

Competent clinical supervision: Emerging effective practices

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With the recognition that clinical supervision is a distinct professional practice comes the necessity for identification of effective practices. In this competency-based era, a meta-theoretical, interpersonal framework is provided in competency-based clinical supervision in which specific attention is paid to the strengths and emerging competencies of the supervisee and to the clinical and supervision competencies of the supervisor. In this article, the authors address the state of the literature on effective clinical supervision and the specific knowledge, skills, and attitudes that comprise competent supervision. A brief summary of research on several particular pivotal areas (e.g. alliance, multicultural competence, legal, and ethical issues) is included. A self-assessment device is provided for both current supervisors and supervisors-in-preparation to assess readiness, competence, and areas in which additional training and experience are desirable. Finally, a vignette illustrating the implementation of effective supervision practices is provided.

Keywords: supervision; clinical supervision; competency-based supervision; supervision competence; effective supervision

Clinical supervision plays the central role in the development of competence of a counseling psychologist. It provides experiences that are essential to the process of learning how to competently practice as a clinician as well as facilitates the acquisition of professional attitudes that provide the foundation for ethical practice throughout one's career. While training is often assumed to be the primary (or exclusive) responsibility, supervisors are charged with the duty to ensure the welfare of clients and to serve as gatekeepers for the profession, so that only those who are qualified become psychologists. With the recent recognition of clinical supervision as a distinct professional practice (Falender et al., 2004; Fouad et al., 2009) comes the necessity for determining competencies of supervisors and supervisees, what comprises effective supervision, and further, to identify the mechanisms to achieve these. We take up each of these issues from a competency-based approach to supervision oriented to the articulation of best practices drawing upon theory and the empirical literature.

All supervision models aim to enhance competence; however, competency-based supervision (Falender & Shafranske, 2004, 2012a) offers an explicit, meta-theoretical approach to the assessment and development of competence. This approach identifies the specific knowledge, skills, attitudes, and values that form foundational and advanced

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professional competencies in measurable terms (Falender & Shafranske, 2007). It emphasizes a clear articulation of training goals and the means to achieve the goals, processes of evaluation, and feedback, and entails a relational approach in which supervisee and supervisor collaborate within the power differential. Congruent with the competency movement, competency-based clinical supervision provides an evidence-based model for the practice of supervision.

Effective supervision practices

Increasingly, efforts are being made to identify the components and practices that facilitate effective clinical supervision (Borders et al., 2011; Falender, Burnes, & Ellis, 2013; Falender, Ellis, & Burnes, 2013; Falender & Shafranske, 2014; Kune & Rodolfa, 2013; Ladany, Mori, & Mehr, 2013). In the following sections, we present summaries of effective supervision components and practices that have been proposed or empirically supported.

Some consensus has emerged on components of competent, and ostensibly, effective supervision (e.g. Borders et al., 2011; Falender et al., 2004; Ladany et al., 2013), but many have not been studied empirically and those that have may rely on supervisee or supervisor appraisal of efficacy. The following supervisor practices to be modeled and communicated to the supervisee, derived from those consensus resources, are proposed as a roadmap for practice and empirical analysis:

Attitudes

- Acknowledging and appreciating that responsibility for the client and supervisee lies with the supervisor.
- Valuing ethical principles and code of ethics.
- Demonstrating respect for the supervisee and client(s).
- Respecting and valuing diversity of all members of the supervision triad (client (s), supervisee/therapist, and supervisor).
- Valuing self-reflective practice, including self-assessment and acknowledging limits of competence, knowing what he/she does not know (meta-competence).
- Valuing commitment and proactive efforts to enhance clinical competence, and embracing lifelong learning.
- Appreciating and empowering the supervisee as appropriate, supporting and encouraging the supervisee's development, including identification of supervisee strengths and efficacy.
- Valuing and expressing respect for the supervision process, supervisee competence, and emerging developments.

Skills (including the requisite knowledge of each in order to enact)

- Clarifying and ensuring understanding of supervisee roles and supervisor expectations.
- Articulating the balance of supervisory roles of protection of the client and public, gatekeeping for the profession, and enhancing the functioning of the supervisee to develop to their potential.

