

Establishing Supervision Goals and Formalizing a Supervision Agreement

A Competency-Based Approach

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Over the last decade, competency-based models have breathed new life into the education and training of professional psychologists, including their clinical supervision. The work of Falender and colleagues (Falender & Shafranske, 2004; Falender et al., 2004) and the objectives-based approach to supervision (Gonsalvez, Oades, & Freestone, 2002) are examples of such competency-based approaches. While the enhancement of competence has always been an important consideration within clinical supervision, “since the dawn of the new millennium, focus on supervision competence and [therapy] competencies has ratcheted up to a level of emphasis and scrutiny that lacks parallel across the entire 100 year plus history of supervision” (Watkins & Wang, 2014, p. 15). For the field-based clinical supervisor, the implications of these changes are not always apparent.

In this context, the present chapter serves the following functions: an information-disseminating function, by unpacking for supervisors how a competency-based paradigm might influence key aspects of supervision (namely, establishing supervision goals and formalizing a supervision contract); a reflective function, by inviting and challenging supervisors to carefully consider the merits and demerits of the paradigm (and its alignment to their own supervisory practices); and finally a supportive function, by providing guidelines, templates, and resources that may help supervisors adopt the paradigm.

Adopting a Competency Approach in Supervision

Although the notion of competence is old, the development of a taxonomy of competencies has only recently occurred (Fouad et al., 2009). Assessment require-

ments within universities have long been weighted toward the traditional evaluation of knowledge, to the neglect of relevant skill, relationship and attitude-value competencies (Milne & James, 2002; Pachana, Sofronoff, Scott, & Helmes, 2011). Finally, contrary to the tenets of the competency paradigm, accreditation criteria for training programs have been weighted toward “inputs” such as the number of practicum, supervision, and coursework hours that a student should undertake; rather than “output” measures, such as whether students could demonstrate assessment and intervention skills at an acceptable level of proficiency (Pachana et al., 2011).

Competency-based models, appropriately tailored to the unique character and processes of clinical supervision, have the potential to improve the pedagogic standing, scientific status, and the overall effectiveness of supervisory practice. Significant initial progress has already been accomplished within psychology (Kaslow, 2004; Kaslow et al., 2007, 2009; Rubin et al., 2007). The discipline of clinical supervision has a rare opportunity to harness the momentum of a revolution to initiate systemic change and effect substantive progress.

The adoption of a competency approach to supervision plans involves at least three practical tasks: designing competency-based developmental plans (CDP) for supervisees within clinical placements;¹ high-fidelity implementation of such plans, and evaluation of all aspects of the supervision program against the principles of the competency approach. The focus of the current chapter is on the first aspect: designing a CDP for supervision. Designing a CDP has many similarities with goal-setting in supervision. However, in practice, goals in supervision plans rarely adhere to core principles of competency-based approaches. Therefore, the term, *competency-based developmental plan* will be used in the current chapter to identify a comprehensive supervision plan in which all components (learning activities, supervision methods, assessment, and evaluation) are guided by a competency-based pedagogy. A preliminary conceptualization of such a program has been outlined previously (Gonsalvez et al., 2002), and that earlier model will be revised and elaborated here. The stages may be schematically represented as per Figure 12.1.

The development of a CDP for supervision is an important and essential first step in the adoption of the competency paradigm. It forms the blueprint for all of the learning and teaching activities within the supervision program. It comprises three supervisory tasks, designated by the three rectangular boxes in Figure 12.1: (1) assisting supervisees to formulate their own competencies for the placement; (2) finalizing competencies for supervision through a process of information delivery, reflection, and consensus-building; and (3) designing an implementation plan. There are several overarching considerations and processes that have a bearing on each of the supervisory tasks (Figure 12.1, oval box). This chapter is structured into six sections. Overarching considerations are discussed first after which the three supervisory tasks are discussed. Establishing a supervision agreement or contract is discussed next, followed by a summary and concluding comments.

¹ The generic term *placement* will be used in this chapter to identify external field placements, clinical placements, external practicum, externships, clinical rotations, and internships.

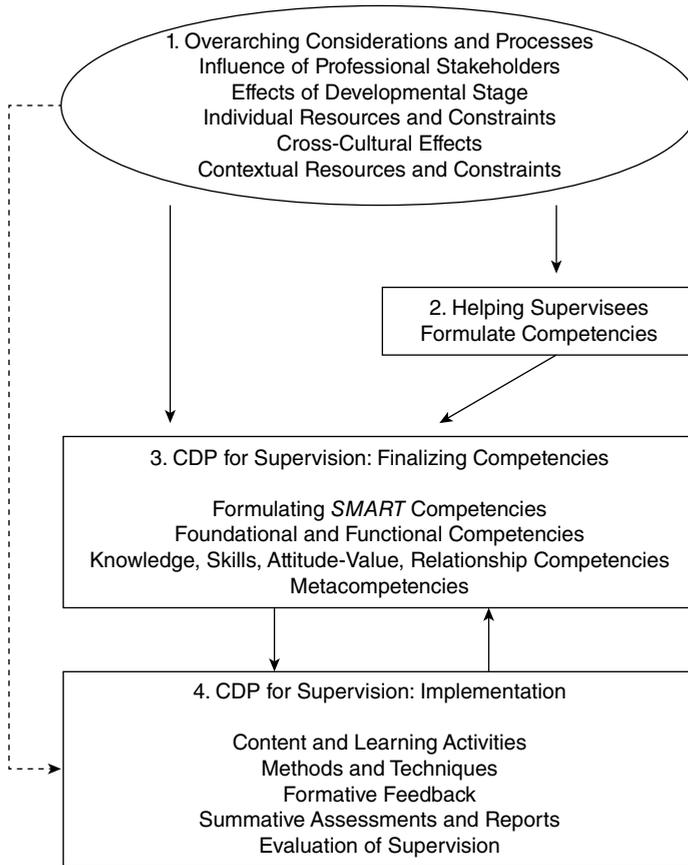


Figure 12.1 A competency-based developmental plan (CDP) for supervision: Supervisor tasks and processes. Adapted from Gonsalvez, Oades, and Freestone (2002). Reproduced with permission.

Overarching Considerations and Processes

Influence of professional stakeholders

In the past, the supervision space was, in a sense, hallowed turf, a private and confidential space shared between the supervisor and supervisee. An important change ushered in by competency-based approaches is the entry of a third entity into the supervision space: the professional stakeholder. While some supervisors have welcomed such enhanced professional interest in supervision, others have resented the intrusion or are ambivalent. Common concerns are that having “Big Brother” poring over the supervision process may change the delicate dynamic within the supervisor–supervisee relationship and undermine supervision effectiveness. Further, regulatory bodies appear keen to extend their audit from professions in training to fully qualified professionals, by attaching requirements to renewal of licensure or by introducing supervisor accreditation requirements (e.g., Psychology Board of Australia, 2010).

