ADDRESSING THE VARIABILITY IN TRAINING QUALITY AND ADVANCING PSYCHOTHERAPIST DEVELOPMENT THROUGH COMPETENCY-BASED CLINICAL SUPERVISION

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Abstract: *Clinical supervision is the cornerstone of professional development in the mental health field (Falender & Shafranske, 2004, 2021). It is "a critical if not the most critical facet of the psychotherapy training endeavor" (Watkins, 1997, p. 9). Supervision ensures the quality of care and the welfare of clients, facilitates the trainee's emerging clinical competence and professionalism, and safeguards the public and profession by serving as a gatekeeper (Shafranske & Falender, 2016). The supervisory relationship provides a context for developing clinical competence, enhancing self-awareness, supporting metacompetence, and establishing the supervisee's emerging professional identity. In that regard, supervision has been found to have salutary effects on the supervisee (Knox & Hill, 2021). However, variability exists in the quality of supervision provided. Regretfully, inadequate and harmful supervision occurs, compromising the supervisory relationship and negatively impacting patient care as well as the supervisee's professional development (Falender & Shafranske, 2021). In this article, we discuss the role of clinical supervision during the initial training phase and throughout the ongoing development of the psychotherapist. We emphasize the benefits of implementing a competency-based approach by highlighting essential principles. Also, we suggest that supervision quality contributes to either the supervisee's experience of clinical work as a healthy involvement or may accentuate personal and professional stress and exacerbate difficulties in psychotherapy practice.*

Key Words: *Clinical supervision, Professional development, Psychotherapy training, Professional identity*

CLINICAL SUPERVISION: INITIATING AND SUSTAINING PROFESSIONAL DEVELOPMENT

Clinical supervision, paired with experiences working with clients, appears to have a sustaining influence throughout a clinician's career. Within clinical training, relationships and experiences gained in clinical supervision provide the formative experiences

supporting professional development. Survey data suggests that engagement in clinical supervision plays a critical role in the continuous professional development for numerous clinicians. An international survey of about 4000 psychotherapists (Rønnestad et al., 2019) reported that when asked to indicate the influence of 14 factors on their overall development as a therapist, "Getting formal supervision or consultation" ranked alternately second or third to "Experience in therapy with clients." Novice therapists (< 1.5 years of therapy experience) ranked it first (Rønnestad et al., 2019, p. 223). Besides the estimates of salience, the frequency of its use shows the importance of supervision. As expected, given their training trajectory, *Novice* therapists and *Apprentice* therapists (1.5-3 years) engage in supervision; however, it is notable that *Graduate* therapists (3-8 years) and *Established* therapists (8-23 years) continue to use supervision, 71.0 percent and 61.1 percent respectively, and over 41 percent of *Senior* therapists (23-54 years) reported currently receiving supervision (Rønnestad et al., 2024, p. 8.). Continued participation provides one measure of its role in professional development, but what about the actual impacts of supervision on the psychotherapist-in-training or supervision or consultation on the practicing psychotherapist?

Ellis and colleagues (e.g., Ellis et al., 2014; Ellis et al., 2017) and others (Bang & Goodyear, 2014; Hendricks & Cartwright, 2018; Hutman et al., 2023; & Ladany et al.,1999) provide a global snapshot of the quality of clinical supervision in the United States, Ireland, South Africa, and South Korea. The survey results reflect variability, including bad and harmful supervision. For example, a high incidence of inadequate supervision, which entails failing to meet the criteria of minimally adequate supervision (Ellis et al., 2014), and harmful supervision, which includes supervisory practices that result in psychological, emotional, and/or physical harm or trauma, was reported in a comparative study between the United States and Ireland (Ellis et al., 2015). Results revealed that 79.2% of supervisees in Ireland and 69.5% in the United States were adequately supervised, and 40.3% in Ireland and 25.2% in the United States had received harmful supervision. In addition, 92.4% of supervisees in Ireland and 86.4% in the United States reported receiving inadequate supervision at some point in their careers, and 51.7% in Ireland and 39.7% in the United States indicated receiving harmful supervision. On a positive note, 51% of respondents in Ireland and 55% in the United States reported receiving exceptional supervision. This may be characterized as a collaborative, growth-fostering relationship attuned to the supervisee's developmental needs; however, some supervisees report having received both harmful supervision as well (Hutman et al., 2023).