- Remaining mindful and attuned to ethical and legal aspects of supervision and practice including appropriate boundaries, informed consent, and confidentiality.
- Knowing various supervision modalities (group, individual, video, or live observation/review).
- Forming a supervisory alliance.
- Collaboratively assessing supervisee competence (with supervisee self-assessment and supervisor feedback).
- Collaboratively developing goals and tasks to achieve the goals.
- Collaboratively constructing a supervision contract based upon goals, tasks, and developing competencies, providing informed consent regarding expectations, logistics, and monitoring (Falender & Shafranske, 2004; Thomas, 2010).
- Infusing diversity among client, supervisee, and supervisor into clinical and supervision practice.
- Reflecting on and respecting worldviews, attitudes, and biases, of client, supervisee, and supervisor, and infusing understanding of these in conceptualization, assessment, and intervention.
- Considering and factoring in contextual (e.g. setting, community, and diversity) factors in clinical practice and supervision.
- Assessing, monitoring, reflecting on, and enhancing specific supervisee competencies.
- Enhancing supervisee reflection on clinical practice and the process of supervision.
- Observing directly – using live or video and observation to provide behaviorally anchored feedback on competencies and identified supervisee goals.
- Monitoring and assessing competencies and providing ongoing feedback regularly with supervisee – positive and corrective feedback anchored in competencies.
- Engaging the supervisee in skill development using interactive and experiential methods (e.g. role play and modeling).
- Providing didactic input appropriate to the supervisee’s emerging competence and learning needs.
- Ensuring fidelity to the treatment intervention (Schoenwald, Mehta, Frazier, & Shernoff, 2013).
- Attending to personal factors, unusual emotional reactivity, and countertransference, and engaging in management of these to inform the clinical process.
- Identifying strains and ruptures to the supervisory relationship and repairing them.
- Engaging in evaluative processes to assess the quality of the supervisory alliance and the effectiveness of clinical supervision.
- Seeking, reflecting on, and incorporating feedback from the supervisee on the supervision process and progress.
- Knowing the limits of one’s own competence and taking steps to enhance competence in relevant areas.

In the next sections, several specific areas will be addressed and reviewed to provide a structure to what is currently known and supported in clinical supervision research.

Supervisory alliance

The supervisory alliance has emerged in supervision research as an essential component of effective supervision (Bernard & Goodyear, 2014; Falender & Shafranske, 2004, 2007, 2014; Pearce, Beinar, Clohessy, & Cooper, 2013); neglecting its importance would ignore a vast literature base demonstrating its centrality to the practice of supervision (Falender & Shafranske, 2004, 2007, 2012b, 2014; Ladany, Brittan-Powell, & Pannu, 1997; Ladany, Ellis, & Friedlander, 1999; Ladany et al., 2013). Fostering a strong supervisory alliance is a key component of evidence-supported supervision practices. The formation and maintenance of a supervisory alliance are not simply foundational to the process and outcome of supervision, they are a core competency in the practice of supervision (Falender & Shafranske, 2007; Ladany et al., 2013).

The concept of the supervisory working alliance was derived from Bordin's (1983) work on the therapeutic working alliance between client and therapist that he extrapolated to supervision. He identified three key aspects necessary for a working alliance in any relationship, (i) agreement on goals, (ii) agreement on tasks required for goal attainment, and (iii) a relational bond between partners. The supervisory working alliance model developed by Bordin (1983) "is the foundation for determining the effectiveness of supervision" (Ladany, 2004, p. 4), and many empirical investigations on supervision have adopted this model to the study of effective supervision. However, the extrapolation from Bordin's therapeutic alliance model did not consider the power differential within the supervisory dyad, given that supervision is inherently an evaluative relationship, and the multiple responsibilities and roles of the supervisor (Falender & Shafranske, 2014).