Professional stakeholders include the regulatory bodies that can mandate teaching and training inputs, including coursework and practicum hours and the demonstration of key competencies (outputs) before a professional is registered or licensed. These regulatory bodies include the Health Professions Council (United Kingdom) and the Psychology Registration Board (Australia). In the United States, licensure is regulated on a state-by-state basis. A second group of stakeholders is constituted by professional societies, such as the American Psychological Association (APA, United States), or the British Psychological Society (BPS, United Kingdom). The third group comprises training institutes, such as universities. Service agencies in which placements are conducted form a fourth group. Until recently, competence statements from such regulatory and professional bodies were generic and couched in terms sufficiently amorphous to encompass most supervision conducted. The recent decade has witnessed significant progress in these statements, including a clearer specification and a more systematic organization of professional competencies (Fouad et al., 2009; Hatcher & Lassiter, 2007; Hunsley & Barker, 2011; Kaslow et al., 2007, 2009; Roth & Pilling, 2007, 2008).

An implication for training institutions (e.g., universities) is the requirement to design a curriculum of competencies that both aligns with the prescriptions of regulatory and professional bodies (Pachana et al., 2011), and captures their unique character (in terms of philosophy and pedagogic approaches to training).

For today's clinical supervisor, it is important to gain a good working knowledge of the competency frameworks of key stakeholders, and to understand their implications for supervision process and outcome *before* supervision commences. A key point of conflict is often the fact that the person designated the consumer varies between the stakeholders involved in clinical supervision. For example, the service agency's primary concern may be the benefits accrued by their clients (the client in the counseling room) and the welfare of and costs incurred by their staff (e.g., supervision time). For training institutions, the supervisee is the primary consumer, while regulatory authorities are primarily concerned with protecting the interests of the public. Such differences in perspective may create conflicting expectations for supervisees' caseloads, for the frequency of supervision, or for reporting requirements. It is important to recognize that multiple lists of essential and desirable learning outcomes from diverse stakeholders may compete for attention and crowd the supervision agenda. Valuable supervisor skills include the ability to differentiate among and prioritize competing demands, and to maintain good communication with competing stakeholders during the placement. It is also important for supervisors to become aware of their own reactions to the entry of professional stakeholders into the supervision space and ensure that negative reactions do not adversely impact the supervision process.

Effects of developmental stage

For decades, models of supervision have been dominated by developmental theories. However, these models have only offered broad brush stroke accounts of development. There has been lack of clarity with regard to detail, and poor specification of the nature and determinants of transitions between developmental stages (Watkins, 1995; Worthington, 1987). Supervision models that use a competency framework as

their starting point and progress to applying this framework within professional education and training are more amenable to task analyses and specifications, leading to a taxonomy of competencies across domains and functions. It appears sensible to integrate these traditions, and initial attempts have been made (Falender et al., 2004; Fouad et al., 2009; Gonsalvez et al., 2002). When developmental stages are imposed on competency frameworks, a matrix emerges that includes two or more dimensions: domains of competence (e.g., counseling skills, ethical practice, professional skills) and stages of development (e.g., novice, advanced beginner, competent, proficient, expert; Blackburn et al., 2001). The competence domains may be further categorized into foundational and functional domains (Fouad et al., 2009; Rodolfa et al., 2005), or alternatively into competency types (knowledge, skills, attitude-value, and relationship; Gonsalvez et al., 2002), giving rise to two slightly different three dimensional matrices. In summary, developmental theory has the potential to inform and enrich competency-based models. The supervisee's developmental level in various domains should guide the choice of competency domains for the CDP and the levels of performance to be attained in each domain. Further, the supervisor's and supervisee's developmental stage will influence the way they respond to supervision activities, methods, and assessment.

For training institutions, the implication of an integration between developmental approaches and competency-based pedagogy is that the sequence of placements may influence training outcomes, with sequences that are developmentally appropriate, leading to better outcomes. The implication for research is that the model offers a theoretical framework that spawns a range of questions that have valuable training implications. For instance, what are the core competency domains? How independent or similar are the normative developmental trajectories across domains? Is progress among domains affected by similar or different supervision styles and methods? Does supervisory alliance affect all domains in a comparable manner?

Individual resources and constraints

Each supervisor brings to supervision a distinctive set of experiences, a range of expertise, and a unique profile of strengths that together have the potential to shape and alter supervision processes and outcomes. Psychologists work across diverse treatment settings, populations, client issues, and engage in a range of professional activities. Consequently, attempts to match competency lists prescribed by professional stakeholders with supervisor and supervisee preferences should occur early in supervision.

It is helpful to design CDPs that acknowledge and build on the professional and personal strengths of the supervisor and the supervisee. An implication for the supervisor is to become more aware of the range and limits of one's competence and expertise, and to plan professional development experiences for oneself, in a fashion that parallels the design of learning outcomes for the supervisee. Further, it is important to recognize that in the "new scheme of things" professionals are called on to demonstrate competencies (e.g., through completion of workshops and assignments, or through consultation and supervision), rather than to merely assume they have acquired competencies through experience (Gonsalvez & Milne, 2010). Becoming

aware of the range and limits of one's competence and expertise, and planning professional development experiences for oneself, in a fashion that parallels the design of learning outcomes for the supervisee, is part of the fun and challenge of professional growth as a supervisor.

Effects of theoretical orientation Recent attempts to map out supervisor competencies have led to the description and detailing of general and specialist supervisor competencies (Roth & Pilling, 2008). The identification of generalist competencies is consistent with findings demonstrating that supervision across specializations in psychology (and indeed across disciplines; Kavanagh et al., 2003; Strong et al., 2004) share a large number of common elements. Specific competencies include competency sets associated with specific therapeutic orientations. This raises the question whether supervision outcomes are influenced by a supervisor–supervisee match for preferred therapeutic orientation. Unfortunately, the empirical research on orientation matching and supervision outcomes is paltry and preliminary, and the results have been inconsistent. Perceived theoretical similarity yielded higher perceived supervisor effectiveness for a group of counseling interns in one study (Putney, Worthington, & McCullough, 1992), but the superiority of such matching has not been demonstrated in relation to the supervisory working alliance or the supervisees' developmental progress (Blaisdell, 2000). Also, any observed advantages for matched orientation may be mediated by working alliance or by the way these differences are handled, rather than whether any such differences were present (Dodds, 1986). Nevertheless, it is reasonable to assume that the supervisor's perceived competence and confidence with regard to therapeutic orientation would influence their list of preferred competencies for the placement.