Surveys of psychotherapists conducted by Rønnestad, Orlinsky and colleagues (e.g., Orlinsky, 2022; Orlinsky et al., 2001; Orlinsky & Rønnestad, 2005; Rønnestad et al., 2019; Rønnestad et al., 2024) and of supervisees (Hutman et al., 2023) provide entry points to examine the specific impacts of clinical supervision during the training and throughout a psychotherapist's career. Although a discussion of Rønnestad and Orlinsky's research program is beyond the scope of this article, we discuss their findings about two cycles of clinician experience, i.e., *Healing Involvement* and *Stressful Involvement*, that affect professional development and treatment. Then, we consider the impact of "developmentally positive supervision" (Rønnestad et al., 2024) on promoting clinical engagement and professional growth.

Two cycles of therapeutic work and growth appear to converge in the training phase and throughout the development of the psychotherapist. *Healing Involvement*, an

empirically derived, higher order dimension, "reveals the nature and extent to which therapists perceive themselves as skillfully, warmly and effectively interacting with the patients; capable of coping constructively if difficulties arise; and deeply interested and absorbed in their work" (Orlinsky et al., 2024, p. 1442). This experience incorporates elements of the therapeutic relationship and involves basic relational skills, agency, an affirmative relational style, and constructive coping (Evers et al., 2019). Such experiences likely bolster satisfaction and self-confidence and encourage continued clinical engagement and skill development. Although salient throughout one's career, such positive experiences play a critical role in the early training of a psychotherapist when the supervisee is 'learning the ropes' and managing phase-specific professional anxiety and doubt.

Of course, working with clients is just that – it is work, and during clinical training (and throughout their careers), psychotherapists will face innumerable work-related challenges and pressures. They will face strains and ruptures in therapeutic relationships (Safran & Muran, 1996, 2000), clinical impasses, and treatment failures. Muran and Eubanks (2020) observed:

> Every therapist has experienced moments of pressure, even those marked by bursts of emotion, such as a surge of anxiety when a patient threatens to self-harm, a flash of irritation when a patient is condescending or critical, a pang of hopelessness when nothing seems to be working, or even a more sustained experience, such as a struggle to remain alert while a patient drones on and on and on. Therapists have to perform under pressure every day. (p. 4)

Therefore, trainees and therapists alike will inevitably experience periods of *Stressful Involvement* in which they "find themselves having difficulties in practice, coping non-therapeutically with those difficulties (e.g., by blaming patients or avoiding dealing with them); and themselves experiencing anxiety or boredom in sessions" (Orlinsky et al., 2024, p. 1442). Such experiences are associated with complex interactions with the psychotherapy process, treatment outcome, and personal feelings of insufficiency or inadequacy (Evers, 2019). *Healing involvement* (HI) and *Stressful Involvement* (SI) are complex yet common phenomena in varying degrees in any therapist's experience. A survey of a multinational sample of trainees found that most experienced a moderately positive experience (i.e., HI from just under 'moderate' to almost 'much' and SI from less than 'slight' to nearly 'some'). Increases in HI were reported in a three-year longitudinal study of clinical training (Evers, 2019), whereas the incidence of SI remained constant (see also Dennhag & Ybrandt, 2013; Orlinsky & Rønnestad, 2005). Experiences of HI and SI play a role in the psychotherapist's development as they prepare to address clinical challenges and challenging patients.

Orlinsky and Rønnestad proposed a cyclical-sequential developmental model in which two concurrently operating cycles – one positive and one negative – "can be visualized as spiraling forward in time" (Rønnestad et al., 2019, p. 223) and "the actual course of a therapist's development is determined by the balance between these two interrelated and partially penetrating cycles . . ." Orlinsky and Rønnestad, 2005, p. 167). Experiences of *Healing Involvement* are linked to *Currently Experienced Growth*, enhance the therapist's work morale, clinical motivation, therapeutic understanding, etc., and establish the conditions to develop skills and build confidence. Further, such experiences

encourage a positive developmental cycle that advances the training agenda and provides a bank of resources to endure *Stressful Involvement*, counter therapist depletion, and forestall therapist disengagement.

Clinical supervision is integral to assisting the supervisee to stay engaged in this challenging learning process that involves both positive and negative cycles, which can lead to experiences of satisfaction, growth, and resilience, or dissatisfaction, doubt, and disillusionment. These challenges are acute for novice trainees, who may become overwhelmed when facing high levels of *Stress Involvement*, are insufficiently prepared to conduct psychotherapy, or are in training settings in which competent supervision is unavailable. One paramount implication of these studies is trainees "while in practicum should be given the opportunity to experience their work as predominantly *Healing Involvement* and minimally as *Stressful Involvement*" (Rønnestad et al., 2019, p. 224). The aim of providing positive clinical experiences during training requires, in part, careful assessment of the individual supervisee's clinical readiness and "entrustability" (ten Cate, 2005; Falender & Shafranske, 2021) and selection of cases aligned with the supervisee's present skill level and experience. Further, highly skilled, competent supervisors, adequate clinical supervision time, training tuned to the unique client population(s) served, and social support within the training setting are needed to support trainee development.