In developing a strong supervisory alliance, the personal characteristics and behaviors of the supervisor such as warmth, empathy, genuineness, respect, flexibility, a nonjudgmental stance, and transparency are important factors (Falender & Shafranske, 2004; Ladany et al., 2013). Supervisors are more likely to build and maintain effective supervisory relationships and to promote trainee self-efficacy by using supervisory skills such as encouraging developmentally appropriate autonomy, expressing confidence and trust in trainees' abilities, providing positive as well as constructive feedback, demonstrating their own clinical expertise in the service of trainee growth, and being responsive to supervisee's individual learning styles (Falender & Shafranske, 2004; Ladany et al., 2013). When they perceive that the supervisory relationship is strong, supervisees report stronger satisfaction with supervision (Ladany, Ellis, et al., 1999), improved cultural competence (Ladany et al., 1997), and fewer nondisclosures and greater disclosure in supervision (Ladany, Hill, Corbett, & Nutt, 1996; Ofek, 2013; Walker, Ladany, & Pate-Carolan, 2007). Although much of the research on the supervisory alliance is limited to trainee self-report, there is significant support that the development and maintenance of an alliance is a sine qua non of effective supervision (Falender & Shafranske, 2004, 2008, 2014; Ladany et al., 2013). When ruptures in the supervisory alliance occur, and as tension emerges between trainee and supervisor, repairing such strains functions to strengthen and preserve the supervisory relationship and impacts the clinical process (Falender & Shafranske, 2014; Safran, Muran, Stevens, & Rothman, 2008; Tracey, Bludworth, & Glidden-Tracey, 2011).

Multicultural and diversity competence

Multicultural and diversity competence is an ethical imperative in clinical care (American Psychological Association [APA], 2000, 2003, 2010) and also in supervision (Falender, Shafranske, & Falicov, 2014). While many psychologists value practicing with multicultural competence, a gap exists between perceived competence in diversity and actual clinical practice (Hansen et al., 2006), and between knowledge of appropriate practice and actually enacting such practice (Sehgal et al. 2011). Supervisors also perceive themselves as more multicultural competent than their behaviors indicate. Trainees report that the onus of infusing diversity into their supervision discussion is often placed on them (Duan & Roehlke, 2001; Green & Dekkers, 2010) and substantial harm is inflicted by supervisor's lack of competence (Jernigan, Green, Helms, Perez-Gualdrón, & Henze, 2010; Singh & Chun, 2010).

Diversity competence is essential to effective supervision; therefore, insufficient attention to such issues is likely to result in ineffective supervision. Supervisor willingness to discuss cultural and diversity issues in supervision has been associated with a stronger supervisory alliance (Duan & Roehlke, 2001; Gatmon et al., 2001). Importantly, as supervision contains an inherent power differential, supervisor attention to power and privilege issues becomes increasingly important. A supervisor's lack of awareness of power, privilege, diversity issues, and multiple identities operating within the supervisory dyad and within the trainee–client dyad has a deleterious effect on supervision (Falender & Shafranske, 2014; Falender et al., 2014).

Best practices around multicultural competence include self-awareness of one's own multiple cultural identities and the impact of supervisor worldview on supervision and the clinical work, adopting a position of cultural humility, exercising meta-competence, and not erroneously assuming one is competent in facilitating culturally responsive supervision. Engaging in reflective practice and identifying areas for further growth in multicultural competence is part of a commitment to a lifetime of learning – a core value in professional psychology – and pertinent especially to issues of multicultural competence. A supervisor's transparency in acknowledging gaps or limitations in knowledge or the challenges in implementing culture-sensitive approaches to treatment provides an opening for mutual discussion and models meta-competence and commitment to enhancing multicultural competence.

Ethical and legal competence

Competence in ethical and legal issues in supervision includes facility in the identification of and application of ethical, legal, and professional standards to complex legal and ethical issues along with proactively addressing them in supervision (Fouad et al., 2009). Nonetheless, supervisees perceived that approximately half of their supervisors committed ethical violations that impacted the quality of supervision (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Wall, 2009). The most frequently reported violations of ethical guidelines included issues around performance evaluation, confidentiality in supervision, and ability to guide interventions from other theoretical perspectives. Ethical guidelines with respect to these issues require special attention at the outset of supervision and are best addressed with the collaborative creation of a supervision contract, a gold standard for best supervision practices.