Supervision approaches, personal preferences, and relating styles In the face-to-face context of individual supervision, complementary interpersonal attitudes, approaches, and supervision styles have the potential to enhance the supervisory relationship and promote the acquisition of competencies. Significant differences among supervisors occur on a number of dimensions, including directiveness; structure and organization; support and caring; and ability to be challenging, to be consultative, and to be interpersonally sensitive. Further, supervisors differ in terms of their ability to vary their supervisory styles to meet situational demands. Despite wide differences among experts on several other matters concerning supervision, there is an expert consensus about the importance of the supervisor–supervisee relationship and its influence on supervision process and outcome (Beinart, 2014). This core determinant of supervision deserves special consideration in supervision planning. The current chapter is not focused on the effects of the supervisory relationship but on how this core determinant should be given appropriate consideration during supervision planning. Yet, despite the emphasis on the supervisory relationship within both the theoretical and empirical literature (Bernard & Goodyear, 2009; Milne, 2009), we know little about whether weak alliance early in supervision is predictive of future ruptures in the supervisory relationship. It is also unclear whether similar or complementary supervisor–supervisee styles or preferences strengthen working alliance and supervision effectiveness, and whether such effects are mediated by matching or

complementary supervisor–supervisee developmental stages. Given the undeveloped state of knowledge in this area, the best approach in practice may be for supervisors to become aware of and avoid unhelpful supervisor styles and patterns (Liese & Beck, 1997), and to develop accurate awareness of their own supervision approach and style. Such heightened awareness may help the supervisors to be alert to the potential for mismatches between their supervision approaches and supervisees’ expectations. The supervisory relationship is also likely to benefit if supervisors encourage supervisees to similarly engage in reflective practices (see, e.g., Bennett-Levy & Thwaites, 2007) aimed at enhancing awareness of professional and personal qualities, and their preferences in supervision. This will assist supervisors in adjusting their style to developmental level and learning style of the supervisee.

Cross-cultural effects

Factors such as ethnicity, gender, and religious identity of individuals in supervision, and cultural differences within the supervisor–supervisee dyad, have the potential to influence the supervision process. Effective supervisor strategies to engage supervisees in the formulation of a CDP may vary across countries and across culturally different supervisees within a country. For instance, Tsui and colleagues (Tsui, Ho, & Lam, 2005) have drawn attention to interesting differences between Chinese and Western perceptions of roles, boundaries, and “appropriate behaviors” within supervision. Specifically, strong Chinese conventions of “giving face” (protecting the supervisor from embarrassment or from “losing face” by superficial agreement with the supervisor’s opinions and compliance with supervisory intentions) have the potential to affect the nature and meaning of a supervisee’s interactions. If cultural differences are not appreciated, a Chinese supervisee’s failure to articulate a different opinion may be misinterpreted as engagement and agreement, or as lack of independence. The concept of *qing* among the Chinese (Tsui, 2004) also has implications for the supervisory relationship. Maintaining an appropriate professional supervisory relationship (in Anglo-Saxon terms) may be construed as being overly formal, cold, aloof, and even as disapproval within Chinese and other south Asian cultures. Hence, while competency-based approaches are expected to be relevant across continents and countries, cultural factors are likely to influence the choice, form, and delivery of a supervisor’s interventions. From the supervisor’s perspective, it is important to be sensitive to cultural issues and their impact on supervision, to ensure that one acquires new cultural competencies or supervises within one’s area of cultural competence (see Hernandez, 2008).

Contextual resources and constraints

Common contextual factors include the nature of the service provided (e.g., inpatient/outpatient) age, type, and severity of client/client problems (child/adult; anxiety/depression/relationship problems), and learning opportunities available during placement within psychology (e.g., case conferences, research seminars, group programs, and multidisciplinary activities, such as ward and grand rounds). Table 12.1 summarizes the main points about the foregoing procedures and processes.

Table 12.1 Overarching considerations for CDPs.*Best-practice guidelines*

1. Acquire a good working knowledge of competency frameworks from key accreditation bodies and professional societies.
2. If the supervisee is a student, obtain competency lists from the supervisee's training institution along with "input" requirements concerning caseload, case type, and supervision.
3. If applicable, obtain competency lists and requirements/recommendations about the practicum from the service agency at which the placement will be conducted.
4. Obtain relevant information to help you assess the supervisee's developmental stage (e.g., previous supervisor's report; inventory to assess development). Have the supervisee submit representative samples of performance (e.g., recording of therapy session) if this is warranted.
5. Become aware, acknowledge, and build the program around your strengths and values.
6. Cultivate an awareness of how you are faring yourself, personally and professionally, on the burnout–thrive continuum and the effect of this on your supervision.
7. Become aware and acknowledge gaps within the supervision program and explore options to bridge these gaps.
8. Design a list of peer expertise and learning activities (e.g., ward and grand rounds) that will build on and enrich learning outcomes from the primary supervisor's input.
9. When supervising an individual from a different cultural background, gain an understanding of cultural factors affecting supervisory processes through education or supervision.

Helping Supervisees Formulate Their Competencies for Supervision

Goals and competencies in supervision

The task of formulating a program of competencies shares several characteristics with goal-setting, which has a long and valued tradition within clinical supervision. Within therapy, goal-setting skills are a key component of the therapeutic alliance (Horvath & Greenberg, 1989; Horvath & Symonds, 1991), which is recognized to be an important determinant of treatment outcome (Horvath & Symonds, 1991). There is expert consensus that the formulation of goals is also an important supervisor competency (Falender & Shafranske, 2004; Roth & Pilling, 2008) and this has empirical support (Milne, Sheikh, Pattison, & Wilkinson, 2011). Unfortunately, this supervisory task is often poorly prioritized or inadequately applied (Gonsalvez & Freestone, 2007). An examination of the reasons for this may help address the problem. First, there is often a lack of clarity with regard to goal definition, and a poor appreciation of characteristics contributing to effective goal formulation. It is worth remembering that clinical supervision has been primarily influenced by two traditions with their constituent paradigms and metaphors: teaching and therapy. Regrettably, the confluence of these two paradigms has also generated a host of terms with ambiguous and overlapping conceptual boundaries. To a large extent, goal-setting in supervision practice often mirrors procedures adopted in the counseling

room. The term “goal,” as in the negotiation of therapy goals, is often used in a fairly broad manner to designate both generic and specific goals. On the other hand, within the education parlance, a goal refers to a “broad and general statement of . . . intention” and not to be confused with a “learning objective or outcome” that refers to “a clear measurable outcome” that the learner can demonstrate (Newble & Canon, 1995).

Competence is defined as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (Epstein & Hundert, 2002, p. 227). Competencies are defined as “demonstrable elements or components of performance (knowledge, skills, and attitudes and their integration) that make up competence” (Kaslow et al., 2009, p. S34). In this context, competencies are more akin to specific learning outcomes that are executed at a high level of proficiency. In other words, a key characteristic of the competency paradigm is to start with the end in mind. This means that a key initial task for supervisors seeking to design a CDP is to invite supervisees to formulate a list of specific and personalized competencies that they plan to attain by the end of the placement.

