TRANSCRIPT

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COMPETENCY-BASED SUPERVISION

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Falender: Welcome everyone. I hope that this will be just a little interactive and we'll have, at least, a little bit of fun, because clinical supervision in any context is a lot of fun.

I was in this morning's meeting briefly, and one of the most remarkable things I heard was that 70% of your staff did training at the VA. How important is supervision then, because you are, in fact, grooming your future staff.

This is a critical process. I mean, supervision is critical to everyone, but to think about and actually to know that these are people who have a great probability of remaining with you for their careers.

And I have to advertise a little here with pictures of my book. Unfortunately, the colors don't look as pretty here, and my favorite one is the blue one. But anyway, they're nice.

We're going to be learning about supervision. Well this is like preaching to the choir, you all know why. Mainly, many of you are doing this because of licensure and training reasons; supervisees are doing it for degrees and licensure.

But you know what we're finding also is that there are all kinds of other benefits of clinical supervision that are becoming known internationally. And it's really, I think, one of the most exciting things; that we're talking about supervision not just for licensure, but supervision for the whole life span.

Now, you may say, "Aren't you talking about consultation?" Those of you who were at the evidence-based treatment roll-out know about that too, and others of you may know about it also, anyway.

But the reality is that some people are also calling it "supervision through the lifespan," because it is a dissemination of information from someone, theoretically, who has somewhat of a knowledge base, even though it's collaborative. But we'll get to that in a moment.

Anyway, so in and throughout one's career, supervision decreases emotional exhaustion. And this is a very robust finding across multiple major studies.

And through decreasing emotional exhaustion, it reduces turnover intent. People don't want to leave. They feel supported. It's a protective factor.

The thing that I wish we had more of is looking at treatment outcomes, and how supervision impacts that. We're just beginning to see that, because there are new studies, in fact one that just came out in *TEPP* (*Training and Education in Professional Psychology*, that 16% of variance is provided by supervisors, but that's a very small preliminary study.

This is a huge area of research. If you want to really get famous, you should do research on supervision and client outcomes.

Anyone who writes a book has a definition. Let me just tell you before we get to the definition though, what we're going to be doing today is doing a really brief overview of many, many areas about core competencies, in terms of clinical supervision.

Supervision has transformed. It's no longer the kind of thing that we learn through osmosis, simply by doing whatever our supervisors did or didn't do, or consciously not doing what our supervisors did because it wasn't so good or effective, or actually heinous in some instances.

So, supervision is becoming much more structured, much more organized, not that the creativity or the excitement of it is diminished. It's simply that we have more of an objective in mind, and more of a direction, and more of a structure to what we're doing.

So, with that in mind, we have a definition. *Supervision is a distinct professional activity*. And some of you say, "Well, yeah."

But, you know, that's only been for about the past decade, except for counseling psychology, because they have been involved in study longer.

But even so, what we mean is that you need specific training in this--it's not something one just knows--*in which educational training aimed at developing science-informed practice*--which is very much what the VA is rolling out right now, which is so exciting--*are facilitated through*, and this is what's so big, *the collaborative interpersonal process.*

Now I should not be up here on this podium/dais, whatever you call it, because I should be down on the floor with you all, because supervision is collaborative and interactive. It's no longer some senior person speaking down, and then the supervisee receiving the word.

It's a co-construction, and remains there. What about beginning supervisees? Our position is that, even beginning supervisees, their tremendous strengths, perspectives, and values, all kind of things that they contribute, that we need to be cognizant of, okay?

It's multifaceted and *involves observation, evaluation, feedback*. How good are we at feedback? You know? Isn't it so amazing? Here we are, trained as psychologists. We are not good at feedback.

There is some indication that, not only do we not give constructive feedback, we may not even be giving positive feedback. How is learning going to take place without feedback? So we'll be talking about that later.

Facilitation of supervisee self-assessment; this is something that most of us do not learn in graduate school. Did you all learn to self-assess? Yes, so we really need to begin self-assessing ourselves, and we need our supervisees to have a self-assessment grid which they are constantly referring to, and which really serves as the core of their training, in terms of direction.

Then there's the *acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving*; multiple realities. Please feel free to interact and ask questions. Your questions are pertinent to the discussion directly.

Building on the recognition of the strengths and the talents of the supervisee, we like to call it a strength-based approach. Does that mean we look only at strengths? No. It just means we build upon strengths, but of course we look at the entire spectrum of functioning.

Supervision refers to self-efficacy, and ensures it is connected in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large.

So that's only part one of the definition. Sorry. We've got two more parts to go. It's such a big definition.

SUPERVISORY SUPER-ORDINATE VALUES

Falender: The second part is supervisory super-ordinate values. And the first of those is integrity-in-relationship. And I think all of this is important, but the integrity piece is gigantically important.

Supervisors who do not model integrity are associated in about 80% of studies that are done, with supervisees who commit boundary crossings and even boundary violations. Now we didn't discuss this yet, so what's a boundary crossing?

Boundary crossings are things like giving gifts or having lunch with one supervisee, or kind of marginal things that aren't really violations but are sometimes contextually driven, sometimes just a question mark. Touch is a boundary crossing.

Anyway, boundary violations - what's a good example of a boundary violation? You're too shy, speak up; it's a three-letter word.

Audience: sex

Falender: Sex! Or exploitation. Okay, so what I was talking about, then, are supervisors who have sex with a client or a supervisee, who model those kinds of behaviors.

And that's really highly problematic, of course. Similarly, though, supervisors who are valued are associated with supervisees who incorporate their theoretical model for up to five years after completion of their training.

And that's only been studied for five years, and the conjecture is that it's for many, many years, in fact, perhaps a whole career. So the power of the supervisor is very great, even though, in certain circumstances, supervisors don't feel that power.

We really are role models. So remember the integrity piece.

Strains or ruptures to the supervision relationship, which we'll get to, are really an important part of problems, and they're also an important part to process with your supervisees, and we'll have some time to address that a little. Not acknowledging them (strains and ruptures) can destroy the supervision.

But we're not perfect, so we make a mistake. We simply need to process it, and admit it, and talk to our supervisee about it, if we recognize it. If we don't, we need to watch our supervisees to see if they're responding differently to us.

Anyway, the second part is the ethical values-based practice. And again, that competence demands ethics, and it's so important for us to be cognizant of the fact that our ethics and our values are woven into everything we do and everything we say and all our interventions and everything that happens with supervision and with therapy.

And they need to be acknowledged more overtly than covertly. The appreciation of diversity is the inescapable framework of all of our beliefs, and all people are multi-cultural beings. I've had supervisees who come in and say, "I don't have a culture - I'm just white." So, that's not okay. It's really important for us to think about the vast number of diversity characteristics and how they interact. And we'll be talking about that again as we proceed, because it permeates every aspect. Then, science-informed evidence-based practice; the questioning attitude of all of us. Also, that we want our supervisees to pose questions and to engage in a process of inquiry. I'm sorry, it's the endless definition.

This is the third part, and the end. Okay, now the core or the pillar of supervision is the relationship. And this is meta-theoretical. Every supervisory interaction should be based upon a strong supervisory relationship. And the development of that relationship is really a core value, and a critical piece of being a competent supervisor. Also it's a foundation that's shared, and we'll get back to that. Inquiry is facilitating the discussion of all of those factors that influence the perspectives and judgments that we make, and the educational practices as we teach. So, we finally got through the definition. Okay.

Now, what's the difference between supervision and consultation? Anyone know? Quickly. There's one huge difference and some other smaller ones. I'll give you a hint: licensure. In consultation, both people are licensed, or independent practitioners asking a peer about something, or getting input from a peer. There's no express liability in consultation. You are functioning in a protected setting. It's

different from being in some other setting that's much less protected, you know what I mean? Yes, it's Okay. It's institutional liability more, not that you should treat it any differently, but it is different.

Power, there's a lot of power in supervision. Is there power in consultation? Absolutely not, and there's no responsibility, really, except that you want to do the best you can in consultation, but if the protégée, or the consultee, let's say consultee, does not want to take your advice, is that okay? They can just say, "That was really interesting, but I don't want to do that." Right? Can a supervisee do that? No. Mentoring is promoting, helping, facilitating the career, providing professional role modeling, all kinds of things like that, there's no power differential exactly, although in theory there's a little. But there's no evaluation. So if you're mentoring and supervising, what should you do? You should clarify it and use informed consent, and say, "This is going to get a little complicated. We're now at a point in the year when I'd like to be, if you've asked me to be, your mentor. And I would be pleased to do that, but remember, I'm still your supervisor, so I'm still going to be evaluating you. So I'm going to be changing hats now and then. Sometimes I'll be evaluating you; sometimes I'll be mentoring you." It can be very confusing otherwise, and actually quite disruptive to the supervisory relationship if it's not voiced.

Okay, stages of change. Why did I stick this slide in here? Is she in the wrong place? We know she's just coming back from Europe, so she's a little mixed up maybe. No, in fact, all of us need to assess ourselves and our supervisee, in terms of where we are in the stages of change. A supervisee is pre-contemplational. What do they say? What would be a statement they might say--a pre-contemplation supervisee-- about supervision? "Thank you so much for accepting me to this internship. I learned everything I needed to know in graduate school, and so I'm going to be sitting here going through the motions, but I really don't need to meet with you much, so let's have really short meetings. I think 3 to 5 minutes to meet will be sufficient." Now they may not verbalize that, but that may be what is clear to you after about 15 minutes. That that's how they feel. Have you ever had one of those? You know, they exist. Okay. Whereas those who are progressing through this, in contemplation, they're beginning to think maybe there are one or two things that they can maybe learn, and then in preparation or action they're really ready and eager for supervision. And you know we're the same. We're eager to learn, or less than. When I first took a job as a training director, one of my staff came up to me and said, "I just want you to know that everything I needed to know I learned in graduate school. So if you think you're going to get me to learn anything else, forget it." So that would be an example of what stage? Pre-contemplation, okay?

What percent of us are really eager to change? This slide is about change in a major health organization from long-term treatment to brief treatment. Does that sound about right? Change is hard. Only 20-30% of them wanted to change. There is resistance to change.

How complex is competence? And you know what our half-life of knowledge is. What's the half-life of the doctoral psychologist's knowledge? Dubin, in 1972, said 10-12 years. But Ballas and Boren and others said, in five years; half the facts are replaced within a typical span of graduate school, through obsolescence or atrophy.

And on the other side of this, knowledge is cascading upon us. I took a break between this morning and this afternoon and I read ten new supervision articles. The knowledge is just coming out so quickly we can hardly keep up with it really, an unbelievable amount. Plus we need to be critical. And we need to teach our supervisees to be more critical, because not everything you read should be integrated into your functioning. And on the other side, it takes an estimated seventeen years for randomized trial results to be incorporated into the practice community. So that would not be you all, but usual care facilities, seventeen years, like evidence-based training, neuropsychology, things like that. Then we have the problem of statistically illiterate practitioners. The vast majority of people who are practicing do not know how to read the evidence-based literature, and really understand what the statistical analyses are, and whether all of this is really even valid. Furthermore, there's a whole new report that came out from the Institute of Medicine that shows us that maybe half of the people receiving, maybe even maybe half of the people we're seeing, maybe a little more, do not understand what we're giving to them in written form. That they do not have very advanced literacy. And think of all of our consent forms, and all of our elaborate kinds of conceptual things that we say, and how complex our thinking is. We may be really going over people's heads. So if you're interested in this, the Institute of Medicine just came out with this in 2009. It's such an interesting report.