A supervision contract addresses ethical standards (i.e. pertaining to informed consent for supervision), expectations and parameters for supervision and the training experience (i.e. start and end dates), procedures for evaluation, and supervisor and supervisee roles and responsibilities, among other issues (Falender & Shafranske, 2004; Thomas, 2007, 2010). The supervision contract plays an important role in the formation of the supervisory alliance and sets the groundwork for an effective supervision experience. For example, a supervision contract may address issues related to supervisor style, such as theoretical orientation in therapy and supervision, requirements and approach to reviewing videotapes (e.g. initially reviewing video for all therapy sessions and then shifting responsibility to supervisees to identify video portions for review), and individual supervisor expectations (e.g. level of preparation for supervision including literature review of effective treatments for client diagnoses). The supervision contract addresses limits of confidentiality in supervision, expectations for supervisee disclosures, and evaluation procedures as well as possible supervisor actions (e.g. indicating that the issue is beyond the purview of supervision and the supervisee needs to address it through personal therapy or other forms of intervention). The supervision contract is a living document, such that changes and new goals will be added as previous ones are met.

Confidentiality

While supervisors address confidentiality of client information, supervisee confidentiality and privacy may be overlooked. Description of the limits of confidentiality in supervision includes describing normative reports and evaluations to licensing boards, graduate schools, training teams, and administrative staff members. As trainees are engaged in what may often feel like a vulnerable relationship marked by a power differential, clarity regarding supervisors' multiple roles, the promise of transparency in feedback, the limits of confidentiality in supervision, and ensuring that no evaluation is a surprise are essentials.

Expectations for trainee disclosure

Trainee disclosure is a necessary component for effective supervision. Without such disclosure, a supervisor cannot confidently carry out the supervisory tasks of protecting the trainee's clients and helping to promote to trainee's competence. Although it may seem obvious to expect appropriate trainee disclosure, many trainees report engaging in nondisclosure in supervision for a variety of reasons including perceived unimportance of the disclosure, fear of negative evaluation, and belief that the issue is too personal (Hess et al., 2008; Ladany et al., 1996; Mehr, Ladany, & Caskie, 2010; Yourman & Farber, 1996). In order for trainees to have reasonable expectations of what information belongs in the supervisory discussion (namely information needed to attend fully to the care of clients and to the professional development of the trainee), it is best to explicitly stipulate supervisor expectations for trainee disclosure. Supervisees should understand the types and characteristics of emergencies at the setting and the appropriate steps to contact the supervisor. Supervisees are informed that required disclosures include all legal and ethical potential issues (but this may be limited by meta-competence, so supervisors are responsible for educating on this), including boundary crossing with clients, supervisee errors or situations that they were unclear what to do, countertransference or supervisee/therapist

reactivity and its impact on client treatment and on the supervisee, and supervisee behavior that may place client care at risk and that also may be a legal or ethical infraction or a prelude to such. Supervisors are responsible for welcoming and promoting supervisee disclosure by responding sensitively and appropriately to disclosures (Falender & Shafranske, 2004; Hess et al., 2008; Ladany et al., 1996; Ofek, 2013) and providing clarity when the disclosure has an explicit evaluative component (e.g. if the supervisee issue impacts client care and is not able to be resolved within the supervision relationship).

Evaluation

Trainees are acutely aware that they are being evaluated. Strains and ruptures in supervision occur around evaluation or its omission. Procedures for evaluation must be set forth at the outset of the supervisory relationship (APA, 2010, 7.06) and as part of the supervision contract. Expectations regarding ongoing performance monitoring, feedback, and evaluation and formal written evaluation and scheduling are laid out. The supervisee's self-assessment serves as an important reference point in the evaluation process with the supervisor's targeted feedback reflecting on the supervisee's self-report.

Managing ethical and legal issues in supervision is no easy feat as tensions often exist between the multiple roles and responsibilities of the supervisor. Supervisors have the primary responsibility to ensure client welfare, while also monitoring and promoting trainee competence, building and maintaining a strong supervisory alliance, providing positive and corrective feedback, providing evaluations to graduate programs and training institutions, maintaining statistics for accrediting bodies concurrent with performing gatekeeping functions, and simultaneously managing their own (often additional) job responsibilities within the institution. Clarity and forthrightness in addressing the multiple roles of the supervisor with the supervisee is an excellent strategy.

