (0.99)
10. SR does not appropriately structure the supervision session (i.e., there is either too much or too little structure; III)	165	18	67	74	6	1.59 (0.73)	164	6	20	44	94	--	--	1.62 (0.84)
Cluster 4														
16. SR *is unresponsive to SE's verbalized training/supervision needs* (VI)	165	137	23	4	1	**2.79** (0.50)	165	89	53	10	6	5	2	5.27 (1.07)
17. SR is unresponsive to SE's disclosures about personal difficulties affecting his/her professional performance (VI)	165	116	38	9	2	**2.62** (0.65)	164	53	67	9	11	10	14	4.61 (1.56)
14. SR lacks knowledge of the treatment or assessment procedures that the SE has been taught in graduate school (IV)	165	36	68	52	9	1.79 (0.84)	164	8	11	38	34	38	35	2.85 (1.42)
13. SR and SE often differ in their conceptualization of cases (IV)	165	23	75	61	6	1.70 (0.75)	164	3	6	31	43	37	44	2.55 (1.27)
12. SR and SE often differ in which therapeutic approach is best suited to achieve the treatment goals (IV)	165	26	66	65	8	1.67 (0.80)	164	4	16	33	38	35	38	*2.79 (1.39)
15. SR has limited knowledge about SE's theoretical orientation (IV)	165	20	72	70	3	1.66 (0.71)	163	8	12	44	34	36	29	*2.99 (1.40)

(continued)

Counterproductive Experiences (Category)[a]	Adverse Impact Rating						Rank Order							
	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS[b] *(SD)*	*N*	1	2	3	4	5	6	*M*[c] *(SD)*
Cluster 5														
♦22. SR misuses power and authority (VIII)	165	158	5	1	1	**2.94** (0.32)	165	146	10	3	2	4	--	4.77 (0.76)
19. SR asks SE to participate in an activity (e.g., edit an article the SR wrote for publication, purchase items from supervisor) for the sole benefit of the SR (VIII)	165	62	57	37	9	**2.04** (0.90)	164	6	61	45	30	22	--	2.99 (1.12)
20. SR makes inquiries about inappropriate areas of the SE's personal life (e.g., "Are you dating anyone?"; VIII)	165	45	66	45	9	1.89 (0.87)	165	9	43	53	40	20	--	2.88 (1.10)
18. SR initiates (or attempts to initiate) a dual-relationship with SE (e.g., invites SE to attend a personal event outside of supervision; VIII)	165	37	49	58	21	1.62 (0.97)	163	10	30	38	41	44	--	2.52 (1.24)
21. SR attempts to help the SE resolve a personal conflict unrelated to his/her professional performance (VIII)	165	26	56	56	27	1.49 (0.94)	164	5	18	23	46	72	--	2.01 (1.14)
Cluster 6														
23. *SR does not demonstrate respect for the SE* (IX)	165	152	12	0	1	**2.91** (0.34)	165	133	24	8	--	--	--	2.76 (0.53)
24. SR does not demonstrate empathy for the SE (IX)	165	112	42	11	0	**2.61** (0.61)	165	20	10 5	40	--	--	--	1.88 (0.59)
25. SR demonstrates unnecessary inflexibility (e.g., in scheduling, case conceptualization; IX)	165	75	73	16	1	**2.35** (0.68)	164	10	37	11 7	--	--	--	1.35 (0.59)
Domain D: Professionalism														
Cluster 7														
28. SR discloses negative personal opinions about the SE's clients (II)	165	43	80	37	5	1.98 (0.78)	164	70	61	33	--	--	--	2.23 (0.76)
27. SR discloses negative opinions about the profession, his/her career, or colleagues/staff/the training site (II)	165	32	79	48	6	1.83 (0.78)	164	48	65	51	--	--	--	1.98 (0.78)
26. SR often makes highly personal disclosures about his/her personal life during supervision (II)	165	28	63	60	14	1.64 (0.86)	163	44	41	78	--	--	--	1.79 (0.84)