The findings of Ellis and colleagues (as previously discussed) take on added significance considering the conclusions of Orlinsky, Rønnestad, and colleagues. The adverse effects of clinical work dominated by *Stressful Involvement* are exponentially exacerbated in settings of *Inadequate Supervision*, particularly in the case of *Harmful Supervision*. Such a 'worst case' scenario constitutes a precarious situation that poses significant risks for patient welfare, the trainee, and the training institution. Although it would logically follow that inadequate supervision, lousy supervision, or harmful supervision impacts therapy outcomes and patient welfare, it has not been adequately studied, and, therefore, the premise has not been empirically established.

CLINICAL SUPERVISION: HELP OR HINDRANCE

The quality of clinical supervision provided during clinical training contributes in countless ways to the trainee's effectiveness as a psychotherapist. At the surface of supervised clinical work, the supervisor (1) ensures that accurate clinical understanding and diagnosis have been performed; (2) therapy goals have been identified, consistent with the patient's needs, motivation, and capacities; (3) an evidence-based treatment approach has been developed; (4) entrustability in the supervisee's ability to conduct the treatment has been confirmed; and (5) procedures are in place to consistently observe and monitor client welfare and provide evaluation, feedback, and training to the supervisee. Below the surface of the required supervision components and activities are the relational, interpersonal, and values dynamics that contribute to the supervisory relationship and impact the development of a viable and sustaining supervision alliance (Falender & Shafranske, 2004, 2021). We suggest that the supervisor's lived-out commitments to integrity, ethics and science-informed practice, and to the welfare of clients and trainees, together with interpersonal skills and professional competence (both as a clinician and supervisor), are essential to establishing developmentally positive supervision. Adequate

or exceptional clinical supervision is required to support the supervisee in managing the challenges of learning to conduct psychotherapy.

Clinical supervision becomes the 'container' for the supervisee to process their personal, emotionally charged experiences and advance their learning as a novice psychotherapist. This supervisory 'holding' environment is particularly the case when trainees are engaged with challenging patients and in complex clinical situations that might be classified as *Distressing Practice* (Orlinsky et al., 2024) in which *Stressful Involvement* overshadows rewarding experiences of *Healthy Involvement*. A highly respectful and collaborative supervisory relationship and alliance is required to support the trainee and to manage the clinical challenges. Conditions of inadequate supervision or harmful supervision make such distressful clinical situations worse and potentially contribute to therapy failures and supervision strains and ruptures. As Orlinsky and colleagues (2024) put it,

> allowing trainees to get into supervisory relationships, that they perceive as critical and judgmental, and with which they are dissatisfied, could heighten [*Stressful Involvement*] by creating a situation that Rønnestad and Orlinsky (2005) termed double traumatization - that is, struggling to cope with one's supervisor while also, struggling to cope with one's patient. (p. 1451)

The provision of competent, if not exceptional, supervision is of tantamount importance to ensure the highest standards of patient care, mitigate doubts and disillusionment in supervisees, facilitate their competence development, and encourage full engagement in clinical training. The quality of the supervision will determine whether clinical supervision was a help or a hindrance to the supervisee's growth and patient welfare. This is also the case when a professional psychotherapist seeks consultation.

Supervisors have the primary responsibility to ensure the quality of clinical supervision. They must be well-educated and trained in supervision as a unique professional competence to facilitate, develop, and sustain effective supervision. We suggest employing a competency-based approach as a framework to establish developmentally positive supervision and consultation (Falender & Shafranske, 2020).