Okay, what is professional competence? Much of what we're going to be talking about today is based upon the definition from Epstein and Hundert, and this comes out of the medical literature, and this is [she quotes], "Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, reflections in daily practice for the benefit of the individual and community being served." It depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence. This is the definition on which all of our competency work has been built. It's the framework. And it's for medicine, social work, nursing, or psychology, for everybody. This is the definition.

Now, Kitchener and others have suggested to us it's easier to know what's *not* competent than it is to know what *is* competent. And you know how accurate that is. Think about your supervisees. When you get a supervisee, or even a staff member who's not competent, how quickly you know, sometimes. Pretty quick? Maybe.

Okay. So what is competence? Well, we shouldn't skip anything. As applied to psychology, competence involves an understanding, and performing tasks consistent with one's professional qualifications. I feel like I'm putting you to sleep. This is not a good thing. So, we need something more lively. Is there an issue in terms of competence? Would you say that's one of your biggest issues: competence and assessing competence? And moving into it? Yes?

Audience comment: I just wanted to say that we're starting to make sure that supervisors are competent in the first place, so then we can make sure our trainees are competent. And that's why I wanted to be here today. I want to be able to go back and help the staff do their own self-assessment, so they'll be prepared for training.

Falender: Okay, what I'll do is, as soon as I can, I will email you a supervisor self-assessment form, so you can begin to look at that. This is a critical piece, so you're absolutely right. There are two things, really, I think, that have to be addressed next. One is supervisors' competence. And I do agree with you. If supervisors are not competent, it just breaks down the entire system. And sometimes, you know how shy we are about feedback to our supervisees? How shy are we about feedback to our peers, or subordinates? Are we good at it? We are horrible, truly horrible. Yes.

Audience: I think it would better for both trainees and supervisors if we had more and better ways of becoming confident about the feedback that we're giving, rather than being [inaudible].

Falender: That's what we're going to do. Within five minutes you're going to have a way to give feedback really systematically, maybe ten, maybe a little longer, but before the break you're going to have a way to give feedback more specifically, and to really target things on the feedback. So, I think you're absolutely right that that's a critical piece, to feel confident. That's one of the reasons. There are many reasons why people do not give feedback, and that's one of them. We don't feel secure about the measurement of competencies or anything else; therefore, we don't give feedback. Because if we don't have good psychometrics or a good structure, then how can we give the feedback? What are some other reasons we don't give feedback? It's uncomfortable. We spend most of our lives trying to get these good supervisory relationships and we're worried that if we give feedback we're going to interfere with that relationship. But you know what? The research that has been done shows us that supervisees prefer--not just at the time, but even 20 years later--they prefer supervisors who gave large amounts of critical feedback. I should say, in the medical field they didn't like them at the time, but they liked them in retrospect. In psychology, theoretically, we like them at the time, too. You were going to say something else?

Audience: [Inaudible]

Falender: There's a sense of hopelessness, because of all kinds of structural regulations, perhaps. Although I still feel, maybe I'm wrong, because I've never functioned within a union, but I train a lot of people, especially in Canada who are in unions, and I still feel that if you can document that they are not meeting performance criteria, that it's a good thing. No? Maybe? But I understand the hopelessness. Sometimes there's that same sense of hopelessness even with supervisees who are students, because you know this is so much trouble, do I really want to spend the amount of time it's going to take to do this? Do I have the energy? I don't think so. I'm overwhelmed as it is. And this is really big. So we become gate slippers instead of gatekeepers, and this is not a good thing. Well, that was fun. We should keep doing this. Yes?

Audience: There's a feeling among supervisors that the ... [Inaudible]... has changed. We've seen the evolution in this over the past 10-12 years, I'd say. And then we speak about the idea that it's too much trouble, now every once in a while [inaudible word] just isn't up to speed, as they always were. Yet they are very resistant to feedback and seem shocked that [inaudible].

Falender: Did you all hear that? He's saying that we're socializing students, and I think it's true, from kindergarten virtually. We're socializing students to expect "A"s. And the only ones who get through to

us actually are those who only got “A”s. They've never gotten anything but an “A” in their whole life, for the most part, or they wouldn't be at the VA, because they wouldn't be accepted. They wouldn't have been accepted to graduate school to begin with, and then they wouldn’t be accepted. So the problem is that we've got to recalibrate, and this is really what I advise people to do. To put in the brochures, and it doesn't discourage people, there are really quite a few places that are doing this now, put in the brochures, that our expectation is that this internship, or even practicum, is going to be a time of great learning. This is not like graduate school; this is different. Therefore, if we're on the Likert scale of 1 to 5, don't expect to ever get any rating during this internship more than a 3. And this goes in the training materials from Day 1. I mean day minus 400, because they look at it in the time before they even come, and then you stick to it, and it's hard to stick to because there's so much pressure, but if you've told them in advance, it's a big plus. Someone back here, yes?

Audience: Another issue with giving feedback, and its two-fold, is historically people would often have one supervisor per unit location. Well, now, especially with my program, you could have 3 or 4 supervisors; one main supervisor and people supervising based on their experiences. So, too, it can be challenging how to get consistency for people we’re using on the same level, and then this year we ran into an issue where a supervisor may not notice something that's becoming a problem…[Inaudible]…,so that the Training Director provides the feedback, and they're wondering why the supervisor didn't provide the feedback, and how do you discuss that in the…[Inaudible]?

Falender: Right, I think that’s a huge pivotal problem that each of you intrinsically needs to organize. And the reality is that it has multiple dimensions to it. There are just so many parts to it. One is confidentiality, and all of our supervisees need to know--do you know how many of our supervisees think that what they tell you about themselves or about their work is confidential? Quite a few. If you ask them tomorrow, "Is what you tell me about anything besides your client confidential?" Many, many, many, and an average of the studies that have done that, about 80% think everything is confidential. So that's part A. So they don't know, first of all, that you all are talking about them, because part of the training environment is talking about them. In a good setting, you talk about your supervisees. You share information with a training team. That needs to be told to them upfront. That's another thing they need to know, that you are discussing them in the process of facilitating their development. So that's part A.

Part B is that you should be meeting as training groups. Everyone, even across settings, if you are meeting supervisees, even if it's telecommunication or distance supervision, you need to talk about your supervisees. And once we get to the competency measures, you'll see, we'll talk about them in the frame with this. But you need to be sharing information. And you need to be clear about the feedback. Who's going to be giving the feedback? The reality is that not all supervisors are good at giving feedback. There are certain supervisors who only want to give good news. You know that's true. They never want to be the ones to give bad news. They never want to give *any* corrective feedback. They just don't and they won't. And this may be a competency that’s problematic. But it's a reality. So you have to figure out how you're going to balance that, because it's very confusing to trainees when, in fact, one supervisor is telling them, "You are wonderful, you are doing such great work, keep it up." And then they come in to you and you say, "Well, let's look at the competencies document, um, these seven

things I want to go through very carefully because ..." And the trainee says, “But I just came out of supervision with Dr. Jones and she told me ....” So it's very hard. You really need to clarify this and work together as a team at your particular site, and be clear about what your anchors are.

So let's move ahead to anchors, and then we'll come back to more of these things. Much of this is derived from the competencies conference. Fouad et al., Kaslow, Rodolfa, and major workgroups came up with the competencies. And then there's the whole piece about meta-competence, which is a pivotal part, and that is, many of us do not know what we do not know, and our supervisees especially do not know what they do not know. So this is a critical part of training. If we rely only on what they tell us about their clients, they only know what they know, and even the best-intentioned supervisee cannot tell you what they do not know, because they don’t know they don’t know. So how do you get around that? Besides competencies, which is one way, another is you need, at some point, somehow, to either observe them or watch a video or have an audio tape. You have to. Can you?

Audience: [inaudible]

Falender: Okay. Well, then that’s good. Most of you say yes, but some of you are just sitting there. So that means either it's a no, or you're thinking about it, or something else.

Audience: There are a lot of forms involved.

Falender: There are a lot of forms involved. It's worth it. It's absolutely worth it to get all those forms, because in informed consent, you're modeling ethical practice while you're doing it. It's perfect.

Audience: There are some technical barriers too.

Falender: Technical barriers too. I don't say you have to watch every supervisee with every client. That's not what I'm saying. What I'm saying is you need to have a smattering of observations. And the higher the smattering the better, but at least some, please, at least some. Otherwise, all you know is what they tell you they're doing. And although I'm sure they mean well and they're trying to tell you, they really don't know. And that gets back to meta-competence.

So, we need to really enhance their meta-competence. So another way we’re going to be reinforcing this is helping them understand what they don't know, and making them think about it more, because it's not something that comes up much in graduate school. I'll tell you this really quickly. How careful, or how good are we at self-assessment? As supervisors, how good are we at self-assessment? How good are psychologists at self-assessment? Professionals are not, none of us are very good at self-assessment. We have not been trained in it. We don't know how to do it. The people who self-assess themselves the highest are those--this comes from the medical literature, but it's been supported in multiple venues--and that is those people who rate themselves highest are those who by other objective means are quite low. So people who rate themselves high, typically, by other objective means, are very low. Whereas, those who by objective means are very high, how do you think they self-assess? Low, because they see so many things that they don't know, they're always thinking about what they don't know and what's next and things like that, so our accuracy is really problematic, so we cannot even

model accurate self-assessment at this point. So it is critical that we all, I think, begin self-assessing and getting practice in it.

This is becoming more critical because licensure is going to be changing. If you're following the zeitgeist and reading the literature, you'll see that MDs are at the forefront of this, and that re-licensure is just around the corner. And part of its coming from the UK, and part of it's just coming from the world, and the knowledge explosion and all these things. That is, how do we really know that people are competent post-licensure? I mean, some people would argue that we don't even know if people are competent at the point of licensure because "competency" is comprised of three pieces, right?: knowledge, skills, and values or attitudes. What do our licensure exams focus on? Knowledge. Do we look at skills? Maybe we do, hardly at all. And values? Forget it. So, that's an issue. Anyway, there's a movement now, the, FSMP, the physicians' regulatory group, is now, by 2012 they are going to have a revalidation process for physicians, to revalidate them, and it's not clear what it's going to look like. In UK the story of Dr. Harold Shipman, you don't know about that? I'll tell you really quickly, it's a physician who was practicing in a rural area and he was seeing a large number of patients and he was associated with very high rates of prescriptions for narcotic drugs. And the regulators came and asked him about it and he said, "Well they're in pain, I've got to give them medicine." Well, his rates skyrocketed, went up, up, up, so the regulators came back and did a more thorough assessment and found that he was addicted, and he was addicting all of his patients. So, he was censured for about four minutes and then he moved to another part of UK where the records did not follow him, and he set up practice again, and this time he did in-home visitation. And he saw the elderly, in their homes, how popular is that? His practice skyrocketed, but shortly people began noticing that his patients were dying. So they questioned him. He said, "Well, I see old people, they die, what do you want me to do?" However, one day he had an appointment with the daughter of a leading magistrate in the UK, and the daughter happened to have spoken to her mother at like 10am, and the mother said, "I'll see my doctor at 11 and then I'm hopping on the train to come into London to go on my cruise and I'll see you next week for a nature walk and we'll have tea at the Savoy," and she was dead at 11.30.