Counterproductive Experiences (Category)[a]	Adverse Impact Rating						Rank Order							
	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS[b] *(SD)*	*N*	1	2	3	4	5	6	*M*[c] *(SD)*
Cluster 8														
29. SR unfairly criticizes SE's primary theoretical orientation without opportunity for respectful discussion (IV)	165	100	53	10	2	**2.52** (0.67)	162	162	--	--	--	--	--	--
Cluster 9														
♦32. SR has an apathetic attitude toward supervision (VI)	165	94	55	13	3	**2.45** (0.72)	165	109	30	26	--	--	--	2.50 (0.75)
31. SR appears to be distracted in supervision (VI)	165	47	85	31	2	**2.07** (0.72)	165	37	96	32	--	--	--	2.03 (0.65)
♦30. SR not prepared for supervision (e.g., has not reviewed chart notes or has not reviewed tape of therapy session submitted by SE; VI)	165	17	70	74	4	1.61 (0.70)	163	19	40	104	--	--	--	1.48 (0.70)
Cluster 10														
33. SR sometimes ignores important agency policies or directs the SE to do so (VII)	165	78	69	14	4	**2.34** (0.74)	159	159	--	--	--	--	--	--
Cluster 11														
34. *SR expresses attraction to SE* (VIII)	165	153	7	3	2	**2.88** (0.46)	159	159	--	--	--	--	--	--
Cluster 12														
37. Inadequate environment/office space is provided for supervision (e.g., supervision conducted in non-confidential location, such as a restaurant; IX)	165	63	63	33	6	**2.11** (0.85)	163	69	50	44	--	--	--	2.15 (0.82)
36. SR does not provide guidance about professional development as a psychologist (IX)	165	42	71	45	7	1.90 (0.83)	164	54	49	61	--	--	--	1.96 (0.84)
35. SR is frequently late for supervision (IX)	165	35	76	49	5	1.85 (0.78)	163	35	67	61	--	--	--	1.84 (0.75)

(continued)

Counterproductive Experiences (Category)[a]	Adverse Impact Rating						Rank Order							
	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS[b] *(SD)*	*N*	1	2	3	4	5	6	*M*[c] *(SD)*
Domain E: Assessment/Evaluation/Feedback														
Cluster 13														
41. SR has changing performance expectations of the SE, i.e., inconsistent expectations (I)	165	131	33	1	0	**2.79** (0.42)	164	88	36	29	11	--	--	3.23 (0.97)
40. SR fails to clearly communicate performance expectations to the SE (I)	165	98	54	13	0	**2.52** (0.64)	163	40	65	38	20	--	--	2.77 (0.96)
39. Supervisor's performance expectations are developmentally inappropriate (i.e., too high or too low in light of the SE's experience and competence; I)	165	81	72	11	1	**2.41** (0.64)	163	28	50	60	25	--	--	2.50 (0.95)
38. SR does not encourage the development of mutually agreed upon goals of supervision (I)	165	38	85	39	3	1.96 (0.73)	162	11	11	35	105	--	--	1.56 (0.89)
Cluster 14														
42. *SR is often insensitive when giving feedback (e.g., provides feedback in a disrespectful manner, makes critical judgments of SE without providing constructive feedback; III)*	164	135	25	3	1	**2.79** (0.49)	163	149	14	--	--	--	--	1.91 (0.28)
43. SE and SR do not agree about the means to achieve the supervisory goals (i.e., how the training goals will be met; III)	165	43	82	37	3	**2.00** (0.75)	163	14	149	--	--	--	--	1.09 (0.28)
Cluster 15														
44. SR does not consider the developmental needs of the SE (VI)	164	79	68	16	1	**2.37** (0.68)	153	153	--	--	--	--	--	--
Cluster 16														
45. SR does not regularly provide adequate evaluative feedback (e.g., feedback that assists in the SE's development; VII)	165	58	78	28	1	**2.17** (0.72)	163	131	20	12	--	--	--	2.73 (0.59)

(continued)

Counterproductive Experiences (Category)[a]	Adverse Impact Rating						Rank Order							
	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS[b] *(SD)*	*N*	1	2	3	4	5	6	*M*[c] *(SD)*
Cluster 16 (continued)														
47. SR does not consistently review charts/progress notes of SE (VII)	165	26	79	52	8	1.75 (0.78)	163	19	93	51	--	--	--	1.80 (0.63)
46. SR does not consistently review audio/videotapes or provide live supervision of SE's clinical work (VII)	165	10	55	84	16	1.36 (0.74)	162	13	51	98	--	--	--	1.48 (0.64)
Domain F: Problems of Professional Competence														
Cluster 17														
♦48.The SR gives the SE a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision (I)	165	156	6	2	1	**2.92** (0.36)	152	152	--	--	--	--	--	--
Cluster 18														
•49. SR does not appear to address professional competence problems in other trainees (X)	164	58	75	23	8	**2.12** (0.82)	150	150	--	--	--	--	--	--
Domain G: Ethics/Legal/Regulatory Considerations														
Cluster 19														
51. *SR directs the SE not to file a mandated report (e.g., for child abuse) when the SE reports clear instances of abuse, intent to harm, etc. (VII)*	164	148	11	1	4	**2.85** (0.54)	162	81	50	19	6	4	2	5.19 (1.08)
♦55. SR unnecessarily reveals SE's personal disclosures to other clinical faculty or staff without any ethical or professional justification (VII)	164	127	30	6	1	**2.73** (0.56)	162	42	53	35	20	5	7	4.53 (1.31)
50. SR does not help, is not available to discuss (outside of scheduled supervision), and/or tries to avoid involvement with ethical dilemmas or emergency situations (VII)	164	129	27	7	1	**2.73** (0.56)	163	38	35	40	30	15	5	4.22 (1.39)