COMPETENCY-BASED CLINICAL SUPERVISION: AN INTENTIONAL APPROACH IN CLINICAL TRAINING

Competency-based clinical supervision (Falender & Shafranske, 2004, 2007, 2014, 2016, 2021, 2023) provides an overarching framework and a practical approach, which is aligned with the provision of *Developmentally Positive Supervision*, which in turn is associated with *Currently Experienced Growth* (Rønnestad et al., 2024). Its approach is consistent with the general supervisory principles outlined by Rønnestad and colleagues (2019), which emphasize establishing a supervisory alliance, using a supervisory contract, creating a reflective culture in supervision, addressing the complexity of therapeutic work (including consideration of social classes and intersectionality), regulating the level of challenge on the supervisee, and providing appropriate scaffolding and corrective experiences to enhance development (p. 218). Competency-based clinical supervision is:

> a metatheoretical approach that explicitly identifies the knowledge, skills, attitudes, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and requirements of the local clinical setting. (Falender & Shafranske, 2021, p. 19).

It reflects the aims of the competencies movement to bring greater accountability to the healthcare professions and to ensure the well-being of clients, facilitate the development of competence, and protect the public (Falender & Shafranske, 2023). Implementation of the approach supplies best practices to support the supervisee, form a trusting and collaborative relationship and alliance, and facilitate competence development. Further, the approach opposes a laissez-faire approach to supervision in which inadequate or harmful supervision may take root.

Although a comprehensive explication of the approach is beyond the scope of this article, the following features and best practices stand out as essential:

1. Facilitate the development of the supervisory alliance (including the collaborative identification of the goals and the means to achieve the goals) and monitor the state of the alliance over time, e.g., events that strengthen or strain the alliance, and identify and build upon supervisee strengths, address and repair strains and ruptures;
2. Adopt an "intentional" stance to competency development as the ongoing focus of clinical supervision collaboratively identifying strengths and areas in development and scaffolding areas of lesser competence;
3. Identify the competencies that will be the focus of training, including their constituent components (i.e., knowledge, skill, and attitudes) that are assembled to form the competencies and work to enhance those in development;
4. Collaboratively develop a supervision contract that provides a framework for the work of clinical supervision, the scope of clinical practice, and administrative requirements, and identifies the roles and responsibilities of the supervisor and supervisee and the observation, evaluation, feedback, and training processes. Discuss issues related to the power differential, commitment to transparency and integrity, and approaches to remedy strains that may occur during supervision;
5. Collaboratively plan the structure of the supervision sessions, including the "before session" activities that prepare for the session and the activities that will follow the session. The structure and processes of the session should be continuously evaluated and modified as required to ensure effectiveness;
6. Identify processes of observation (e.g., direct observation, in-session, video, transcripts, use of patient measures such as the WAI, OQ45) and evaluation, and collaboratively engage in formative and summative evaluation and provide feedback that enhances education and training;
7. Give ongoing evaluative and supportive feedback that encourages reflection and leads to specific learning opportunities, which enhance professional competence;
8. Encourage reflective practice and address the roles of individual diversity, culture and context, and personal factors affecting the therapeutic (and supervisory) relationships (i.e., countertransference and parallel processes), and ensuring cultural humility;

9. Ensure that all supervisees have received adequate training to make sure all services are provided in accordance with legal, ethical, and professional standards.

The provision of competency-based clinical supervision is supported by continuous education and training of supervisors, including the use of supervision of supervision (SOS). Through a thorough review of beginning supervisors' video and feedback provided, supervision of supervision provides a structured approach to enhance competence in providing competency-based clinical supervision (Falender & Shafranske, 2021).

As clinical supervision has been described as the "missing ingredient" (Falender, 2018), it is critical that increased recognition and dedicated training occur. Clinical supervision is the only competence required by the Committee on Accreditation of the American Psychological Association that is not formally assessed (Rodolfa & Schaffer, 2019). This speaks to the lesser importance attached to training and execution of clinical supervision. Supervisees frequently comment on the significant omission of clinical supervision training as it tends to be cursory and embedded with other topics, generally receiving substantially lesser attention. As supervision is the foundation of future psychologists' training, it is essential that this omission be corrected, and that substantially more dedicated training and practice occur. Individual and system-wide commitments to the principles embodied in competency-based clinical supervision hold the possibility of correcting the variability in the quality of clinical supervision provided and advancing exceptional supervision (Falender & Shafranske, 2023).

Attention to the supervisee's readiness to engage in clinical supervision should also be addressed. Ideally, a series of training experiences would include learning how to be an effective supervisee (*Getting the Most Out of Clinical Supervision: A Guide for Practicum Students and Interns*, Falender & Shafranske, 2011) followed by dedicated training with effective skills, knowledge, and attitudes to ensure supervisees attain adequate preparation for practice. Through dedicated attention and training, including the implementation of a competency-based approach, future generations of psychologists will develop requisite skills, knowledge, and attitudes to ensure competence in clinical supervision.

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