And she had signed over all of her assets to Dr. Shipman. Dr. Shipman--his picture is right there--killed himself in his cell in 2004, and to date, 280 exhumed bodies, he killed.

So, why is this relevant? In the UK, this set off a tremendous furor; along with seven other white papers. How do we really know our medical professionals and our allied mental health professionals are competent? And the answer was, we don't.

So regulation was taken away from the professions themselves, moved to a neutral board, and a whole process of revalidation is in process. Why am I telling you all this? Because there are a lot of questions about competency, and this all comes back to competency, and how we are going to know.

How do we know about competencies in psychology? The document I would really encourage you to use the most is Benchmarks. How many of you are familiar with Benchmarks? Almost everybody. This is good. Well. If you're doing practicum, you should definitely look at the ADPTC document also. That

is a wonderful, wonderful document. It's available online. Benchmarks is available in TEPP, Training and Education of Professional Psychology 2009, Supplemental Issue. In its entirety.

So that's really awesome. There are all these others, CCTC and NCSPP, everybody has developed their own competencies document. The one I love, and I have to tell you I was on the committee, is the Benchmarks. I think that Benchmarks is awesome, and you could see--I gave you a little hand-out that includes some sections of Benchmarks--regarding the last example, being able to follow institutional policies about turnaround of assessment reports. That would be a lovely one. You would say, "Let's look at Benchmarks," because what I encourage you to do is to use this document, or one like it.

You can tailor it more specifically, and I'll give you a little task in a minute to think about together. You use this document to have supervisees self-assess when they first arrive. On day one, they self-assess at their appropriate level. They tell you where they are in terms of these dimensions,—you can use a Likert scale, you can use it as you want to. And again, you do that rating 1 through 5, anchoring that they're not going to be perfect on everything. So you have *them* self-assess first.

Audience: [inaudible].

Falender: See that's the perfect model. You do it in the first week. You have them self-assess on everything. That entire document, or if you don't like that one you could look at the practicum document, which is amazing also, and many people have adapted the practicum document so that's applicable for internship. They simply use it and they make it…If you look at Hatcher and Lassiter's, it has competencies that practicum students should have completed by the end of practicum, you just keep extrapolating from that. And it's a good focal beginning.

Audience: [inaudible].

Falender: She's doing a pre-test and an assessment during the first week. She's having them do an actual test report on the WAIS and various other personality tests.

Audience: [inaudible].

Falender: Excellent. It is. And it also is a way to help them enhance their self assessment. The other option would be to have them actually videotape a client in the first week or two, and to go over it with them. Because of course they're going to be just a beginner, but still it's a wonderful beginning to really start with something that is on line, so to speak, with real data.

And, there are other things I would have given for feedback, just to get back to this. I would have also told them, if you look at B on page one, I mean I would even consider A, about broadened self-awareness, about self-assessment, monitoring, and reflectivity regarding professional practice, reflection-action.

I would really be concerned that that supervisee was not cognizant that they were so far behind, and was not bringing it up, was not saying to me, "You know, my other supervisor hasn't said anything, but I'm a little perplexed because I know in the contract it says I have to do 27 assessments, and I've only

done one, so I'm a little worried about that." Right? That is really bad. And B: accurate self-assessment, consistent monitoring, and evaluation of practice activities, that's right there, right? It's right before our very eyes.

Willingness to acknowledge and correct errors, the ability - all of this, and you can read the whole thing. Almost everything would be applicable. So just be thoughtful about this, because this might mean that many of the tools are available at your fingertips. Now this is a consensually-developed document. Do you know how many groups commented, including the VA, on this document?

Lots. Lots and lots and lots. All the ones up here and everybody else commented, gave feedback, and we integrated it into the final document. It's in press right now, and Fouad, Kaslow, and others are writing it up for publication, it's in press, in *TEPP* (2009).{ Benchmarks is published in a special edition of *Training and Education in Professional Psychology*, 2009}

If you're supervising other disciplines, look at those, because those are excellent competencies documents for other disciplines. Physicians have so many I couldn't fit them all in. Physicians have thousands. Dentists are at the forefront. Dentists have the most competency documents, and the most elaborate, and more. I get carried away. I'm sorry I gave you so many. But there are also some--The ones for substance abuse treatments are excellent. And you can download them; all of them are downloadable, virtually. And then there are the health psychology ones, for you who are in health psychology.

Then there's the toolkit. The toolkit is in the same edition of *TEPP*. It is "how do you do this," and it's exactly like what we were talking about, some parts of it. We're really thinking about moving toward more structured interactions, observation, and coming up with actual observational schema to rate supervisee's performance. Many are working on this and some have come up with preliminary ones, but many settings are doing it, specific to their setting.

So it would include things like tracking affect, covering the substantive areas, engagement, many, many different dimensions. You would actually observe with the supervisee, either live or through videotape, and provide specific feedback and coding of their interactions.

Of course physicians use robots and actors, so they have a client come in who has been highly trained to present a problem, with some particular diagnosis, and then they have each resident or medical student interview them, and then they rate the session. But these are all possible ways: simulations, role plays, all kinds of ways.

Audience: Let's say the obvious to everybody in this room. It's time-consuming. It's very, very time-consuming. With the workload they are giving us, it's hard to find time to supervise.

Falender: Okay, can I tell you what the answer to that is? The answer is it is very time-consuming at the beginning, but it saves you light-years as you progress. It takes the front-loading piece to do. But if you do this, you then make up the goals and objectives for their training year, based on your observations of

their self-assessment. And you're working on specific things that they have targeted and you have targeted.

Now if they say to you, something like, at the beginning, "Well, I really feel like one of my greatest strengths is that I'm really good at discussing multiple diversity identities in case presentations and the impact of these on treatment plans. That is my greatest strength. Multiple identities, I've taken so many courses, I have great diversity experience. I'm awesome." The first case that comes in is--what should we make it?--very diverse. I want you to suggest one, a complex multiple identity.

Somebody give me one quickly, quickly? Okay, a young man who just got out of the service who was born to an Arabic-Jewish couple who experienced severe PTSD and is now having a sexual identity crisis. And this supervisee says, "Well, I'm starting the PTSD treatment tomorrow, I think he's really ready and I'm going to just plunge right in." And you say, "Well how did the consideration of all the identity factors factor in?" and he says, "Oh, that's not relevant because he has PTSD." So then you would open this and say, "I'm a little confused about your knowledge, about how you rated yourself to be so high on this particular item."

This way, honestly, I've been doing this a long time, and this saves time. You've got it all anchored there, it's not like you have to start from square one, because you've already discussed this, they've already rated it, you've already taken it into account, and it really is easier. Plus, your whole evaluation, like you were saying, maybe you should let other people know about your specific program, what you're doing, because your whole evaluation, and your tracking and your monitoring, is completely tiered from day one, and it's all related to this. Yes?

Audience: Along those lines, we spent the last two years modifying all of our evaluations and approach to it, and … [inaudible]…behavioral anchors, and kind of narrowing it down to a couple of good foundational, functional competencies, and all the different domains of them, and the rating scale, in order to meet the criteria… [inaudible]… meeting numerous levels of competency. So, this person's at the entry level of the internship. This person is where they should be, you know, in the internship. And, this person is at the exit level of the internship.

That only left us with three categories. And what we found is that that works, as far as us doing the number graduating them, and because we feel like they've been at the normal level of competence, but it hasn't given us a good form for providing feedback over the long-term. That was our feedback this most recent year, was there wasn't much range there.

Falender: Yes, that would not be my ideal. I think you're really on the track, but I don't think it's quite there yet, because it's like if you've got, like many of the forms in Los Angeles, are," I'm worried about the person", or "They're Okay". That's what the schools often send. Either you've got a big worry about them, or they're Okay. That's not enough variation because they'd have to be really bad, probably, to be worried, but there are so many people who fall in the middle point between worry and Okay.

So you need to be thinking about your scaling. And you need to be thinking about not - I don't like the idea of intense elaboration from the Benchmarks and making more specifics. I really think maybe we

should be more general because, then, I think it gives you greater flexibility to give the feedback. Because if you start rating them and saying, "You're Okay," then they're Okay and that's the end of it. Whereas -

Audience: There wasn't an okay or not okay.

Falender: It is three points?

Audience: Well, it's a seven point scale, talking about rating them from the practicum level all the way up to the professional level. So it's a seven-point scale, but realistically, we're really only dealing with them in a range between two and four. And there are certain criteria for having four. There are certain criteria for three, and they're based on all three [Inaudible]. But ultimately, it's not a very good … [Inaudible]… the interns.

Falender: I understand. I really don't have a great answer. I really just think it doesn't sound quite right because it seems like it gets a little more complex and the scaling is everything, where you set your points and performance criteria, but I haven't seen it so I don't know. And it sounds like it came out of adversity, or part of it. Oh, Okay good.

Audience: [inaudible].

Falender: Oh, okay good.

Audience: Following the guidelines and using them in the… [Inaudible].

Falender: Well, the reality is that as you do this you'll learn. And you see what works and you will see what doesn't work. And if it doesn't work, you'll adjust it and you'll remove some of the criteria. The ones who are very highly demarcated - I was somewhere which shall remain nameless a few weeks ago where they had a 74-page document that they had derived from Benchmarks. And they had every possible point. I mean, how they came up with this, really, I mean, they must have had to spent nearly every day since the Benchmarks document came out working on it, but anyway, it was way too specific, and it was useless because no one wanted to do it, first of all.

Second of all, it was-- it just didn't work. I'm really talking about formative, and I think in formative it is done right. Some of it, I do understand, it's not there yet, possibly, especially in differentiating between the supervisee --back to this one maybe--who actually has a lot of skills that are really quite competent, that has some glitches that might turn out to be hugely problematic. So, with those, it's more complex, and I don't think we're there for some of it. But I prefer you to use it formatively, because I think it will change your life.

COMPETENCIES - ASSESSMENT OF RISK TASK

Falender: We're going to do a task. Okay, our task is--I want you to think about it. I think you should do it as pairs. Okay, you have a task. The task is that when you to turn to someone near you, or even two people near you, and I want you to think about assessment of risk. Like suicide risk for example. I want

you to think about--should we do it for internship? Okay. For your interns--beginning--what knowledge, skills, and values would you write out if you had a document you were giving them on day 1? What knowledge, skills, and values would you expect them to have, coming into internship? You want an example of value? Who can think of an example of value or attitude? Yes.

Audience: That any expression of suicide ideation is to be taken seriously.

Falender: That any expression of suicidal ideation is to be taken seriously. That is an attitude. Excellent.

Audience: [inaudible].

Falender: I heard the end, but I didn't hear the beginning. Wait a second.

Audience: I had a student who had a patient who had the attitude or value that suicide was an acceptable means in their culture.