(continued)

Counterproductive Experiences (Category)[a]	Adverse Impact Rating						Rank Order							
	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS[b] *(SD)*	*N*	1	2	3	4	5	6	*M*[c] *(SD)*
Cluster 19 (continued)														
53. *SR speaks about clients in a recognizable way (e.g., using their name) in public areas; VII)*	164	83	54	24	3	**2.32** (0.79)	161	5	10	45	61	34	6	3.21 (1.06)
54. SR directs the SE to use a therapeutic approach in which the SE has not been adequately trained (VII)	164	26	103	31	4	1.92 (0.66)	161	2	5	12	33	63	46	2.21 (1.11)
♦52. SR appears intoxicated in a social situation related to the training rotation (e.g., holiday party; VII)	164	32	54	49	29	1.54 (1.00)	162	0	9	11	11	36	95	1.78 (1.18)
Cluster 20														
♦56. SR has a sexual relationship with SE (VIII)	164	159	2	0	3	**2.93** (0.42)	163	152	6	5	--	--	--	2.90 (0.39)
57. *SR makes jokes/comments with sexual innuendos (VIII)*	164	120	30	11	3	**2.63** (0.69)	163	10	115	38	--	--	--	1.83 (0.52)
58. SR discusses another SEs' professional clinical performance or clinical competence (VIII)	164	86	56	19	3	**2.37** (0.76)	162	4	42	116	--	--	--	1.31 (0.51)
Cluster 21														
•59. SR fails to provide the minimally required amount of supervision (X)	164	94	54	14	2	**2.46** (0.70)	162	155	7	--	--	--	--	1.96 (0.20)
•60. SR does not use a supervision contract (X)	164	19	41	59	45	1.21 (0.97)	162	8	154	--	--	--	--	1.05 (0.22)

Note. MRS = mean ranking score; SR = supervisor; SE = supervisee; *N* = number of responses; NoE = No Effect; MinE = Minimal Effect; ModE = Moderate Effect; SigE = Significant/Major Effect; M=mean; *SD* = standard deviation.

[a]Items with MRS ≥2.0 from Kakavand (2014) study are italicized; a diamond (♦) indicates new items suggested during Kakavand's study; a dot (•) indicates new items added to target aspects of APA Guidelines (2015) not covered by other categories.

[b]Mean rating scores of ≥2.0 (Moderate-Significant/Major Effect) are shown in bold.

[c]This column shows mean ranking scores; items with asterisks (*) are listed out of rank order.

Table J2

Rating and Ranking Survey Results – Categories

Counterproductive Experiences	*N*	Adverse Impact Rating SigE =3	ModE =2	MinE =1	NoE =0	MRS *(SD)*
Category I – Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflict						
♦48.The SR gives the SE a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision	165	156	6	2	1	**2.92** (0.36)
41. SR has changing performance expectations of the SE, i.e., inconsistent expectations	165	131	33	1	0	**2.79** (0.42)
40. SR fails to clearly communicate performance expectations to the SE	165	98	54	13	0	**2.52** (0.64)
39. Supervisor's performance expectations are developmentally inappropriate (i.e., too high or too low in light of the SE's experience and competence)	165	81	72	11	1	**2.41** (0.64)
38. SR does not encourage the development of mutually agreed upon goals of supervision	165	38	85	39	3	1.96 (0.73)
Category II – Inappropriate Supervisor Self-Disclosure						
28. SR discloses negative personal opinions about the SE's clients	165	43	80	37	5	1.98 (0.78)
27. SR discloses negative opinions about the profession, his/her career, or colleagues/staff/the training site	165	32	79	48	6	1.83 (0.78)
26. SR often makes highly personal disclosures about his/her personal life during supervision	165	28	63	60	14	1.64 (0.86)
Category III – Supervisory Alliance and Relationship Problems						
42. *SR is often insensitive when giving feedback (e.g., provides feedback in a disrespectful manner, makes critical judgments of SE without providing constructive feedback)*	164	135	25	3	1	**2.79** (0.49)
9. SR *does not address strains or conflicts between SE and SR*	165	104	50	10	1	**2.56** (0.64)