Supervisor self assessment

We present a quick tool for a supervisor self-assessment based on competency-based supervision that supervisors may utilize to determine what areas of competency-based supervision they practice and those in development. For each domain below, we articulate specific behaviors that encompass best practices for supervision, including forming a supervisory alliance, multicultural/diversity considerations, legal/ethical/professional issues, and evaluation and feedback.

Assumptions

The supervisor is competent to treat any client assigned to the supervisee (of diverse diagnoses, multicultural presentation, and appropriate intervention).

The supervisor is competent in the practice of clinical supervision including the following components:

Supervisory alliance/relationship competencies

- Purposefully forming a supervisory alliance (i.e. by demonstrating such qualities as warmth, empathy, genuineness, etc.) by collaboratively developing goals and tasks for supervision.

- Addressing with transparency the power differential within the supervisory dyad including elucidating the supervisory roles of protection of the public, gatekeeping for the profession, and enhancing the supervisee's competencies, monitoring and evaluating the supervisee.
- Collaboratively creating a supervision contract, delineating supervisor and supervisee roles and responsibilities, supervisor expectations, and performance criteria.
- Eliciting supervisee goals and collaboratively forming an agreement on goals and tasks to be used to achieve goals.
- Identifying strains to the supervisory relationship and addressing and repairing them.

Multicultural/diversity competencies

- Modeling self-reflection and self-assessment about one's own multiple diversity identities and the impact of this on case assessment, intervention, and conceptualization.
- Demonstrating multicultural competence and awareness of areas requiring further growth.
- Reflecting on worldviews, attitudes, and biases, and infusing these in conceptualization, assessment, and intervention.
- Facilitating respectful dialog concerning diversity and the multicultural identities of the supervisor and supervisee.
- Infusing diversity competence among client, supervisee, supervisor into clinical and supervision practice.

Legal/ethical competencies

- Clearly presenting aspects of informed consent at the outset of supervision.
- Discussing specific limits of confidentiality in the supervision process.
- Modeling attention to ethical and legal standards and monitoring supervisee knowledge and adherence to these guidelines.
- Being clear and transparent about supervisor multiple roles and responsibilities (i.e., ultimate responsibility to protect welfare of clients, gatekeeping responsibilities, and responsibilities to help trainees develop competence).
- Maintaining records of supervision and describing to the supervisee types of records kept and who has access to them.
- Describing procedures for remediation of trainee performance.
- Describing procedures for due process in the setting to understand supervisee rights.

Evaluation and feedback

- Clearly articulating evaluation methods at the outset of supervision.
- Providing trainee with evaluation forms to be used throughout the supervisory experience.

- Clearly defining timeframes for formal evaluations.
- Supporting trainee self-assessment and incorporating that in feedback process.

Is the feedback provided

- Frequent.
- Specific and behaviorally anchored.
- Provided close in time to the behavior or the review.
- Delineating the knowledge, skills, and attitudes/values that require attention.
- Identifying existing strengths on which developing competence will be supported.
- Framed in a developmental orientation.
- Inviting reflection and articulation of the specific area of competence targeted for development.
- Leading to discussion of learning outcomes and strategies, including ways to enhance learning during supervision.
- Describing next steps in developing competence and suggesting self-assessment strategies and describing the form of assessment to be performed by supervisor.
- Engaging the supervisee to set and to commit to specific performance expectations.
- Inviting feedback regarding the process.

Vignette illustrating effective supervision practices

Marietta finished orientation and is beginning supervision in her internship at the university counseling center. During her first supervision session, her primary supervisor, Dr A., described the competency-based supervision approach and invited Marietta's collaboration in formulating the supervisory contract, which would provide the foundation for their work together. Dr A. encouraged her to self-assess on Competency Benchmarks (Fouad et al., 2009), to identify foundational and functional competencies expected for development as a psychologist. In this way, Marietta will assess her strengths and identify areas needing improvement as well as understand the process of developing a supervisory alliance. Dr A. encouraged her to do some reading on supervisee role induction (Falender & Shafranske, 2012b; Vespia, Heckman-Stone, & Delworth, 2002) to ensure mutual understanding of the expectations and parameters of supervision. Then they collaboratively developed goals and tasks for supervision incorporating Marietta's self-assessed areas (at the point of readiness for entry to practice) she would like to address:

Foundational competencies: professionalism

Consolidation of professional identity as a psychologist; knowledgeable about issues central to the field; and evidence of integration of science and practice.