Falender: That suicide was an accepted, or even possibly honorable, means in their culture. Okay. And that would be referring to the client. You could have a supervisee who felt that autonomy is important, that the client should be allowed to kill themselves if they make that decision. That would be a value—another great example that is important to know. Okay, so spend a few minutes on this task. Do you know what you're doing? No? Okay. Let's just start with knowledge. That's the easiest, right?

Audience: Knowledge of risk factors.

Audience: Resources.

Audience: Protective factors.

Audience: Institutional policies and procedures.

Audience: State laws, regulations.

Audience: Knowledge of when to seek service

Falender: When to seek service. And that gets into a value as well, right? Okay.

Audience: And a skill.

Falender: And a skill! Yes, super. Anyone else? Yes.

Audience: [Inaudible]

Falender: Okay, you're moving this into skills, probably. That's great. How well they assimilate, integrate, and accumulate, and interview and combine all the information. Great. Yes.

Audience: I was wondering about a state like Oregon, where their position on suicide and the whole rationale now for suicide as legal.

Falender: Yes, that would be a contextually important piece to know about. You need to read your newspapers and have your supervisees be aware, because if they move from Vermont--maybe Vermont is not a good example--if they move from another state, then in fact they need to be aware that there are different normative values in different settings, at least potentially. It's a perfect example. No, seriously. But that's again back to values problems, possibly, and knowledge. Skills, more skills, and more skills. Yes?

Audience: To engage the patient in safety, and assess the safety.

Falender: Yes, to engage the patient in safety, assess the safety. Yes. Excellent.

Do you know that in the literature now… Kleespies and others talk about how graduate schools do not train suicide assessment? Like about 60% of practicum students, and even interns, have not had enough formal training in suicide assessment, and what they find is--You know how they find out how they do it? When a supervisor says we'll assess them for suicidality, how do they find out?

Audience: They Google it.

Falender: They Google it. That's the main way. They Google it. Some of them ask peers, but mainly Google. I left that part out, too. There's a whole growing literature on it. Do you know that the most frequent resource that our incoming supervisees are using? Wikipedia. When they have a question they go to Wikipedia. So how much even more critical is it that we train in critical thinking? Wikipedia is not peer-reviewed. Both university and graduate students are using that as a major resource. Anyway, back to our exercise, what about values, and how do values play in this? Now there are stereotypes, I think, you have to be aware of. Yes?

Audience: [Inaudible]…evaluating openness to learning experience and… [inaudible].

Falender: Absolutely. And openness to even having the discussion. Not the belief that, "If I talk about suicide it's going to make them want to do it." Yes?

Audience: [Inaudible] related to what AP just said about if the legal issue is different from the professional issue. That just came out recently.

Falender: It's really turning out to be an additional complexity with this and the 1.02—Are you all on the list-serv, so you're hearing the whole debate about 1.02? Well, it's whether or not we should change our ethics code to--in the light of torture and human rights. And whether, in fact, since the last ethics code was written, prior to the experience of torture by people in this country, and now many people who are on the ethics code development panel are saying that that was not even on their radar screen, torture, whether we need to rewrite it. This is one of the biggest debates today, about what to do--whether we need to rewrite the code. Or whether it should stand as it is.

And on the list-servs, which I'm on many--and I was reading them all while I was in Europe, they--I'd say it's divided, between, "We absolutely should not change the ethics code," and then those who are saying, yes, that we have to change the ethics code, because we have to really integrate it based on

aspects of torture. And others are saying no. So, I'm not going to give an opinion. I'm sorry, I know you were expecting an answer from me, no, I think the beauty of that, as far as it relates to supervision, is introducing the supervisees to the debate and helping them to think about it. Seriously, that's what is critical here. Not to impose an opinion like that, but to help them to think it through. Because that's such an important developmental piece of our whole profession, helping them and letting them know about list-serves, and that they should be members of various divisions. They should be involved in all this, and at the forefront of their professional development with membership in state organizations. Sorry. Okay. What else? Those were all the values?

Audience: [Inaudible—something about respect for rules]

Falender: See, this is so important: respect the rules. And the worst thing, I think, is a supervisor who is disrespectful of the specific setting they are in. That supervisor attitude models disrespect for the entire system. This undermining happens so many times, I cannot even tell you. The supervisees come back to me, because I teach a lot of different levels of people, and they say, "My supervisor said that I should not even think about X, child abuse reporting, I should not even think about it because it could really destroy the family," or, "I should not even think about the rules in this particular setting." It's really not an okay thing. We really need to model integrity and ethical practice, and work internally to change what you don't believe in, but not acting it out through supervisees. So, respect for the organization you're in. Okay, that's a little linear, but I do believe that. It's very important. Otherwise you're teaching supervisees such a mixed message.

Audience: … Another value is respecting the values of the organizational culture that you're in, because the VA has a particular culture, and it drives many of the things we do, whether we agree or not.

Falender: See? Yeah, that would be a critical piece, the organizational culture, and helping them to understand it, how it relates to the services we provide, how it's evolving in this era, how these things are working. Okay, anything else?

Audience: I had a situation where an intern needed to internalize a value or a responsibility that, even though she was an intern, she was a trainee, she had supervisors, and in clinical crisis she was the one that this patient was going to for help. And so she felt that she needed to consult with the supervisor, and that she could step back and say, "Okay, now he's in crisis. This is not my fault." And she needed to accept the responsibility as a professional.

Falender: That's a really important point. Really. This is hugely important. Yes?

Audience: What was the question?

Falender: Oh, she was saying that the supervisee needs to learn that they can't just step back when a crisis arises, like suicidality, and turn it over to their supervisor. That they can't just throw up their hands and say, "Oh well. I'll call my supervisor." It's something that they need to learn to manage and consult on, or to get supervision, but to manage on the front line.

There's something else that I wanted to talk about. There's so much more. I was thinking, there are supervisees who I see, now maybe they are atypical, but they say things like—they see a Vietnam Vet at the VA, and they say, "They need to get over it. Vietnam was so long ago. They've got to get over that. That's crazy. I don't want to deal with that." [Audience laughs at an audience member comment] I didn't hear what you said.

Audience: That's the recovery model.

Falender: That's the recovery model. [laughs]

Okay. We need to consider client-directed approaches! Oh yes, we're supposed to be taking a break. Okay. We're supposed to be helping to figure out all kinds of attitudes, and we very rarely address attitudes. So we encourage you to really think about attitudes, as well as knowledge and skills, in each of the areas that you're doing training in.

At this point we will take a break for twelve minutes.

BEST PRACTICES IN CLINICAL SUPERVISION

Falender: I have a high standard for feedback. We should be giving feedback--now this person who said it's too much work--we need to give feedback every single time we meet with supervisees. Not only do we want to give it, we want to receive it. What does that do? That desensitizes supervisees from being so worried about giving feedback. Also, we need to neutralize the feedback, at least at the beginning, so that they can feel comfortable giving feedback about such things as what they'd like to have happen in supervision, and the process.

So, what we're working on is process tools to try to determine, like what percent of the time--sometimes things like, they feel that we believe we're doing wonderful supervision, it's just the best hour we've ever had with them, and we ask them what actually happened during that hour, from their perspective, and they say 80% was kind of administration, and 20% was kind of clinical and talking about the cases, but it felt like a lot of it was really administrative. It's really important. And that is the kind of feedback I think they will give you. They'll give you feedback very easily about what happened in the last hour, or I have sometimes about 20 different categories, sometimes ten, depending on what mood I'm in, about what kinds of things happened during the last hour. And really, that's a beautiful beginning, to ask them, because they get used to it, and they are pre-programmed, and it opens the door to more feedback.

Whoops, what happened? Okay, we talked about the supervision contract strongly indicated as becoming a standard of practice. In fact, some people have already said that it is the standard of practice for supervision. There are examples of that in many sources, including the appendix of our first book. My website and the APPIC web site have examples of supervision contracts.

Evaluation articulated and used; in other words, what supervisees are going to be evaluated on. You know what one of the big deficits is, we talk about all this, but we don't say what's going to happen if they don't meet criteria. This is really an important piece. And I think we learn this only through bad

experience. When you have a supervisee who doesn't meet criteria, and you don't have it completely articulated, then you learn that you should have. So be thoughtful about that; exactly what things are core requirements and what things are more optional.

The supervisor needs to facilitate reflective practice, even though we're stressed out. Are you all stressed out? You are? There are a few “no”s and a few “yes”s. The rest of you are neutral? That means what?

Audience: You don’t know you’re stressed out.

Falender: Hmm? You don’t know you’re stressed out? That's in the last part today, we'll get to that. We attend to supervisee feelings, concerns, reactions, and especially if there is conflict or strain, and really attend to it. Don't just let it pass. And we integrate the multiple identities--and this is the tricky part—because it’s not just for clients, it's not just the supervisee, it's even the *supervisor*, our own multiple identities. How easy is that for us? That's a big blank stare. That means maybe not, do you think?

Audience: Tell us what the right answer is. [Laughter in audience]

Falender: You want to know the right answer?

Audience: [Inaudible—something about multiple roles]

Falender: Absolutely. You know how to take on multiple roles. I think I was talking about something a wee bit different. It would be like me saying to supervisees, during the development of the alliance, self-disclosing something about myself. Like for example, saying, “Each of us approaches clients from different perspectives, and part of this relates to our worldview” and, for example, “I'm older,”--that always works with my supervisees, because they're all decades younger--and furthermore, I moved from the mid-West after graduate school, and therefore--I don't think I've done it today, but I punctuate my speech often with kind of animal analogies, like barnyard, like closing the barn door after the cows. I say these things. They just slip out, not that I grew up on a farm, but they connote a certain worldview, in terms of certain traditional, value.

But anyway, I go into that. I just go very, very lightly into it, as a form of opening the door to the fact that we each have perspectives. Now that's been very useful for me and for many supervisors, because supervisees may respond very quickly and say, "I'm so glad you raised that, because that's an important part of my training, too. I come from X, Y, and Z, and I am bisexual, and I really do have certain perspectives on these things, and I'm really glad we’re going to be able to process them.” Or they just sit there, which is absolutely fine with me. But then later, when a client presents with a particular profile, then I say, “You know, from my perspective, being older, it's difficult for me to empathize with the multiple piercings of this client, and I really think this is an area, we really think about, because I have a certain perspective on it that might be different from yours.”

And they're going to say, "Yes, you do. That's pretty normative. Haven't you been watching TV? Don't you ever get out much?" They don't say that. But you know what I mean. That's what they're thinking,

probably. So, this is the conversation I believe we need to be having more, and the easy part is the client. The harder part is the supervisee, and the hardest part is the supervisor. Supervisees are being trained to do this in graduate school. This is part of their curriculum, to talk about themselves, to talk about their multiple identities, how they fit together, and how these relate to their clients, impressions, attitudes, and behaviors.

Okay? Then, of course, the supervisor models enough goals, legal and ethical standards of practice, and makes sure that the supervisee knows what they are. We make a lot of assumptions, but they may not know, so we've got to be sure. And that gets back maybe to the context. Fif you're in a state that has legislated Tarasoff. They may have moved from a state where Tarasoff was "duty to warn," to a state where "duty to warn" was a violation. So be thoughtful and informative Okay.