(continued)

Counterproductive Experiences	*N*	Adverse Impact Rating SigE =3	ModE =2	MinE =1	NoE =0	MRS *(SD)*
Category III (continued)						
11. SR is inflexible in his/her approach to supervision (i.e., how supervision is conducted)	165	58	78	26	3	**2.16** (0.75)
43. SE and SR do not agree about the means to achieve the supervisory goals (i.e., how the training goals will be met)	165	43	82	37	3	**2.00** (0.75)
•8. SR does not attend to the development of the supervisory relationship	165	37	82	44	2	1.93 (0.73)
10. SR does not appropriately structure the supervision session (i.e., there is either too much or too little structure)	165	18	67	74	6	1.59 (0.73)
Category IV – Supervisor/Supervisee Style and Competence						
•3. SR lacks knowledge or skill in the competencies required in clinical management and oversight of cases, e.g., lack of knowledge in diagnosis	182	113	56	12	1	**2.54** (0.64)
29. SR unfairly criticizes SE's primary theoretical orientation without opportunity for respectful discussion	165	100	53	10	2	**2.52** (0.67)
14. SR lacks knowledge of the treatment or assessment procedures that the SE has been taught in graduate school	165	36	68	52	9	1.79 (0.84)
13. SR and SE often differ in their conceptualization of cases	165	23	75	61	6	1.70 (0.75)
15. SR has limited knowledge about SE's theoretical orientation	165	26	66	65	8	1.67 (0.80)
12. SR and SE often differ in which therapeutic approach is best suited to achieve the treatment goals	165	20	72	70	3	1.66 (0.71)
Category V – Cultural Insensitivity						
6. *SR uses or assumes cultural/racial stereotypes when discussing clients*	176	132	35	8	1	**2.69** (0.58)
7. SR does not consider the impact of the client's cultural identities in diagnosis, case conceptualization, or treatment planning	176	92	71	10	3	**2.43** (0.68)
4. SR does not consider the impact of his/her own and SE's cultural identities	176	56	80	39	1	**2.09** (0.75)
5. SR does not encourage the use of culturally appropriate interventions	176	51	85	37	3	**2.05** (0.75)

(continued)

Counterproductive Experiences	*N*	Adverse Impact Rating SigE =3	ModE =2	MinE =1	NoE =0	MRS *(SD)*
Category VI – Failure to Address Needs of the Supervisee						
16. SR *is unresponsive to SE's verbalized training/supervision needs*	165	137	23	4	1	**2.79** (0.50)
17. SR is unresponsive to SE's disclosures about personal difficulties affecting his/her professional performance	165	116	38	9	2	**2.62** (0.65)
♦32. SR has an apathetic attitude toward supervision	165	94	55	13	3	**2.45** (0.72)
44. SR does not consider the developmental needs of the SE	164	79	68	16	1	**2.37** (0.68)
31. SR appears to be distracted in supervision	165	47	85	31	2	**2.07** (0.72)
♦30. SR not prepared for supervision (e.g., has not reviewed chart notes or has not reviewed tape of therapy session submitted by SE)	165	17	70	74	4	1.61 (0.70)
Category VII – Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior						
51. *SR directs the SE not to file a mandated report (e.g., for child abuse) when the SE reports clear instances of abuse, intent to harm, etc.*	164	148	11	1	4	**2.85** (0.54)
♦55. SR unnecessarily reveals SE's personal disclosures to other clinical faculty or staff without any ethical or professional justification	164	129	27	7	1	**2.73** (0.56)
50. SR does not help, is not available to discuss (outside of scheduled supervision), and/or tries to avoid involvement with ethical dilemmas or emergency situations	164	127	30	6	1	**2.73** (0.56)
33. SR sometimes ignores important agency policies or directs the SE to do so	165	78	69	14	4	**2.34** (0.74)
53. *SR speaks about clients in a recognizable way (e.g., using their name) in public areas)*	164	83	54	24	3	**2.32** (0.79)
45. SR does not regularly provide adequate evaluative feedback (e.g., feedback that assists in the SE's development)	165	58	78	28	1	**2.17** (0.72)
54. SR directs the SE to use a therapeutic approach in which the SE has not been adequately trained	164	26	103	31	4	1.92 (0.66)
47. SR does not consistently review charts/progress notes of SE	165	26	79	52	8	1.75 (0.78)
♦52. SR appears intoxicated in a social situation related to the training rotation (e.g., holiday party)	164	32	54	49	29	1.54 (1.00)
46. SR does not consistently review audio/videotapes or provide live supervision of SE's clinical work	165	10	55	84	16	1.36 (0.74)