Joint goal-setting with supervisees Supervisors often appreciate the advantages of engaging the supervisee in setting goals for supervision jointly. However, they observe that supervisees have problems formulating goals: supervisee goals are often overly general (*I want to become a good therapist/psychologist*), and/or are naive and ambitious (e.g., *I would like to become an expert in eating disorders*). Several factors contribute to poor goal-setting skills among supervisees. Peer conversations about “difficult and complex clients” sensitize novices to the difficulties rather than the rewards of being a counselor or psychologist, leaving them feeling uncertain, inadequate, and dependent. They often respond by being overly trusting and dependent, assuming that the supervisor knows best. Having no knowledge of the terrain, quite understandably, they have difficulty charting a path to progress. Under circumstances where several supervisees compete for an available placement, supervisees may consider it prudent to agree with whatever the supervisor suggests. The context makes it inviting for the supervisor to assume the mantle of the expert and prescribe a set of competencies for the placement.

There are several reasons why the supervisor should not be lured into taking sole charge of formulating the competencies for a placement. Thinking deeply about and articulating the competencies the supervisee desires to achieve is productive in its own right. It raises self-awareness, strengthens engagement in the supervision process, and is likely to enhance the supervisory alliance. Regardless of whether or not supervisees can explicitly articulate the competencies they would like to attain, it is likely that, at the conclusion of placements, supervisors will be evaluated against implicit expectations. Moreover, the opportunity to reflect on the set of competencies that one values is an excellent opportunity to foster reflective practice in an area central to professional identity. Finally, an important developmental transition is the progress from dependence to assuming responsibility over one’s professional journey toward competence. There is no better place to start than with giving supervisees responsibility to jointly formulate their personal CDP. To this end, a more deliberate and systematic effort to help supervisees with this task is warranted. There are several

strategies that are useful in assisting supervisees to identify, articulate, and compile a meaningful set of competencies for themselves. Information about how to formulate SMART competencies (covered in the next section) and the provision of templates with core domains (e.g., assessment, conceptualization, intervention skills), including examples of relevant competencies, may be a good initial step. Supervisees who require additional support may be offered, as examples, competency lists designed for peers at the same developmental stage. Almost invariably, supervisees have made considerable commitments of time, effort, and financial resources to their training. Above all, supervisees often have a large part of themselves invested in their careers and aspirations, which makes what transpires in supervision personally relevant and profoundly meaningful. Having supervisees' actively engage in setting their personalized set of competencies for placements provides the supervisors with an excellent opportunity to get to know and understand their individual supervisee.

Enhancing the supervisee's awareness of their own strengths and needs

Developing self-awareness through analysis and reflection is an important competency for all professionals, especially for psychologists and counselors. An awareness of one's personal and professional strengths and needs, and a nondefensive openness to both positive and corrective feedback, is probably the best predictor of a supervisee's response to supervision and potentially their rate of progress during a placement. Hence, having the supervisee participate in meaningful self-awareness exercises is a good way to commence supervision. Further, it is crucial that any blueprint for a supervision program attempts to build on the strengths of both supervisor and supervisee in addressing the supervisee's developmental needs.

Representative questions posed to the supervisee may include the following:

- What strengths and needs do you believe you bring to your role as a therapist/counselor?
- Do you have preferences in terms of a theoretical orientation? How strong are these preferences? What experiences have shaped your preference?
- How important to you is it for a supervisor to share/have a different therapeutic orientation than the one you have?
- What knowledge and skills do you believe you already possess as a family/cognitive-behavioural/psychodynamic therapist?
- What specific skills would you want to develop or enhance?
- How do you typically cope with the pressures of client work/academic load/combo of above? Are there self-care practices that work for you?

Novice supervisees may find this task more difficult and more anxiety provoking than their more experienced peers. Often, they are concerned about the possibility that their answers may be incorrect or are "not insightful enough." In fact, it is not expected that the task would reveal an accurate appraisal of a supervisee's capabilities and attitudes. Any focus on the valence or "correctness" of the answer is missing the point. The point is rather to emphasize the relevance of asking the question and to encourage supervisees to develop powerful self-awareness and reflective processing, skills that have largely been ignored in prior academic training.

Table 12.2 Assisting supervisees formulate a personalized list of competencies.*Best-practice guidelines*

1. Ensure the supervisee understands the importance of formulating a personalized list of competencies that the supervisee would like to attain during the placement. Insist on a written draft.
2. Commence the process of goal setting and reflection several weeks before supervision commences. Assist them in this process by providing them with relevant resources (information about the placement, information about how to formulate *SMART* competencies, and guidelines you have drawn up, or examples of adequate and inadequately formulated competencies).
3. Offer additional support and scaffolding if initial effort by the supervisee is unsatisfactory. This can be achieved by providing supervisees with a template or matrix with common domains, offering examples of different types of competencies including knowledge, skills, attitude, and relationship, providing them with a program of competencies designed for a peer at the same developmental stage, or providing different sets of competencies that span developmental levels just below and just above the supervisee's current developmental stage.
4. Following submission of an initial draft of competencies, have supervisees identify the overlap and areas of mismatch between their personal list and the competencies recommended by relevant professional stakeholders. Supervisees may then progress to revise and prioritize their list of competencies.
5. Match the level of assistance you provide to the supervisee's developmental level.
6. Have the supervisee identify a profile of perceived strengths and needs that will help inform and customize planned learning outcomes.

A reflective focus on the supervisees' needs and strengths early in the supervision process has the potential to provoke self-doubt and anxiety. Supervisee anxiety is best evaluated and managed on a case-by-case basis. It is also important to bear in mind that designing supervision plans without a fair impression of how a supervisee views themselves, or what skills they believe they bring to their roles, is a good recipe for future ruptures in the supervisory relationship. Table 12.2 summarizes some of these points.

CDP for Supervision: Finalizing Competencies

Assisting the supervisee to formulate a personalized list of competencies for the placement experience is a useful first step, but a program of competencies formulated solely by a supervisee is rarely comprehensive or adequate simply because it requires expertise that professionals early in their career have not had the opportunity to develop. Therefore, the supervisor bears the ultimate responsibility to ensure that the supervision plan is comprehensive and meets best-practice guidelines. The supervisor's task is to facilitate informed discussion about and to align the supervisee's plan with the requirements and recommendations of relevant stakeholders, including the

supervisor. Finalizing a list of competencies and designing an implementation strategy are arguably the most vital supervisor tasks, and so should be executed through active collaboration and consensus-building with the supervisee. It is hard to conceive of an effective supervision program without a carefully choreographed master plan that underpins its various activities and the active and open engagement of the supervisee in these activities. The ability to formulate *SMART* competencies and the ability to formulate a holistic program of competencies are two essential hallmarks of an adequate CDP for supervision. Each of these will be addressed later.