Best practices are--first of all, this is so important. This is a question that keeps coming up. This is a best practice--that the supervisor first examines his or her own clinical and supervision expertise and competency. That is definitely a best practice. And that is a big step for upgrading your supervision status, because that is true and established. Second of all, is identifying the expectations, including standards, rules, and practice. Really critical. Third, setting specific competencies. Fourth, collaboration, and developing that supervision contract. Clear communication, including the competencies, the goals, the tasks, and the logistics. And last, the supervisor models and engages the trainee in self-assessment and development of meta-competence from the onset of supervision and throughout.

Okay, so for the alliance. First of all, mutually defined goals and tasks are identified. Now, you may say, well, that's pretty straight forward, because in your setting the goals and tasks are set out, right? But the reality is that each supervisee is approaching it somewhat differently I think, so they have certain things they're really working on harder. Right? So, you need to identify what those things are, in terms of knowledge, skills and values. What are the areas that you are really addressing. And this contract is a living document. It's not just one you develop one day, and that's it for the year.

When supervisees attain success, they identify new goals . You determine what you're going to contribute and what they're going to contribute to their p process of achieving that. The greater the clarity, and the greater the collaborative identification of these, the greater the emotional tone you create with your supervisees. And the better the emotional tone, the better the supervision progress is going to be, the whole progression of supervision.

The emotional tone is characterized by mutual-respect and caring. And it really is shaped by the degree-- going back to that early slide about the super-ordinate values--the super-ordinate values are critical to the development of the supervisory relationship. The items about integrity, respect for diversity, ethical practice, and attending to the current status of the field by evidence-based practice, being current and up-to-date. The keys to the alliance are clarity, including difference and feedback, transparency, and no surprises. I promise my supervisees, and I encourage you to do it as well, that you're not going to surprise them with feedback at the end of the year.

The minute you have concerns about them, you are going to tell them. You're going to give them the feedback. You are going to process it with them. Because you know why? It's an informed consent privilege that they have the right to know, and they have the right to correct it. Many, many supervisors harbor feelings about their supervisees about how they're not comprehensive in their assessment of a certain protected client. They're not going to tell them, because they think it's developmental, and they think the supervisee is going to pick it up. Then they go home and worry about it and think about it and think about it. Weeks go by and months go by, and three months in they say, "You know, I'm have been really concerned about your assessment skills for some time."

And the supervisee wonders, "If you were concerned, why didn't you tell me on day one, so that I could have really focused on it?" It's just not okay, so be thoughtful. The feedback needs to be immediate. You know, if you're not sure, you don't have to be 100% sure to tell them. You should tell them if you're worried. Do you agree? Yes?

Audience: I think we have a tendency to overblow our fears about how they are going to react, and how they're going to take it. [The rest is inaudible]

Falender: I think that's a wonderful example. Did you all hear that? I think our own fantasies about feedback and about how vulnerable supervisees are most often are not correct. Also, it's giving them a chance and treating them like adults. It's not treating them like children or babies. It's treating them like individuals who are in development and who are professionals. So, we need to toughen ourselves up before we can toughen them up.

That gets to a question that came up during the break about how to develop more assessment of values and attitudes. And I was suggesting that you might want to use the exercise that we did on risk assessment, actually with your entire training group. I know you're telling me you might not have time to do this, but in the orientation week, you might be able to do this, to have the supervisees themselves think about what attitudes are really important in some of the core behaviors or expectations you have for them and yourself, some of the most difficult things. That would be a beginning. And then have them self-assess on those values and attitudes, and talk about it. It's really a very, very wonderful thing to do.

Okay, now, also definition of all power differentials, including administrative. You all have multiple roles that you were indicating, and, yes, you're used to it. But, sometimes the supervisees are shocked by it because you can be an administrator, you can have all kinds of—how many different roles do you have? I bet you have a lot--Yes, so you're changing hats a lot, so to speak, and they may be very different. So, articulating these things and letting them know, especially letting them know if it's going to affect them in some ways, and maybe spelling out what those ways are, so at least they can anticipate it and bring it up when it becomes an issue. Integrity and continuous constructive feedback given as well as received can be very helpful in this process.

How good are we as Supervisors at getting feedback? I often train supervisees. And in the supervisee group, I tell them that they should be giving feedback, a lot. So, they often provide supervisors with feedback and say that really wasn't a very good idea [audience laughs]. It sounds good, but it didn't

work. They all can give the feedback sandwich. That's one of their favorite things, and actually that's a favorite supervisory thing too. It's that they say, "You are a wonderful supervisor. I wish we'd talk about theory just a little bit more, but I am learning so much this year, it's just wonderful!"

And the supervisor says, "Theory?! Theory is my middle name. I can't believe you don't think that I'm talking about theory. In fact, I'm so concerned that you think I'm not talking about theory that I wonder if you're even listening. In fact, I'm going to write this up." Be thoughtful, that we want model accepting feedback.

You think that I'm making it up, don't you? No, I'm not. I'm sorry, I'm not. So, what do we know? We know from research that a strong supervisory working alliance, developed the way I talked about, with goals, and the tasks, and the emotional tone--its predictive of advanced supervisee competency with multicultural issues, effective evaluation, supervisee self-disclosure, which is an issue we'll talk about, satisfaction with supervision, and even disclosure, or self-disclosure of counter-transference reactions--all those things. Most of that is from research from Ladany, Shafranske's lab, and others.

Okay. What about when strains occur? Do you ever have strains in supervision? Never. A few people are shaking their heads. Do any of you have strains in supervision? Can you think of a strain you want to share, that can be on the tape? Or we can turn it off. Any of you have a strain, or want to disclose a strain? How do you know if there has been a strain in your relationship? Do you know that the vast majority of supervisees report that there have been strains in their supervision relationships? Think about your own supervision. How was it conducted, and how was it received? Do you ever remember any strains occurring? No? Perfect? Creaseless? Wrinkle-free?

Well, sometimes there are strains, and what happens is that they become cyclical and spiral. It can be really subtle. Not that I'm trying to make you nervous about the process with your supervisees, but an example of a strain that happened to me recently, actually, was, I was doing group supervision, and someone came in at the beginning and said, "There's something I really want to talk about today," and I said, "great." Please just remember because we have the case from last week that I want us to be sure to process about a suicidal adolescent. So, after we finish that, we'll get to your issue. We never got to it because the suicidal adolescent was really complicated and took the entire sixty-three minutes of the session, even beyond sixty.

So, the supervisee never got to discuss it , and I did not remember it. That was a strain introduced. The supervisee really felt hurt. And she did come and tell me later that she really felt like I was not respectful of her potential issue raised at the beginning, I should have made a note or whatever. But that was good that she told me, because I simply did not remember. These things do happen, or we sort of talk over someone. A lot of things can happen that actually can be viewed as disrespectful behavior.

What happens is, if supervisees perceives a strain, they become more withdrawn. They are less forthcoming than they were before. They are withdrawn. They don't talk as much. The supervisee who used to come in and talk all the time, and discuss everything, suddenly is kind of circumspect, and not forthcoming. And on the inside they are possibly responding, acting in or acting out as if an enactment.

So they are reenacting something, perhaps, that happened in another session, and maybe unconsciously. People do that, sorry.

And as a result, we supervisors become increasingly controlling and rigid. We become more demanding. We say, "You used to tell me all kinds of information. Come on, tell me! Tell me about that client that...", you know, whatever. And the more controlling we become, the more withdrawn they become, and it cycles and becomes really, usually, problematic. And actually can become a rupture.

Now, this is particularly important for you all because of the levels of trauma. Do you know what percent of supervisees and practicing psychologists have experienced primary trauma? None? There are estimates actually that it might be rising. Pope and others have said around 33%--30 to 35%--of clinicians, psychologists and trainees have experienced primary trauma. And usually it's coming from families of alcoholics, or child abuse, sexual abuse, things like that. Okay? So, that's a primary traumatization, which may even have resulted in primary PTSD.

Then, we are exposed to trauma. And where could you have supervisees exposed to more trauma than in the VA, right? Your supervisees hear life stories and events, I think, that they could not even dream of, or could have nightmares about. They're just the most traumatic disclosures. Right? So, that's a secondary traumatization on the 33% who are already traumatized. And there are some data that suggest that people who are not primarily traumatized feel guilty that they were not primarily traumatized. So, double whammy. Then, we have the supervision. And the supervisor often may not be empathic, because supervisors are under a lot of stress.

So, you have a supervisee who is not exactly melting down, but feeling pretty overwhelmed by the clients, and the supervisor may not be very supportive, and might say things like, the supervisees are telling me they are hearing a lot of, "suck it up. Just suck it up." Which apparently means, like, kind of—not shape up, but what does it mean?--deal with it. That's it. Just deal with it. Move on. Right? So, that would be not very empathic. And so what we have is, the result would be a strain, or even a rupture in the supervisory relationship, at a time when they need our support most.

And that is called tertiary, or even higher, traumatization, because you're building upon all those levels of trauma. And what can happen is that the supervisees stop disclosing. Or, they engage in spurious compliance, worse yet. Spurious compliance means they say they are doing what you told them to do, but they're actually doing what they think is right. Not a good supervisory outcome. So, you need to really be thoughtful about conflict that does arise, because it impacts exposure to problems and supervisee subsequent behavior.

Now, what do supervisees not disclose? 97% of supervisees in studies that have been done say they do not disclose everything to their supervisors. That's no big shock. So, it's probably 99% or whatever. So, what do they not disclose? They do not disclose if they have a negative reaction to us. That makes sense, right? Absolutely not safe. They don't disclose personal issues. That might be okay, because we don't want to become their therapist.

Oh, I didn't do the difference between psychotherapy and supervision. You all made me skip it. Oh my, we'll do that next, sorry. Okay, they do not discuss clinical mistakes. Is that good? That's terrible! What is supervision if not talking about mistakes? So, we should be modeling not making mistakes, but modeling discussing mistakes that we've made. We all make mistakes.

I chaired an issue of The California Psychologist, and I invited supervisors to write about their own clinical errors. And I invited like 15, thinking I'd get 6 articles or 7. Not one wanted to write about their errors. Actually, one finally did. We had one article, so we had to just put it in a regular article. Of course, I should mention that I didn't end us writing one either. Oh well.

Okay, clinical mistakes. Evaluation concerns 44% of what we talk about. But we know that almost all of them have this concern. So, I guess we should be talking more about that. Next is general observations about the client. And that would be things that they feel are not politically correct, like they don't want us to know that the client really smells and that it's really annoying to them, and It's really upsetting to them, but they don't know what to do, so they don't tell. And negative reactions to clients, they do not tell necessarily. So, this is important data to think about.

Audience: Another one that might be kind of specific to the VA is young female students not being about to talk about sexual innuendos or inappropriate comments made by old male patients, especially when a male is supervising.

Falender: Yes, see that's a wonderful, very problematic one. I actually have a video of that, but it's with an older female therapist with a male client. And that's such an important area, because do you know how little we address that? We're getting to it, though. That's coming up. But you're right. That would be a big one, and especially with male supervisors, a very high lack of comfort.

Before we go to lunch, let's talk about the difference between supervision and psychotherapy. What is the difference?

Audience: Confidentiality. Greater confidentiality.

Falender: Okay, greater confidentiality.

Audience: The goals of the relationship.

Falender: The goals of the relationship, for sure. The focus of the encounter.