(continued)

Counterproductive Experiences	*N*	Adverse Impact Rating SigE =3	ModE =2	MinE =1	NoE =0	MRS *(SD)*
Category VIII – Boundary Crossings/Violations						
♦22. SR misuses power and authority	165	158	5	1	1	**2.94** (0.32)
♦56. SR has a sexual relationship with SE	164	159	2	0	3	**2.93** (0.42)
34. *SR expresses attraction to SE*	165	153	7	3	2	**2.88** (0.46)
57. *SR makes jokes/comments with sexual innuendos*	164	120	30	11	3	**2.63** (0.69)
58. SR discusses another SEs' professional clinical performance or clinical competence	164	86	56	19	3	**2.37** (0.76)
19. SR asks SE to participate in an activity (e.g., edit an article the SR wrote for publication, purchase items from supervisor) for the sole benefit of the SR	165	62	57	37	9	**2.04** (0.90)
20. SR makes inquiries about inappropriate areas of the SE's personal life (e.g., "Are you dating anyone?")	165	45	66	45	9	1.89 (0.87)
18. SR initiates (or attempts to initiate) a dual-relationship with SE (e.g., invites SE to attend a personal event outside of supervision)	165	37	49	58	21	1.62 (0.97)
21. SR attempts to help the SE resolve a personal conflict unrelated to his/her professional performance	165	26	56	56	27	1.49 (0.94)
Category IX – Additional Counterproductive Experiences						
23. *SR does not demonstrate respect for the SE*	165	152	12	0	1	**2.91** (0.34)
24. SR does not demonstrate empathy for the SE	165	112	42	11	0	**2.61** (0.61)
25. SR demonstrates unnecessary inflexibility (e.g., in scheduling, case conceptualization)	165	75	73	16	1	**2.35** (0.68)
37. Inadequate environment/office space is provided for supervision (e.g., supervision conducted in non-confidential location, such as a restaurant)	165	63	63	33	6	**2.11** (0.85)
36. SR does not provide guidance about professional development as a psychologist	165	42	71	45	7	1.90 (0.83)
35. SR is frequently late for supervision	165	35	76	49	5	1.85 (0.78)

(continued)

Counterproductive Experiences	*N*	Adverse Impact Rating SigE =3	ModE =2	MinE =1	NoE =0	MRS *(SD)*
Category X – Supplemental Items						
•59. SR fails to provide the minimally required amount of supervision	164	94	54	14	2	**2.46** (0.70)
•2. Primary SR does not possess current knowledge of, adequate skills regarding, and/or actual experience providing, supervision	182	72	83	26	1	**2.24** (0.71)
•49. SR does not appear to address professional competence problems in other trainees	164	58	75	23	8	**2.12** (0.82)
•1. SR does not possess adequate skills to supervise a particular case	182	48	83	48	3	1.97 (0.77)
•60. SR does not use a supervision contract	164	19	41	59	45	1.21 (0.97)

Note. MRS = mean ranking score; SR = supervisor; SE = supervisee; *N* = number of responses; NoE = No Effect; MinE = Minimal Effect; ModE = Moderate Effect; SigE = Significant/Major Effect; *SD* = standard deviation.

[a]Items with MRS ≥2.0 from Kakavand (2014) study are italicized; a diamond (♦) indicates new items suggested during Kakavand's study; a dot (•) indicates new items added to target aspects of APA supervisory guidelines not covered by other categories.

[b]Mean rating scores of ≥2.0 (Moderate-Significant/Major Effect) are shown in bold.