Formulating *SMART* competencies

There is evidence from a wide range of disciplines that attainment of optimal outcomes requires more than the activity of goal-setting; it requires that goals are operationalized and satisfy key criteria. For instance, Doran (1981) makes a compelling argument that planned outcomes must be *SMART*, a useful mnemonic that captures these criteria. In the current chapter, the mnemonic has been retained but the criteria have been modified to make them applicable to competencies for supervision (*S = specific; M = measurable; A = appropriate to developmental stage; R = relevant and recommended by relevant bodies; T = time-wise*). The first criterion for *SMART* competencies is that they be *specific*, rather than general. The most common problem with supervision goals is that they are overly generic. For instance, “improving a supervisee’s diagnostic and therapeutic skills,” are goals that could apply across a wide range of client populations, severity levels, and psychological disorders. More helpful, specific competencies for a placement in an anxiety clinic that offers services for adults would be “to make accurate diagnostic and differential diagnostic decisions for adult cases of anxiety disorders; to demonstrate competency in conducting exposure therapy across several phobic conditions; and to demonstrate Socratic dialogue skills that promote change of client belief structures.”

The second criterion is that the competency is *measurable*. In the absence of tangible, quantifiable means by which to gauge progress (or lack thereof), there is a greater risk of deviating from the original objective or not meeting the desired outcome at all. For instance, exposure therapy competencies could be assessed by “standard or exemplar” cases, and “Socratic dialogue” could be assessed by validated scales (Blackburn et al., 2001; Milne & Reiser, 2013). Competency measurement will be discussed in greater detail later in the chapter.

The third criterion emphasizes that a goal is *appropriate from a developmental perspective*. This criterion helps differentiate competencies across training and professional levels. For instance, “fostering a therapeutic alliance with cooperative clients” may be an appropriate competency for a supervisee at the novice level, and “establishing and maintaining a therapeutic alliance with ambivalent or resistant clients” may constitute a more advanced competency. Similarly, “to be better able to manage transference and countertransference reactions in therapy” is inappropriately generic and could apply across developmental stages to both supervisee and supervisor.

The fourth criterion is *relevance*. That is, does the competency align with the “bigger picture” aims and competency frameworks recommended by accrediting bodies and professional stakeholders? For instance, “to become competent in hypnotherapy” may be a valuable optional competency under certain circumstances but

may not be included among the list of essential competencies that the supervisor has to endorse at the end of placement.

Finally, a *SMART* competency is one that is *time-wise* and *time-bound*. In other words, attainment of the competency is realistic within the timeframe devoted for the placement and supervision. Hence, for a three-month placement, the ability “to conduct cognitive therapy at a competent level” may be unrealistic, whereas “the ability to conduct cognitive therapy at the advanced beginner level” may be *time-wise*.

Foundational and functional competencies

While we should be cognizant of the benefits of competency-based approaches, we should not lose sight of potential problems. One such potential problem is the proliferation of competency lists that become excessively detailed and tedious. The categorization of competencies into broad domains and the differentiation between foundational (e.g., relationships, ethical, and legal standards) and functional domains (e.g., assessment, intervention) appears meaningful (Rodolfa et al., 2005). There is evidence for at least four broad clusters of clinical psychology competencies (including assessment and intervention skills, psychometric skills, professional skills, and professional values and attributes), but these data are preliminary and warrant further research (Gonsalvez et al., 2013). The danger is that psychology’s obsession to differentiate and divide, then differentiate and divide again, will lead to a maze of competency domains and matrices that will only serve to obscure rather than to accentuate the true character of the competent practitioner. To some extent, this trend may be apparent already, with competency taxonomies becoming more complex, and competency lists growing too bulky for implementation at the grassroots level (Fouad et al., 2009; Hatcher & Lassiter, 2007). Time will tell whether our passion for dissection will yield a clearer representation and a more accurate measure of the practitioner’s core capabilities.

Knowledge, skills, attitude-value, relationship, and metacompetencies

In the past, pedagogic advances in curriculum development have had seemingly little appeal or impact on the way supervision was conducted. Supervisors have felt, with some justification, that the teaching–education paradigm was designed to focus on facts and concepts through the mechanics of cognitive processes. On the other hand, psychological therapies are concerned with subjective truth, and attend to feelings, attitudes, conflicts, and relationships through the mechanics of emotional processing. To have an impact on supervision, the competency-based paradigm has to go beyond knowledge and cognitions and embrace the data of emotions and relationship interactions. To the extent that these processes become legitimate competencies and are given pride of place within competency matrices, we will have taken the first steps toward ensuring we do not flush out the baby with the bath water.

In adapting the competency paradigm to supervision, it is therefore crucial for the supervisor to preserve a holistic approach to competence. One way of doing this is to discriminate among (and assign relevant priority to) the core and high-impact

competencies. Gonsalvez et al. (2002) recommend that a holistic program will comprise a balanced commitment of supervision resources to the four competency types: knowledge (e.g., to demonstrate an awareness of the empirical literature governing cognitive therapy), skills (the ability to conduct with fluency a diagnostic assessment for eating disorders), attitude-value (to become aware of and my responses to clients, to be more open to negative feedback), and relationship competencies (e.g., to demonstrate the ability to form and maintain a working alliance with adult clients).

Within this context, it is of note that several competencies that are at the core of professional training are attitude-value competencies (for instance, unconditional positive regard, regard for scientific evidence, respect for ethics principles, commitment to a client's well-being, openness to corrective feedback). The problem at the root of unethical professional behavior is usually not a knowledge inadequacy or a skill deficiency, but a disregard for ethics principles and a lack of genuine commitment to client welfare, both attitude-value competencies. Devoid of the value aspects of the competency, an in-depth knowledge of the code of ethics will achieve little by way of fostering the development of a competent practitioner. Similarly, respect for empirical evidence and value attached to the scientific method are essential aspects of the scientist-practitioner competency, not knowledge of the empirical literature concerning treatment outcomes. Finally, because relationship competencies hold a preeminent position in professional psychology training, they are best regarded as an independent competency type in supervision (Gonsalvez et al., 2002).

Metacompetencies Recently, there has been a renewed focus on the notion of metacompetencies, such as reflective practice and the scientist-practitioner approach. The development of metacompetencies may be more important and more impactful on long-term outcomes for professional training than the focus on a large number of discrete and specific knowledge and skill competencies (Kagan & Kagan, 1997). Although there is little by way of empirical research to demonstrate the superiority of training programs that focus on metacompetencies early in training, there appears to be expert consensus that reflective practice is important (Bernard & Goodyear, 2009; Milne, 2009). Highlighting the importance of these competencies early in supervision, followed by systematic and ongoing attention during later stages of supervision, may be an effective supervisor strategy.

In summary, from the supervisor's perspective, it is important to ensure that the supervision plan represents a balanced program of competencies with appropriate relevance given to competency domains and competency types.

CDP for Supervision: Implementation

Once mutual agreement about a set of competencies has been achieved, the task for the supervisory dyad is to design an implementation plan that outlines how these competencies will be achieved. Such a plan will involve the planning of four aspects: placement and supervision activities; supervision methods and techniques; formative feedback and summative assessment tasks; and supervision evaluation. Each will be described briefly. A template that may be used to garner this information is provided in Appendix 12.A.