Audience: The evaluative nature.

Falender: The evaluative nature, very much so. The focus of supervision should remain on the client and the client process. It could also relate to the supervision process with respect to the client; however, if the supervisor begins asking questions, which is true in the worst supervision circumstances, like, "Tell me everything about your own experience with PTSD in your life," or "Tell me about your mother, everything," or "Tell me, expansively, everything." Personal inquiries that are apart from the client are not appropriate. It is crossing the line.

Now, this is complicated because countertransference or personal factors are a critical part of supervision. So, if the supervisee seems to be having an atypical reaction to one or a class of clients, it's really good to collaboratively identify this with the supervisee, or to even say, "I've noticed your behavior is really different with young, male, recent combat-returned people, compared to the older male clients that you're seeing, and I'm wondering what you make of that, because I notice much more reticence. What do you think that's about?"

And then they say, "Well, I didn't want to bring it up, but actually, these guys remind me of my brother. My brother's in the service and he has so many similarities to this client, and every time I see them I just see my brother and I remember him." And that is a wonderful disclosure. That is fantastic. And we'll go through in a minute how to deal with that.

Audience: I'm not clear about where do you draw the line in supervision and in measuring. The fact of the matter is that… [inaudible]… is a small part of it. You also have to be willing to assume the role of the professional psychologist…[the rest is inaudible].

Falender: That's fantastic. Yes, what he's talking about is monitoring stress, modeling self-care, and integrating self-care. Now I will say that we are getting the self-care, usually--and this is not a metaphor, but usually I have 2 to 4 minutes left in the presentation to talk about self-care. It's not that I don't value self-care. In fact, it's really a very high priority for me in training, and in my life. But, we have many other things to address. But you're absolutely right. That is part of mentoring.

It's also a developmental part of the training process, making sure that our supervisees are taking care of themselves, and setting reasonable limits for themselves that they will use for their careers. Because we want them to have high career satisfaction, so we need to be modeling that. What you're also talking about is a really good developmental trajectory, that due to our time constraints, I am not talking about today, which is that we really do expect that our supervisees, especially in the VA, are going to move from practicum, to internship, to post-doc. Maybe not all of them within the VA, but they are going to become our colleagues. And, therefore, we are, in fact, socializing them into a system, and we are helping them to feel comfortable in this setting, and to feel dominant in the setting, and to learn the ropes as they go.

So, an important part of that is to say to them self-disclosures that are targeted. They will be things like, "I remember when I was an intern at your level, and how overwhelmed I was about the very great complexity of the system, and the many responsibilities I had, the many layers of command." This is a really good, wonderful role modeling. And this is what they will remember you for: your supervision and your mentoring and guidance. The problem only arises is if you do that without reminding them that tomorrow, or next hour, you're going to be giving them their performance feedback on benchmarks, and you're going to have to tell them that there are some areas, or one area, or three areas that you're really concerned about that you need to develop an actual performance plan around. So, you just need to be mindful of the relationship between you.

I mentor most supervisees eventually, but I try not to mentor them until they're more advanced, because at the very beginning it's too hard and not appropriate. Yes?

Audience: I have a question on therapy. What is the solution between supervisor and mentor… [inaudible]…At some point don't you have to be concerned on a more personal level

Falender: Yes, as long as the focus remains in relationship to patient care. There's a wonderful issue of *Professional Psychology, Research, and Practice*, about two or three years ago, by a number of people who wrote from various perspectives about this very issue--about chronic illness, or an unforeseen illness during the internship year. About how this impacted the individual, and how wonderful supervisors were in terms of being incredibly supportive, but also incredibly respectful of boundaries and thoughtful about the whole process. So, I would really encourage you to work towards that, because I think it is really a prototype for various relationships. If you have trouble finding it, you can always email me and I'll give you the reference. But I'd say it's about three years ago now. *Professional Psychology, Research, and Practice*. And it's a whole section of the issue.

Okay, so if a rupture occurs, let's say there's really a rupture. Can anyone think of a rupture that has occurred? There are certain things that I guess, at a certain point, you have to really trust--back to your question--there are certain things that none of us can do, you know? And it's actually a strength to know. And, of course, the other side of this is--I don't know if any of you know--there's a new edition of the *Journal of Counseling Psychology* that just came out a few weeks ago with a values statement, have you all seen that? It's really quite intriguing. It's a values statement, and it grows from a lot of training directors bringing up issues that supervisees increasingly are coming in saying that there is a group of people they can't work with. Like I'm extremely religious myself, and therefore I can't work with anyone with any sexual identity issues, I just can't, because it's against my religion, or whatever, multiple examples like that.

So, the value statement is that this is about a profession, and it's very nicely worded, this is about a profession, and this is not about you. This is about having respect for the individual that you're seeing, and being able to work with a wide range of people, and that is part of our ethical credo and standard, and therefore, that's what you have to do. So, then there are commentaries on it. It's really an interesting issue, because one question that arises, for me at least, is if you force someone to do something—it's kind of what we were talking about--who really bears the burden?

And I think the person who ultimately bears the burden is the client-- and the supervisee. Because the client senses the attitude, don't you think, ultimately? And it may not be fair. It's not the client's fault. So, this is a very complicated issue, but I think it's an important issue and you should look at that, because it's one of the most intriguing things that have come out recently. Cathi Grus wrote one commentary about it as well. What?

Audience: Where was the article?

Falender: In the *Journal of Counseling Psychology*, the most recent issue. I got it in the mail maybe two weeks ago. Three weeks ago? Something like that. That's the Division 17 Counseling Psychology Journal.

Okay, counter-transference, moving into the world of personal factors. So, you know we're not value neutral. This should not be a shock. So, it does depend on our worldview frames here. Now, how do you feel about using the work countertransference? Do you feel uncomfortable with it? In some places, I call it the C-word. You think I'm joking, don't you? I'm not. Anyway, countertransference or personal factors, or it can be called triggers to emotional reactions. Any of the above. Anyway, these are all related to conscious beliefs, our culturally embedded values, etc. Now, there are objective examples of this, and there are subjective.

Objective would be when a group of people would really see it similarly, like if we brought a video, and everyone said, "Oh, that is a very scary person." That would be a more objective kind of counter-transference, versus a subjective would be uncharacteristic, like the example I gave you of the supervisee who perceived young males to be like her brother. That would be uncharacteristic and subjective. Both of them need to be dealt with and processed. And both of them actually are really significant, and it is a strength to identifyi them.

These are really great strengths in those situations. In order to manage a countertransference--I forgot to tell you this about meta-communication, sorry--you have to have a good supervisory relationship before you can do either meta-communication or management of countertransference. If you don't feel you have a good supervisory relationship, don't try to do meta-communication. And, similarly, don't try to manage countertransference, because this is really something you have to have an existing supervisory relationship. Countertransference is an important informant. It informs the therapeutic process and the positive or negative responses in the therapist.

How do you do it—manage countertransference? First of all, the preface is, in the contract, you let the supervisees know that this is going to be done. The same with meta-communication, you let them know these are processes we use during the training year. That, in fact, identification of counter-transference is a strength. Then, we explicitly orient them to what personal factors are, how these work. We model it. We say things like, "Wow, when you were telling me about that particular client, I was really feeling angry. I wonder what that must have been like for you. You were in the room with them."

And then, we talk about it as a great strength, and then we collaboratively identify the countertransference, and we reinforce it as a competency, and then we get into the steps--lets consider the one about the brother --we first commend the supervisee for bringing it up, identifying it, that's really insightful, positive, great. Then, we engage in helping to differentiate. Take the time to think about what the differences are with this client. Let's really focus on the client. Bring the client's strengths up. So, you're enhancing the empathy and separating from the object that they are experiencing similarity with.

So, they might say, "Well, that's a young man who has experienced so much adversity, and who has really risen above, and he went into the military to get away from a lot of family stress and abuse, and he succeeded. He really did a good job. And my brother didn't have any kind of stuff like that." And then talk about what the client strengths are, that he's so intelligent, he's been taking that course, or whatever it is. To help him differentiate, you give him the assignment of continuing to think about this

and increase empathy and differentiation, and then you put it in a therapy-conceptual frame and move ahead.

Now, the good news is that next week he may come back and say, "You know, that really was like magical. I was able to really see him for who he was, and I'm really feeling good about it. Thank you so much." If it's a repetitious theme however, then you need to be thinking about additional supports outside of supervision, because you do not want to become his therapist dealing with his problems with his brother—and you need to supervise his other cases. Should he continue, you need to cross into the performance arena, if he sees everybody in the VA as being like his brother.. That would not be good. That would get us io a performance track.

Okay, contract is an essential part, and these are all some of the areas that you can put into the supervision contract. You can look at these, and I'm sure you're going to be studying this all night tonight after dinner, and looking up all the websites, and downloading everything onto your computer. These are some of the things you might want to address, but this is really important. Especially, how do you deal with it if you are going to refer a supervisee for personal therapy? Do you ever do that? Do you let them know in advance? Or does that ever happen? Yes.

Audience: [Inaudible].

Falender: And you have EAP, supports for referral?

Audience: [Inaudible].

Falender: He said that it is all documented, exactly what would happen if it came to that. You have a performance manual, and are there many steps that you would go through to get to that point.

Audience: Although we have the EAP, the EAP is operated by psychologists, rather than the mental health service. So, we have some differentiation to get referred.

Audience: I have a question, more than an answer. The only time we had to do that was in a different facility, a psychiatric hospital. My question is, we talk about therapy in terms of...[inaudible]. How could we know when they were finished with therapy in terms...[inaudible]..., rather than even…[inaudible] the problem first?

Falender: You know, this is one of the biggest issues about referring for personal therapy. I mean, it sounds odd. We are psychologists, and saying this is such a big worry, but we have no ability to oversee the therapy. We have no authority to communicate with the therapist. It's a confidentiality situation. We have no ability to really dictate what they are going to focus on in therapy. All we can do is articulate to the supervisee what we want. We can work with the supervisee about what the critical areas are, and go through the benchmarks or whatever documents we have, and let them know these are the things they need to improve. And they need to show some signs, or some documentation that they are improving. Iif it's something like a substance abuse program, there can be really good results sending the supervisee to a program, and they have come back months later with documentation and with all kinds of supports, and have done beautifully.

Audience: We've always handled this on the basis of the intern's actual performance. We tell them that interns are responsible for maintaining adequate mental health that is ordinarily monitored by the usual competency evaluations. And you tell them that we have comportment competency criteria. I mean, like, you've got a schizophrenic trainee who is suddenly showing up with their clothes in disarray. Well, it's inadequate comportment. Do something about it, either by self-appraisal or by obtaining appropriate professional help, and this is the way we are going through each of them. Of course, if you remove somebody in an emergency situation from patient care, you can do a fitness for duty on them with the ordinary personnel criteria. So, there are ways of handling it in terms of performance, without getting into these other things.

Falender: That's exactly what the article coming out in *TEPP* is about, about how to handle it, absolutely within performance parameters. You just stick to performance—because it's none of your business what their diagnosis is. It's not appropriate to be diagnosing our supervisees. What we *are* doing is making sure that they meet the criteria that we've established. And the better our criteria are, the easier it is for everybody, because they know what's expected. And you're right, the professionalism piece is really a nice one, I think, in the benchmarks, because it's got all kinds of items about conducting oneself in a professional manner.