Individual and cultural diversity

Essential Component: independently monitors and applies knowledge of self as a cultural being in assessment, treatment, and consultation.

Behavioral Anchor: regularly uses knowledge of self to monitor and improve effectiveness as a professional.

Reflective practice

Essential Component: reflectivity in context of professional practice (reflection-in-action), reflection acted upon, self used as a therapeutic tool.

Dr A. complemented Marietta on her demonstration of meta-competence in identifying areas for growth and outlined expectations for supervision drawing upon role invocation exercises (e.g. self-assessment on Supervisor Utilization Rating Form adapted from Vespia et al., 2002 in Falender & Shafranske, 2012b, including view of supervision process and receptivity to feedback). Dr A. then discussed her preference for a collaborative relationship within the power differential. Dr A. described her multiple roles (e.g. ensuring client welfare, protecting the public, gatekeeping for the profession, and supporting the growth and professional development of each supervisee), promised transparency, and committed to disclose both positive and corrective feedback as she observed it and to build upon supervisory goals, developing new ones as competence is achieved.

Dr A. described aspects of her own diversity that she is a Caucasian female, 28, a native Californian, who went to graduate school locally and is highly committed to women's health issues. Marietta briefly alluded to her cultural background, sharing that she grew up in the South, identified as an African-American female, and had worked as a teacher prior to returning to graduate school. She is 34 years old, older than her cohort of interns. She noted she sometimes approaches her work from the perspective of an educator and is eager to work clinically with a wide range of clients.

Marietta's first client was Jayden, an African-American male, 20, Christian, on a full scholarship, who moved from New Jersey for college in California, and is in his second year at the university, currently on academic probation. Prior to the intake, Dr A. and Marietta reviewed the preliminary screening conducted by a staff member. Jayden was described as experiencing adjustment issues and is finding the second year college work substantially more difficult even than the first. He is isolated, lonely, and increasingly withdrawn. He had been an honor student and popular in his high school and had had a very difficult first year. Marietta described her initial reaction as maternal and protective. Marietta identified strongly with Jayden and recalled her own feelings of isolation and loneliness at a college far from her home and family. Marietta was certain race, financial pressures, and the move were potent factors in Jayden's presenting problems. Jayden asked whether there was any possibility that anything he said would be told to his parents and she was concerned that she could not promise total confidentiality, but wanted input on that.

Marietta was eager to explore tutorial interventions and to understand more carefully the courses he was taking and the possibility of modifying those courses. Dr A. reflected on the wide range of interventions she was contemplating and asked that Marietta do the same, with the focus of directly reflecting on her self-assessed goals. Dr A. urged Marietta to think about her personal disclosures to her supervisor and how these would be useful in contextualizing and understanding Jayden's situation and developing hypotheses for a treatment plan for brief, cognitive behavioral therapy. Dr A. wanted to help Marietta be more mindful of her preliminary frame of reference, her strong personal feelings, and her own biases based in part upon her personal

experience. Dr A. described the need to be expansive in the intake assessment but to arrive at a treatment plan compatible with the brief model employed in the setting. Marietta reflected on the cultural borderlands (shared identities) (Falicov, 2014) with the client of race, religion, social class, and moving cross-country for education in contrast to the identities she shared with Dr A., gender, and age. Marietta laughingly reflected it was weird to be older than your supervisor! (A point Dr A. noted but reserved to reflect on later). Marietta also said, upon reflection, she was really approaching the intake more from an educational perspective ... again a goal she wanted to address. Dr A. asked if the feedback and comments she had shared were helpful and whether there was anything else she could address.