Content and learning activities

The content that may be covered in supervision is extensive and can span all foundational and functional domains (Fouad et al., 2009), client populations and client presentations. Practical considerations, such as the nature of the services provided at the placement site, may limit the nature of activities and caseload. Supervisees will benefit if supervisors are pro-active and provide them with information about the nature of client services provided at the placement, client-load, supervision frequency and modality (individual vs. group), and other essential practicalities. Additional information, including typical roles and responsibilities of supervisors within the agency, and generic information about the agency, agency staff and other resources (e.g., video recording facilities), will also enable supervisees to make better informed decisions. Where supervisees have an option of choosing between facilities, a visit to the agency site and discussions with staff may be of benefit. In the face of growing diversity of specializations in psychology, it is important for supervisors to openly discuss their area(s) of specialization and the limits of their expertise. It is a good strategy to recruit peer expertise, both within psychology and across disciplines to widen and enrich learning experiences. For instance, attending ward or grand rounds, and then reflecting on medical and nonmedical models, multidisciplinary interactions, and philosophies could be an insightful and stimulating experience for a supervisee. The activity could be used to foster knowledge (diagnostic decision-making trees), skills (case formulation and case presentation skills), attitude-value (the value self and others place on diagnostic labels; one's attitude towards nonpsychology disciplines), and relationship (the nature of one's relationship with peers and professionals from nonpsychology disciplines) competencies. The "reflective" component of the exercise could enhance self-awareness, professional identity formation, and reflective practice competencies. As may be apparent from the above example, the nature and type of competency targeted for growth will determine the range and nature of learning activities chosen for the placement.

Supervision methods and techniques

A range of supervision methods may be used to facilitate the attainment of supervision competencies, including case discussion, role-play, live observation and video review. Recent technological advances in computer technology have made possible the use of sophisticated live monitoring techniques such as bug-in-the-ear and bug-in-the-eye (Bernard & Goodyear, 2009). Real-time direct observation can now be conducted remotely, using video conferencing platforms. Despite current availability of these innovative methods of supervision, simple video recording and review remain practical, versatile and popular. From a competency-based perspective it is important that the supervision methods chosen match the competency-type targeted for change. The promotion of skills development requires opportunities for observation, review, behavior rehearsal and feedback. Hence, the selection of live (e.g., one-way mirror) or delayed monitoring (e.g., video review and feedback), together with the use of role-play would be consistent with skills-training pedagogies. Knowledge-application competencies can be promoted using case-presentations of actual cases and standardized case-scenarios. Participating in co-therapy and independent video review and

feedback from supervisor or peers are recommended for enhancement of self-reflection and self-awareness, because they provide opportunities for self-observation against evaluation by others.

It is worth noting that each supervision method has its own characteristic strengths, rationale, and range of applications. For instance, real-time monitoring through a one-way mirror may be advantageous when direct and immediate intervention is warranted to ensure client care (e.g., during an assessment of suicide risk by a novice, or during a strategic intervention in family therapy; Bernard & Goodyear, 2009). Examples of competencies and examples of appropriate supervision methods for important competency domain are provided in Appendix 12.B and Appendix 12.C, respectively.

A cursory glance at Appendix 12.C highlights the value and versatility of observation methods. Specifically, while self-report may be justified for knowledge-competencies, observation methods are capable of addressing knowledge, skills, attitude-value, relationship, as well as the metacompetencies, such as reflective practice. Perhaps the most glaring example of supervision practice that is inconsistent with the foregoing expert consensus and empirical evidence is the widespread use of case presentation and subjective report in supervision, to the neglect of observation methods (Gonsalvez & McLeod, 2008; Kavanagh et al., 2003). It is illuminating that these practices persist despite recommendations to the contrary by experts (Liese & Beck, 1997; Milne, Leck, & Choudhrie, 2009; Padesky, 1996), despite supervisee preferences for skills training, and despite the acknowledgment by supervisors themselves that more extensive use of observation methods would be ideal (Gonsalvez et al., 2002). At the risk of being provocative, I would like to suggest that this unhealthy supervisory practice survives because of a possible collusion between supervisor and supervisee (see Milne et al., 2009 for more on collusion). From the supervisee's perspective, observation methods raise anxiety and exacerbate feelings of self-doubt and inadequacy in the short term, especially among novice supervisees. From the supervisor's perspective, observation often highlights a "stuck-point" in therapy, followed by a supervisee's request to the supervisor to demonstrate how the interaction could be handled differently. Impromptu role-plays place the supervisor's skills under scrutiny, which may provoke supervisor discomfort. Inadequate training in the effective use of observation methods might further accentuate ambivalence toward these methods (Kavanagh et al., 2003). Thus, avoidance of observation methods benefits both supervisor and supervisee in the short term but, unfortunately, yields less effective outcomes in the long term.

Formative feedback

A key characteristic of competency approaches is the systematic and ongoing monitoring of performance so that progress can be tracked across competency domains and over time. A comprehensive tool kit for the assessment of competencies has recently been published (Kaslow et al., 2009) and principles governing best-practice assessment and challenges in assessing competencies have been described (Leigh et al., 2007; Lichtenberg et al., 2007). Ongoing formative feedback, given in a constructive and interpersonally sensitive manner, has been the backbone of skills-shaping in supervision in the past. The supervision literature has a wealth of information on

formative feedback (see Kluger & DeNisi, 1996), helpful discussions about approaches to feedback (Borders, 1993), and good-practice guidelines about providing balanced feedback (Hattie & Timperley, 2007; James, Milne, & Morse, 2008). From a competency-based perspective, feedback must be competency driven in that it should be sufficiently specific to shape and consolidate targeted competencies, or extend the application of such competencies to newer and more complex situations.

Summative assessments and reports

Summative assessments often provoke anxiety among supervisees. Assessments associated with live or delayed observation (e.g., videotapes of sessions) may accentuate these negative experiences. More recently, regulatory bodies have required training institutions and supervisors to certify that supervisees have demonstrated attainment of a checklist of competencies before declaring candidates ready for practice (e.g., Australian Psychology Accreditation Council, 2010). This gives supervisors less say in the matter. In any case, assessment tasks must be ecologically valid, capable of capturing essential elements of the competency, and be sensitive to changes in performance levels. In forthright terms, the excessive reliance on subjective report, a common practice in supervision, is inconsistent with the principles of valid assessment (Kaslow et al., 2007; Lichtenberg et al., 2007). Key competencies such as accurate diagnostic capabilities, case conceptualization, and counseling (and other intervention skills) require observation of therapist behaviors and performance. Further, the multiplicity of competencies that require monitoring and evaluation warrants a broad repertoire of assessment activities and tasks (Kaslow et al., 2009). Growing evidence suggests that supervisor judgments of supervisees may be vulnerable to rating biases, including halo and leniency effects (Gonsalvez & Freestone, 2007; Knight, 2013; Robiner, Saltzman, Hoberman, Semrud-Clikeman, & Schirvar, 1998). This has resulted in the recommendation for multimethod, multitrait, and multitask assessments (Leigh et al., 2007). The practice of scheduling some form of summative assessments at mid- and end-placement is common and often mandated by accreditation bodies and training institutions. However, a baseline assessment of key competencies, an essential task to track the progression of competency attainment during a placement, is rarely conducted (Gonsalvez & Freestone, 2007).