Okay, the other issue with this--I don't know if you have an issue with what to tell the schools. Is that an issue for you, or should I skip that? No? No.

DIVERSITY FACTORS

Falender: Okay, I didn't go through with you all the diversity factors, but I can gave you example of self-disclosure. These are only some, military experience being of course critical, and always critical, and the multiplicity of them, and how they can relate. And how complex they are, and body size being the most recent edition to the list. Our belief in multicultural competence typically outpaces our behavior. What do you think? We really believe it. In fact, there are surveys that people say, "I am so believing that I am multiculturally competent," but then when they ask those items from the APA guidelines--multicultural competency guidelines--what is our adherence to the actual guidelines? So, we have talked about all three realms. We talked about that. And how do we do it? Well, you know, interestingly, there are low actual rates of discussion of diversity characteristics in supervision, very low rates. And I used to say which ones I thought were the lowest, but the more I read, everything is low. Sexual identity is low. Religion is almost non-existent. Is that different in the VA? Blank stares. That means we don't know, or you don't want to talk about it, or you're getting tired, or who knows. Okay, religion does not come up. You know what? There's a study that came out recently, that they asked supervisees questions about what they didn't disclose. One thing they didn't disclose was that if a client said to them, "I want to pray on this with you," the supervisee prayed on it with them, but did not disclose it in supervision. What percent of psychologists believe that religion is a very critical factor in their lives?

Audience: Twenty to forty percent

Falender: Twenty to forty percent, exactly. And what percent of clients believe that religion is a critical factor in their lives?

Audience: Eighty percent.

Falender: Eighty percent. And it may be that supervisees may be creeping upward. So, they may be in the middle. It's not clear. There's some data indicating they may be higher than supervisors in their belief. So, this makes for a really big disconnect in terms of competency of supervisors knowing what to do with religion, if it comes up at all. And I think there are similar factors in terms of sexual orientation, and multiple other factors. So, what we're finding is that if this is initiated at all, it's not initiated by supervisors, even though supervisors believe they initiate it. But when the supervisees are questioned, the supervisees say, "uh, uh. Didn't happen." Similarly, Toporek et al. [name of researcher?] found that supervisors may not view exposure to cultural differences as being as influential in supervisees' development as supervisees do. So, it's less value even attached to cultural values.

What are some opportunities? Well, first of all, you need to talk about it. It needs to be discussed. We need to open a pathway. We also need to do our own self-assessment on racial identity development. And supervisees who are more racially identity developed than us have less satisfactory supervision experiences. So, we need to think about this. And there are racial identity development measures. Now, I know I was making fun of Googling, but all you really do have to do is Google racial identity development, and almost the first thing that comes up is Ponterotto and Helms Measures, both of them, Ponterotto, and then Janet Helms, Measures of Racial Identity Development, and you'll be there is within two seconds of your putting it in the browser, and you can self-assess. This is a little tricky to self-assess though, because there is a big social desirability component, so you have to want to really think about this and be reflective, and remember you're not showing anyone. It's just for yourself.

Similarly, let's see. We need to think a lot more about relationship with clinical outcomes. You know, inattention to cultural values is not neutrality. Inattention to cultural values is viewed negatively. It's really viewed negatively by supervisees. They feel very disrespected when culture is not talked about. So, sometimes supervisors report, "I'm just really value-neutral about culture." That's negative. [Applause heard in next room] They're doing something really right next door. [Everybody laughs] Okay, what are some of the--Oh, there are the Helm and Ponterotto references, that's good. We need to ask questions, elaborate, be sure that culture, in all of its complexity, is in the conceptualization. Challenge the supervisee to consider culture in the presenting problem , conceptualization, and in the interventions. With international students--Do you have international students? No?

Okay, what about micro-aggressions that occur in your settings? We all are completely filled with micro-aggressions. Micro-aggressions are expressions, words or phrases that could be hurtful toward somebody. What would be an example in your setting? Want me to give you an example? Yes, you all have them, you're nodding. You've got them. One, just one.

Audience: [inaudible.]

Falender: Making sure that a supervisee of a particular ethnic or racial background should always have clients of their own ethnic or racial background. That is a huge micro-aggression.

Audience: Making a comment about the fact that they can speak English well.

Falender: Yes, praising someone and saying, "Oh, you speak English so well!" Yeah. Those are excellent examples. Any more?

Audience: Asking somebody where they are from.

Falendar: Yes. Asking someone where they are from, based on their appearance.

Audience: Assigning Black trainees automatically to Black supervisors, unless they make the request that they want a Black supervisor.

Falender: Okay, that's a different level. Absolutely, that Black supervisees would have to be supervised by Black supervisors, or vice versa.

Audience: What about automatically asking newly hired minority staff if they want to automatically serve on the diversity committee?

Falender: Absolutely. Having only minority staff, and especially newly hired minority staff, on the diversity committee. It's amazing how our diversity committees are all diverse, totally diverse. Anything else? Those were so good. There are even expressions. Anyone got an expression? Um, let's see. "Indian giver," that's a big micro-aggression. "Retarded," "gay," "Let's Jew them down," "Don't gyp me." All of those are major micro- to macro-aggressions.

Now, Constantine and Sue really expanded on this a lot, and observed supervision with white supervisors and Black-- supervisees, and they found all of these categories occurred [points to the screen]. Invalidating issues, stereotypic dysfunctions, being reluctant to give performance feedback because they might be viewed as a racist, focusing on weaknesses, blaming clients of color, and offering culturally insensitive treatment recommendations. So, let's be mindful of this.

FEEDBACK, PROFESSIONAL ISSUES, ETHICS, AND LAW

Falender: Feedback, I think we went over feedback earlier, so I'm kind of speed through this. But, it's really--How many of you assess for client outcome every week? I know, you're probably about ready to lie down on the ground and cry about the additional amount of work that I want you to do at this point, but do you know what they're finding? That even the simple checklist that clients fill out weekly on their presentation, their symptom checklist that is used -- OQ--Lambert's Outcome Questionnaire—you could use something else--the supervisees chart that and bring it to supervision. What Lambert and his colleagues are finding is, especially with very difficult clients, this is making a substantial difference in their outcomes. We don't know exactly why. But just factoring the clientsoutcome information into supervision can be very impactful. And I would encourage you to think much more about outcome assessment; because this is definitely a farsighted development--those of you who are familiar with the

Future of Psychology Summit that just occurred within APA--One of the major findings was that we really need to get in on the outcome emphasis that medicine already has, and we need to do it as well. We also need to link more to primary care and all those areas of medicine, and outcomes are critical pieces in which we need to be training. And what Huntsley tells us is only a minority of psychologists use a measure to assess outcome. And those who do were trained to do so. So, who has the power to do it? You're sitting right here in the room. This is an essential part of supervision, and it's becoming more so.

Okay, well, you should look at two new things. And these are really exciting things. One is, the Canadian Psychological Association has just come out with Ethical Guidelines for Supervision. It is amazing. And why am I telling you about Canada? For one thing, it's a small world with globalization. But not only that, I'm so hopeful that the APA will consider adopting it. But we'll see what happens. It's really an amazingly positive development. Number two is there is a universal declaration of ethical principles for psychologists, which is a wonderful international development. We should look at that too. It's quite amazing.

Okay, do we care about liability, really? You do? Okay. Direct liability you can control. Negligent supervision is direct liability. If you sleep through supervision, you are liable directly. If you do not supervise at a level that is generally accepted by the profession, you are liable. That's negligent supervision. And the reality is now that the standards are being defined so much more that this is becoming actionable. That is, if you do not supervise appropriately, it's negligent supervision. You need to know about your supervisee's work. You need to monitor it. That's part of supervision. Vicarious liability is what supervisors worry about more. Three conditions have to be met. Supervisees voluntarily agree to work, and in the direction controlled by the supervisor, and in ways that benefit the supervisor. That means they're doing the job that's designated. They must be acting within the defined scope of tasks permitted by the supervisor, and the supervisor must have authority to control and direct their work. All of this would definitely be the case, right? And, additional factors are the time, place, and purpose of the act, the motivation of the supervisee--whether they were trying to do something good, or not-- and whether the supervisor could have reasonably expected the supervisee to commit the act. How can we increase our probability to reasonably know whether the supervisee was expected to commit the act? Videotape, audiotape or observing at least once during the supervisee training. It increases the probability of knowing. So, just to have seen them once, minimally.

Okay, other malpractice elements that have to be met to meet criteria for malpractice. A fiduciary relationship, one of trust with the therapist or the client, that the supervisor is working in the best interests of the supervisee or the client, the supervisor's or the therapist's conduct is improper, negligent, or below the standard of care, the supervisee or client suffered harm or injury that is demonstrable, and there is a causal relationship amongst all three. So, there has to be a causal relationship, tying the three together.

Now, an interesting development--getting back to the question about sexual attraction--We do know that our malpractice insurance does not allow us to get payment if we are accused or convicted of having sex with a client, right? Well, the lawyers, redefined this as negligent supervision neglecting

discussion of transference and counter-transference. So, what that means is that they created essentially a standard that is now legally established that we need to handle transference and counter-transference in supervision. That it is expectable—back to the point that you made earlier—It is expectable, when we have young supervisees working with clients, or any age supervisees, it's expectable that there are going to be sexual feelings between them and the client. It's completely expectable. And, therefore, the prudent supervisor watches carefully for signs of boundary issues, transference, and countertransference, and knows how to manage them in the interests of client therapy.

Audience: [inaudible]

Falender: Managing countertransference and the issue of sexual attraction is legally mandated, by two courts. One is the Minnesota Supreme Court, and one is the 9th Circuit.

Audience: So, you're asking... [inaudible]...

Falender: You are observing your supervisee, and predicting and normalizing for your supervisee, "My expectation is that, in certain instances, you might have feelings including sexual feelings toward a client and]..." Sexual attraction towards your client is normative. Eighty-eight percent of psychologists, and in other professions, say that at least once during their career they were sexually attracted to a client. That is completely normative, right? And yet, training or supervision is only adequate in nine percent of the cases. Only half of the supervisees discussed it with supervisors, and supervisors almost never raised it. So, what does that mean for you? It means, I think—and probably most of you are doing this --that this is critical to discuss this with all your supervisees. And you discuss it really carefully. Plus, you discuss what to do if they have those feelings. And, you know, I always have an article, as you may have noticed, about everything. And there is an article about this, but I may have forgotten to bring it. Oh well, if you want the article, it's Hartl, H-A-R-T-L. It's also—I can't remember if it's in TEPP or Professional Psychology Research and Practice. Oh! Is it—Yes! Tell us.

Audience member interrupts with information about the article.

Falender: Okay, let's give you the microphone so you can make a formal announcement.

Audience: Okay, I can't recall the specific title, but the first author is Tamara Hartl, that's H-A-R-T-L. Uh, it was a couple of years ago, maybe three, probably two years ago in Professional Psychology: Research and Practice.

Falender: It's in there? It's in the reference list! And, it's really excellent, about steps for handling sexual attraction. It's an excellent article.