Table J3

Highest and Lowest Scoring CEs with Corresponding Domains and Categories

Highest Scoring CEs (MRS ≥ 2.50)						
		Adverse Impact Rating				
Counterproductive Experiences (Category)[a]	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS (SD)
Domain A: Supervisor Competence						
•3. SR lacks knowledge or skill in the competencies required in clinical management and oversight of cases, e.g., lack of knowledge in diagnosis (IV)	182	113	56	12	1	2.54 (0.64)
Domain B: Diversity						
6. *SR uses or assumes cultural/racial stereotypes when discussing clients* (V)	176	132	35	8	1	2.69 (0.58)
Domain C: Supervisory Relationship						
9. SR *does not address strains or conflicts between SE and SR (III)*	165	104	50	10	1	2.56 (0.64)
16. SR *is unresponsive to SE's verbalized training/supervision needs* (VI)	165	137	23	4	1	2.79 (0.50)
17. SR is unresponsive to SE's disclosures about personal difficulties affecting his/her professional performance (VI)	165	116	38	9	2	2.62 (0.65)
♦22. SR misuses power and authority (VIII)	165	158	5	1	1	2.94 (0.32)
23. *SR does not demonstrate respect for the SE* (IX)	165	152	12	0	1	2.91 (0.34)
24. SR does not demonstrate empathy for the SE (IX)	165	112	42	11	0	2.61 (0.61)
Domain D: Professionalism						
29. SR unfairly criticizes SE's primary theoretical orientation without opportunity for respectful discussion (IV)	165	100	53	10	2	2.52 (0.67)
34. *SR expresses attraction to SE* (VIII)	165	153	7	3	2	2.88 (0.46)

(continued)

Counterproductive Experiences (Category)[a]	N	Adverse Impact Rating SigE =3	ModE =2	MinE =1	NoE =0	MRS (SD)
Domain E: Assessment/Evaluation/Feedback						
41. SR has changing performance expectations of the SE, i.e., inconsistent expectations (I)	165	131	33	1	0	2.79 (0.42)
40. SR fails to clearly communicate performance expectations to the SE (I)	165	98	54	13	0	2.52 (0.64)
42. *SR is often insensitive when giving feedback (e.g., provides feedback in a disrespectful manner, makes critical judgments of SE without providing constructive feedback; III)*	164	135	25	3	1	2.79 (0.49)
Domain F: Problems of Professional Competence						
♦48.The SR gives the SE a negative or failing final evaluation without having discussed his/her concerns prior to the conclusion of the supervision (I)	165	156	6	2	1	2.92 (0.36)
Domain G: Ethics, Legal, and Regulatory Considerations						
51. *SR directs the SE not to file a mandated report (e.g., for child abuse) when the SE reports clear instances of abuse, intent to harm, etc. (VII)*	164	148	11	1	4	2.85 (0.54)
50. SR does not help, is not available to discuss (outside of scheduled supervision), and/or tries to avoid involvement with ethical dilemmas or emergency situations (VII)	164	127	30	6	1	2.73 (0.56)
♦55. SR unnecessarily reveals SE's personal disclosures to other clinical faculty or staff without any ethical or professional justification (VII)	164	129	27	7	1	2.73 (0.56)
♦56. SR has a sexual relationship with SE (VIII)	164	159	2	0	3	2.93 (0.42)
57. *SR makes jokes/comments with sexual innuendos (VIII)*	164	120	30	11	3	2.63 (0.69)
•59. SR fails to provide the minimally required amount of supervision (X)	164	94	54	14	2	2.46 (0.70)

(continued)

Lowest Scoring CEs (MRS ≤1.50)						
		Adverse Impact Rating				
Counterproductive Experiences (Category)[a]	N	SigE =3	ModE =2	MinE =1	NoE =0	MRS (SD)
Domain C: Supervisory Relationship						
21. SR attempts to help the SE resolve a personal conflict unrelated to his/her professional performance	165	26	56	56	27	1.49 (0.94)
Domain E: Assessment/Evaluation/Feedback						
46. SR does not consistently review audio/videotapes or provide live supervision of SE's clinical work	165	10	55	84	16	1.36 (0.74)
Domain G: Ethics, Legal, and Regulatory Considerations						
•60. SR does not use a supervision contract	164	19	41	59	45	1.21 (0.97)

Note. MRS = mean ranking score; SR = supervisor; SE = supervisee; N = number of responses; NoE = No Effect; MinE = Minimal Effect; ModE = Moderate Effect; SigE = Significant/Major Effect; SD = standard deviation.

[a]Items with MRS ≥2.0 from Kakavand (2014) study are italicized; a diamond (♦) indicates new items suggested during Kakavand's study; a dot (•) indicates new items added to target aspects of APA supervisory guidelines not covered by other categories.