Several competencies central to professional training are attitude-value competencies that may not lend themselves to being captured by a brief inventory or rating scale (e.g., unconditional positive regard, regard for scientific evidence, respect for ethical principles, and commitment to client well-being). Therefore, supervision plans should identify behavioral anchors for these competencies, and recommend supervision methods (e.g., video review) that may capture these indices.

Evaluation of supervision

The current chapter is concerned with the formulation of CDPs for supervision, so a detailed coverage of evaluation falls outside its scope. However, it is worthwhile mentioning that key aspects of evaluation must be given due consideration during the planning stage. Ideally, evaluation should include an evaluation of supervisor competencies during implementation of the CDP and assess whether the CDP blue-

print for the supervision program satisfies best-practice guidelines. To be credible, evaluation data obtained from supervisees are best complemented by expert/peer observation and critique.

Resolving differences

It is of paramount importance that the final CDP for supervision is arrived at through consensus and that it reflects a genuine attempt to meet supervisee needs. However, the supervisor also holds responsibilities to protect client welfare and to ensure that professional standards are not compromised. Supervisee anxiety toward observation methods may be effectively managed in a variety of ways, including graduated exposure to the task or, where appropriate, through the use of alternative observational methods (e.g., the use of videotapes in lieu of the one-way mirror). In my opinion, the supervisory practice of certifying the attainment of skills and relationship competencies on the basis of supervisee self-report is indefensible. Should observational methods not be feasible for one reason or another, the set of competencies targeted for development in supervision will require revision or confirmation at a later date.

Establishing the nature of summative assessment tasks and finalizing the schedule for lodgment of supervisor reports (if applicable) are challenging tasks for most supervisors. This is reflective of conflicting roles (supportive and facilitative vs. objective assessor) that the supervisor is called on to assume during supervision. In my opinion, where possible, the summative assessor function should be delegated to an independent professional. Evidence that supervisor judgments of supervisees may be systematically biased is an additional reason to support such a change. (Gonsalvez & Freestone, 2007; Robiner et al., 1998). Table 12.3 summarizes the preceding points.

Table 12.3 CDP Implementation.

Best-practice guidelines

1. Ensure that the CDP is the outcome of active collaboration between the supervisor and supervisee.
 2. Formulate competencies that satisfy *SMART* criteria.
 3. Ensure balanced coverage of competency domains and competency types.
 4. Match type and nature of competencies to supervision methods
 5. Match type and nature of competencies to assessment tasks.
 6. Manage supervisee anxiety with tact and understanding without compromising competency standards.
 7. Ensure the CDP capitalizes on supervisor and supervisee strengths and addresses important supervisee needs.
 8. Recruit the expertise of colleagues and access learning opportunities within the placement context to extend and enrich the supervisee's learning experience.
 9. Design strategies to resolve potential problems/barriers affecting implementation.
 10. Incorporate ongoing and systematic evaluation of all program components.
-

Establishing a Supervision Agreement or Contract

Establishing a supervision plan that includes an agreement about the competencies to be attained during placement, and a blueprint to achieve this may form the basis of a more formal supervision agreement or contract. A legally binding supervision contract may be applicable when the supervisee is paying for the supervision provided. Regulatory, legal, and ethical guidelines differ across countries, states, or provinces within a country, and situations. Hence, offering a general template for a supervision contract will be of limited value. Sample supervision contract outlines are available in several textbooks (see Bernard & Goodyear, 2009; Falender & Shafranske, 2004).

Many supervisors across disciplines and countries provide supervision to trainees or junior professionals as part of their commitment to the profession, or as their roles as senior professionals within an organization. A signed supervision agreement between the supervisor and supervisee(s) will be more appropriate in these circumstances. Key issues that are likely to be of relevance to supervision agreements and contracts are as follows:

- Professional qualifications and expertise of supervisor: Include name, qualifications, current registration/licensure status, areas of specializations if appropriate, training in specialized interventions if relevant (e.g., hypnotherapy), training in supervision, and membership in professional societies.
- Professional details of supervisee(s): Include name, qualifications, current registration/licensure status, areas of specializations if appropriate, and years of experience if applicable.
- Financial terms and other practicalities: List fees, cancellations, and payment for resources if applicable.
- Supervision details: Include frequency, times, and modality of supervision, periods of leave if applicable, and provisions for backup supervision.
- Supervision goals, activities, and methods: Include copies of competency lists and copies of supervision plans for implementation.
- Assessment: Provide details of assessment tasks, schedule of assessments, and assessment reports.
- Roles and responsibilities: Include descriptions of supervisor and supervisee roles and responsibilities. In circumstances where several different persons hold supervisory or management roles (e.g., online managers), identify lines of accountability for what and to whom.
- Case work: Identify document that summarizes (or include details regarding) policies and procedures governing key aspects of case work including caseload and case documentation.
- Adherence to professional code of ethics: Mention the professional code of ethics to which supervisor and supervisee will adhere.
 - Mention issues of specific relevance to supervision and how they will be managed (e.g., including extent of vicarious liability, confidentiality, assessment materials).
- Insurance: Mention indemnity/malpractice insurance requirements, if relevant.

Summary and Concluding Comments

Competency-based models have breathed new life into the theoretical conceptualization and practical delivery of supervision. An essential supervisor competency is the ability to formulate an effective, competency-based developmental plan for supervision (CDP). The chapter outlines for the supervisor a stepwise approach to designing a CDP and provides best-practice guidelines for key components of the task. First, an effective CDP comprises the formulation of *SMART* competencies to be achieved during a placement. To ensure a holistic program, supervisors must then ensure coverage of (and appropriate prioritizing among) foundational and functional competency domains, and across competency types (including knowledge, skills, attitude-value, relationship, and metacompetencies). Further, a well-designed CDP includes a carefully considered schedule of supervision activities, methods, assessment, feedback, and evaluation, activities that are each informed by and aligned with the competencies to be demonstrated. The active engagement of and close collaboration with the supervisee are essential during all stages of the CDP.