Marietta came for her next supervision session having conducted the intake and feeling very positive about the therapeutic alliance she was establishing with Jayden. She was very encouraged that she found herself much more reflective and mindful of her role as psychologist in development and of the impact of her own self on the process. She addressed Jayden's mood, changes in mood, family constellation, friendship network, and financial pressures. She reported he presented as much more anxious than depressed, and the screening measures confirmed this impression. He described test and performance anxiety as central presenting problems and she had begun constructing with him an exposure hierarchy. She was surprised and grateful that Dr A. had guided her away from a more constricted view that might have negatively impacted her ability to gain nuanced understanding. She also reported their supervision discussion had been very helpful and that she was using the specific countertransference frame described in Falender and Shafranske (2012b). She described that using this model increased her attention to self-other differentiation, especially with regard to the similarities of Jayden to friends of her brothers growing up and increased her empathy for Jayden as an individual. Dr A. reviewed a video of the intake and highlighted Marietta's strengths in assessment. Dr A. also reflected with her on how she had steered away from his intense expression of sadness, an observation Marietta confirmed and agreed to address. Marietta also reflected the strong pull for her to "spring back" to education, but in her desire to hold back she may have over-corrected. Dr A. concurred that she appeared to have begun to develop a strong alliance, highlighting her affective tracking and her responsiveness. Marietta reflected that she was appreciative of the feedback and was looking forward to supervision in this mode.

Supervisor Reflections: areas of future discussion included the consideration of diversity statuses among Jayden, Marietta, and Dr A. Cultural borderlands or shared identities of social class, race, and religion (with Jayden) would be important to discuss. Marietta had mentioned age and race differences with Dr A. in passing and are noted by Dr A. as in need of being addressed soon (Falicov, 2014) as they are important not simply for the supervisory alliance but impact perspectives and decisions on client treatment. Also, Dr A. observes that Marietta has a tendency to frame interventions as teaching moments; she reflects that attention needs to be placed on the continuing process of socialization to the professional identity as a psychologist while affirming the experiences and perspectives that Marietta brings from her experience as an educator. General reflections on Marietta's strengths include her self-awareness and openness to discussion, rapport building, and openness to feedback. Her knowledge and skills for implementation of treatments for depression and anxiety is strong. Determining specific interventions focused on a more nuanced assessment of Jayden, whether diagnosis is

anxiety, depression, adjustment, or a combination of factors will be a next step. Issues of Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) (Wise, King, Miller, & Pearce, 2011) and the limits of confidentiality will need to be addressed as well.

Practicing competency-based clinical supervision

Practicing competency-based clinical supervision (Falender & Shafranske, 2004, 2014) that provides a structure for evidence-based inquiry (Milne, Sheikh, Pattison, & Wilkinson, 2011) requires training in supervision (Bernard & Goodyear, 2014) and competence in current standards for supervision guided by evidence. A challenge is that many supervisors have received minimal education, training, and supervision in the provision of supervision and that there is high variability among the training offered to those advancing towards professional practice (Falender & Shafranske, 2014). While graduate education may provide some exposure to clinical supervision as a competency, training and supervision in supervision, which is usually required, if not mandated, for other clinical competencies, appears in general to be lacking. For many, personal experiences in their own past supervision guide their approach to providing supervision (Crook-Lyon, Presnell, Silva, Suyama, & Stickney, 2011) rather than systematic training, which would include supervision of supervision. Given the centrality of supervision to the protection of client welfare, the clinical competence of the trainee, and to the responsibility of gatekeeping, it is vital that educational and training institutions allocate adequate resources to training in supervision (i.e. supervision of supervision). An important step in these processes has been undertaken by the American Psychological Association (APA), Presidential Task Force on Evidence-Based Practice (BEA) (2014), and the Association of State and Provincial Psychology Boards (ASPPB) (Steve DeMers, personal communication, 2013) to identify specific guidelines for the provision of supervision. Guidelines will emerge in the coming years for the provision of supervision (BEA, draft, 2014), informed by the growing scholarly and empirical supervision literature. Expectations will build for the full implementation of supervision practices that have been shown (or theorized) to produce effective supervision both in terms of client welfare and the development of supervisee clinical competence (Kaslow, Falender, & Grus, 2012). It is up to the field to address the challenge of limited resources in order to ensure that the integrity of supervision is maintained and in so doing uphold the duty to ensure quality care and welfare of clients receiving clinical services under supervision.

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