Faithful adherence to the principles of competency approaches has the potential to generate major and enduring changes to supervision effectiveness and efficiency. A key challenge is the competency paradigm's ability to effectively capture and accurately measure the less tangible attitude-value and relationship competencies that constitute the essence of psychotherapy training. It is hard to conduct a clinical supervision workshop without an animated discussion about the unhelpful attitudes of "resistant" and "difficult" supervisees: their reluctance to be scrutinized through observational strategies, their hypersensitivity to critical feedback, and their penchant to be less than diligent in their responsibilities to clients and organizations. While these supervisor observations are accurate, progress within the discipline of supervision will depend also on the readiness for change among "resistant" and "difficult" supervisors and supervisor trainers; our reluctance to submit our supervision to peer observation and expert critique, and our hypersensitivity to challenges that our judgments may be biased. Above all, as supervisors, we could be more diligent in our pursuit of opportunities for growth: to learn from and inspire our supervisees and peers, and to develop competencies that will enhance the "awe and wonder" (Watkins & Wang, 2014) experience in supervision.

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Appendix 12.A Trainee A. Agency: Adult anxiety unit, Northfields Clinic. Placement hours: 300 hr.

<i>Domain and competency type</i>	<i>Competency</i>	<i>Content, casework, time, resources</i>	<i>Methods and procedures</i>	<i>Formative feedback (ff) and summative assessment tasks (S) measures (M)</i>
I. Clinical assessment (knowledge application)	To make accurate diagnoses and differential diagnoses for adult presentations of anxiety	Real cases from clinic (Tue) Standardized cases from case book Feedback: Weekly individual supervision sessions	Case presentation and feedback Use standardized cases scenarios to make diagnoses, followed by discussion in weekly supervision	Feedback following weekly case presentations S: Week 10 (mid-placement); Week 20 (end-placement); M: Therapist performance rating scale: Assessment
II. Intervention (skills)	(a) Conduct a cognitive-behavioral assessment at advanced beginner level (b) Demonstrate Socratic dialogue skills with clients with anxiety disorders kill in structuring therapy sessions without jeopardizing progress through therapy	Real clients from clinic (Tue)	Supervisor demonstration, DVD record of client sessions, role-play	ff: Feedback on DVD, feedback following role-plays S: Week 10 (mid placement); Week 20 (end-placement); M: Cognitive therapy rating scale: self and supervisor
III. Professional multidisciplinary(attitude-value)	(a) Self-awareness: Gain insights into attitudes toward discipline of psychiatry, and medical model, an understanding of cognitive-behavioral interventions for anxiety disorders and to demonstrate level of competence in their application	Grand rounds (Wed) Discussions with registrar and social worker	Complete self-reflective exercise Discuss during supervision	NA
IV. Intervention, multicultural(relationship)	(b) Demonstrate empathy and rapport building with client (a) Demonstrate empathy and rapport building with a client from a different cultural background	Real clients from clinic Client from Aboriginal center	DVD record of client sessions, video review, and feedback	ff: feedback on DVD from supervisor; M = client ratings ff: feedback on DVD from supervisor and Aboriginal psychologist; M = client ratings

Appendix 12.B Competency grid showing sample competencies.

		<i>Competency types</i>			
		<i>Knowledge and knowledge application (WHAT)</i>	<i>Skills (HOW)</i>	<i>Relationship</i>	<i>Attitude-value</i>
Competency domains	Assessment	Disorders: e.g., anxiety Population: e.g., adult Psychological tests Reporting Documentation	Ability to conduct assessments in a competent fashion (includes elements of fluency, time efficiency, pace, and communication style) Ability to conduct interventions in a competent fashion (includes elements of fluency, time efficiency, pace, and communication style)	Therapist–client relationship while conducting assessments. Ability to engage difficult clients, enhance alliance while doing assessments Therapist–client relationship and interactions while conducting interventions CBT: Key cognitions about client and self during interventions	Attitudes toward profession and key professional roles including assessment, intervention, professional development Self: self-doubt, anxiety/confidence Clients: positive regard/, caring, cynical, pessimistic Work: e.g., conscientious, overly responsible, tardy Others including supervisors: e.g., open and responsive vs. defensive
	Intervention	Disorders: e.g., anxiety Population: e.g., adult Psychological tests Reporting Documentation	Procedural knowledge Rationale for choice of interventions Models of psychopathology Knowledge about ethical issues. Competencies to make ethical judgments when given case scenarios	Psychodynamic: Transference and countertransference Supervisor–therapist relationship Relationship with other psychologists and health professionals	Ability to think and act ethically demonstrated in ethical conduct Burn out vs. thriving Professional development
Professional	Ethical–legal: Communication skills Intra- and inter disciplinary aspects: Sociocultural aspects: Professional identity:	Scientist-practitioner mindset (respect for empirical evidence, scientific method, objectivity) Reflective practice capabilities Unconditional positive regard	Oral and written communication skills with other professionals		

Appendix 12.C Competency grid showing appropriate supervision methods.

		<i>Competency types</i>			
		<i>Knowledge and knowledge application (WHAT)</i>	<i>Skills (HOW)</i>	<i>Relationship</i>	<i>Attitude-value</i>
Competency domains	Assessment	Disorders: e.g., anxiety Population: e.g., adult Psychological tests Reporting Documentation	Live demonstration by supervisor Expert videos Monitoring techniques (e.g., one-way mirror) Video tape review (e.g., interpersonal process recall) Role-play activities Assessment by structured, validated scales (if available)	Videotape review methods (e.g., interpersonal process review) Concordance between self- and supervisor report following video review Self-reflection and discussion exercises following actual or e-role play activities Positive feedback on/discussion of observed behavior and conduct Modeling and mentoring Encounter group strategies Experiential work including mindfulness Maintaining personal journals Self-care exercises	Videotape review methods (e.g., interpersonal process review) Concordance between self and supervisor report following video review Self-reflection and discussion exercises following actual or e-role play activities Positive feedback on/discussion of observed behavior and conduct Modeling and mentoring Encounter group strategies Experiential work including mindfulness Maintaining personal journals Self-care exercises Assessment by structured, validated scales or inventories (if available)
	Intervention	Disorders: e.g., anxiety Population: e.g., adult Psychological tests Reporting Documentation	Case presentation and discussion Case scenarios Venn Diagrams Conceptualization charts Test or “standardized” cases Prescribe readings Trainee presentations and seminars Lectures Essays, short answers Multiple choice questions, quizzes Literature searches	Concordance between self- and supervisor report following video review Self-reflection and discussion exercises following role plays Positive feedback on/discussion of observed behavior and conduct Modeling and mentoring Encounter group strategies Assessment by structured, validated scales or inventories (if available) Live supervision methods (if available)	Concordance between self and supervisor report following video review Self-reflection and discussion exercises following actual or e-role play activities Positive feedback on/discussion of observed behavior and conduct Modeling and mentoring Encounter group strategies Experiential work including mindfulness Maintaining personal journals Self-care exercises Assessment by structured, validated scales or inventories (if available)
Professional	Metacompetencies	Ethical–legal Intra and inter disciplinary Identity			