Okay, now very few supervisees have sex with their clients. It is very rare,. There's data on it, but it's very, very rare. So, the reality is that Hamilton and Spruill found some. And what they found was that--they did a retrospective analysis to see how you can predict that supervisees are at risk for having sexual interactions with clients. And what they found was that these were supervisees who had moved from another part of the country. They were isolated and lonely. They had been paraprofessionals in their

roles before graduate school, so they had quasi- friendship relationships with their clients. They were clinically inexperienced, so when clients said to them, "You mean the world to me," or "I love you," they took it quite literally. And, when they actually had sex with the client, it was positive for about fifteen seconds. For the client. So, when they did a retrospective analysis, what they found was that these were supervisees who extended the therapy hour, who had many undocumented phone calls, who dressed up specially for the client, who would follow the client down the street to give directives they forgot to give, who in many cases, the waiting room staff had suspected it, but never told anyone because they had no evidence. But they really thought it was the case, because of the non-verbal behavior in the waiting room, all kinds of things like that. There's a whole checklist that you can look up in Hamilton and Spruill , or in the appendix of our first book.

Now, sexual behavior is happening between supervisors and supervisees. This is a 2006 study, and 3.6% to 48% of psychology and mental health related students reported sexual advances, seductions and/or harassment. That's a pretty big range. This included all kinds of things, including, the one that I think is the most frequent that I hear about is supervisors, male supervisors who want to give a massage of the shoulders to the female supervisee, to relax them. That's a no- a big no. Anyway, 80% or more of mental health educators believe it is unethical or poor practice to engage in sexual contact with a supervisee or student, especially during the working relationship. Okay, where are the other 20%, right? [audience laughs] 13% of all participants said they would to engage in sexual conduct if they knew no one would find out. And many students, over half, would not feel safe to risk reaction if they had firsthand knowledge of sexual contact because of fear regarding their anonymity, and because of possible repercussions. And you know how vulnerable supervisees are. If they have a "bad" supervisor, which gets us back to that point, they cannot disclose. They absolutely cannot tell. Or if the supervisor is doing something "really bad", they cannot tell because, especially in systems, I think--not to be pejorativebut I think, like the VA, and other circumstances like that, they want so much to remain in the system, that they feel that if they make any kind of complaint, they will be forever ostracized. So, they are frightened, and they don't disclose it for years. They'll come back years later and tell.

Okay, those are some boundary crossings things we talked about a little bit. Questions to ask in multiple relationships. Do you have issues about multiple relationships, when to have them and when not, with your supervisees? Not so much? We can move then to boundary relationships for your supervisees with clients. Like, for example, if they're thinking they should go to a wedding of their client. And decision trees, If it's a multiple relationship issue for the internship, this is an excellent decision-making tree (Burian & Slimp slide).

Okay, unprofessional behavior--Well, this is such an important study, because this shows that, if you have supervisees who are unprofessional, this is not going to go away. Physicians really are kind of gutsy, because what they did was, they did a major study— Papadakis et al--looked at graduates of three medical schools who had been disciplined by a state medical board between 1990 and 2003, and they matched them with a control group of similar individuals who had not been disciplined by a state medical board. Now, you know how hard it is to get disciplined by a state medical board, right? Very difficult. So, this is really serious. So, they looked back to their medical school behavior to see if graduate school behavior was predictive of later disciplinary action and what did they find? Yes, highly

predictive. It was predictive in terms of medical school behaviors including severe irresponsibility, attendance, not following up on activities related to patient care, severely diminished capacity for self-improvement, including not being able to accept constructive criticism, argumentativeness, and a poor attitude. So, think about this. We really need to identify and take appropriate remedial steps—and follow through—with supervisees who are not meeting criteria or being professional. This is really serious. It's not going to go away. We have an ethical imperative. This behavior will inflict harm on the consumers ultimately..

Okay, zooming to supervisees who demonstrate competency problems. Here are some of the behaviors that it may be interfering with their professional functioning: Inability or unwillingness to acquire and integrate professional standards. I have an example, but if I had more time I would show you a video of a supervisee who has a shoestring strap dress, low-cut, and it stops right there, and she's about to begin leading an adolescent boys group. And this is her third reminder in the two and a half weeks she's been there. That would be an example of inability to integrate professional standards.

Inability to acquire professional skills I think is usually easier, but not necessarily, because I think in a way, the example we had earlier today was an example of not being able to integrate or acquire professional skill, right?--With your example a long time ago--and inability to control personal stress or psychological dysfunction. That would be the people who burst into tears, or are so emotionally moved by every client they see. They have such an emotional reaction that it interferes with their professional functioning. They don't acknowledge, address it, or understand it, even when it's addressed. The girl with the dress simply did not get it. She kept saying, "I'm accommodating to the weather. It's so hot." The problem is not usually a skill deficit. The quality of services is really affected. And we feel that it’s important how responsive they are to supervisory feedback as well. Individuals who are responsive to supervisory feedback, and really work to change, it's a very positive sign. Usually the problem is not restricted to one area. A disproportionate amount of supervisor time is required. That's an understatement, for any of you who have done this. It's an unbelievable challenge. And the behavior really simply does not change in the small number of individuals who have significant professional competency problems. Your feedback and remediation does nothing.

The latest title for this is, "Trainees with Problems in Professional Competency ,or TPPC. And the way to proceed, I think, in competency training is to identify the knowledge, skills, and values, and the intersection of those, in terms of the areas that they are not succeeding in. That's a really good way of proceeding. I wish we had a word for a remediation plan for all of us, that we should all be on an action plan. We should all be thinking about lifelong learning and development, rather than calling them action plans with a pejorative aspect, because we only put people on action plans like really at the most serious point, and that's kind of unfortunate. It would be good if our contracts could be action plans, and maybe the next step is for supervisors ourselves to have action plans, but that may be in the next millennium, when supervisors are more valued, and have more time for supervision.

SELF-CARE

Falender: Okay, self-care. We have 15 minutes, a lot of time. The pursuit of technical competence does much to recommend it that might inadvertently subordinate the value of personal formation and maturation of the psychologist. I think that's such a nice statement by Norcross. Now, Orlinsky and Ronnestad looked at thousands of mental health professionals, including psychologists, and they identified that a vast majority of them were in a positive career spiral, but a small minority were in a negative career spiral. I think this is a really useful tool for you to think about with your supervisees, and for yourselves. The ones in the positive spiral, in both slides, are on the left side. They currently experience growth. They are feeling involvement in their careers. They feel like they've got affirming relationships with their clients and with their colleagues. They actively utilize professional development resources. They have breadth and depth of case experience, reflection they are engaging in, multiple theoretical perspectives—interesting-, and a sense of assurance, resourcefulness, and flexibility. In contrast, a small group, less than 15% are in a negative spiral, and are depleted. They feel like their career is really quite limited with stressful involvement and a lot of avoidance coping, which is never good. They are experiencing anxiety, boredom, they don't feel safe or supported in their career setting, have very narrow case experience, premature closure towards clients, lacking in therapeutic mastery, and generally just feeling insecure, defensive, rigid, etc. This is a really useful tool for supervisees to self-assess career development, and for all of us, I think, in terms of our development and happiness.

Now, some questions we can ask ourselves are, "If I had a client with symptoms like mine, what would I recommend?" Nobody's laughing, that's a bad sign. [Audience laughs] Okay. If I'm depressed, is it related to the chronicity and severity of the clients I've recently taken on without thinking about it? We need to self-regulate, and how we need to--as the gentleman said earlier--really model self-regulation, and assessing our own coping, because you are all in, I think, one of the most stressful settings, don't you think? You have potentially incredible stress? Okay, good. I got a nod, finally. That's good.

CAREER SUSTAINING STRATEGIES

Falender: Now, what is a career-sustaining strategy? These individuals did a study to look at factors that actually sustain our careers. Now, you all coming here to this VA conference are sustaining your careers. Engaging in CE activities is one of the major career-sustaining activities. I like the positive self-talk one. I think that's really a nice one--engaging in positive self-talk. The rest of them, I think, are kind of predictable. I think you all take vacations, so I don't have to tell you my vacation story. I was giving a talk, and I showed this, and someone raised their hand and said, "Well, if you're doing training, that would not be possible, right?" And the whole group turned and looked, and this person said, "I've been a training director for twenty years, and I've never taken a vacation, because I'm not allowed to go away. You're not allowed to leave your supervisees." And everyone, like in unison, said, "You HAVE to take vacation, so you can delegate. What are you thinking?!" So, at the end of the day, the individual said, "I want to make a statement. My wife thanks you. I thank you. My wife has already scheduled a cruise. We're going away." [Audience laughs] So, just for your edification.

And that concludes the formal part. What I want to see is whether you have any questions or any specific concerns in the remaining time. We still have 11 minutes.

Audience: [inaudible].

Falender: He's asking how you screen supervisees' selection most effectively. I think supervision—you know, I started out with that—and I do want to say that supervision is the highest order. It's a wonderful career activity, and it keeps us vibrant and alive. The way I would encourage you to screen is--it's kind of complicated--but I think that the more realistic you can be--I think someone indicated something early on today about very real kinds of presentations. I think even giving vignettes that supervisees respond to in the interview process. But can I tell you that the year I had probably--I've always had wonderful trainees--But one year, I had the most flexible. We were painting the entire facility during Christmas when people came for their interviews. And it was a complete mess. The smell was pretty bad, but I went in for interviews if people were coming from across country. And it was like an incredible screening device, because the clerical staff told me that certain people said, "How could she have allowed us to come through this mess for an interview?! What an awful thing." Of course, with me, they were all sweetness and light, but the ones who were flexible, and really amazingly positive, and looked through the painting to the fact that it was going to be beautiful or whatever, were the ones who were most successful. But I think--in getting back to your question--I think the more specific to the setting you can be, and the more that they really understand what it's going to be like--and I would have them interview with more than one staff person because multiple perspectives are really good. Have a team of interviewers. I would not do it without interviews. Do all of you interview? Some places now are going just to paper applications, but I think it's really important to have interviews. Do any of you have answers to that? How else do you maximize your skill at interviewing?

Audience: Have them have lunch with the current interns in the program.

Falender: Have them have lunch with your current interns. That's a really great idea too. What else? That's it?

Audience: [inaudible].

Falender: That's right; it would have to be that you are going to let them know, absolutely, that if they are having lunch with the interns, that the interns are part of the selection process.

Audience: [inaudible].

Falender: Make it clear when you're on the performance remediation track. First of all, remember the thing about transparency. With supervisees, I think it's critical that you let them know, as they are approaching it, "At this moment, I want you to know that I'm having some really significant concerns about your performance in X, Y and Z." Now, I think Bob has some input here, and I'm bringing the microphone. But, I think the greater the clarity and the clearer your requirements and expectations, the more they're reviewed after the first time interval. Like, you can--say its paperwork. And the supervisor says, "Okay, you're going on a remediation plan because you're three weeks behind, and I'm going to

document this. And you'll need to bring in all the things," and so forth. In three weeks, they come, they have every piece of paperwork completed, and the supervisor signs off and forgets about it for four months, and not one more piece of paperwork was done between the time that they last checked and the four months, and then you're in terrible shape. So, once you begin the remediation, you need to track the remediation items. Do not just be so relieved that it's over. And I love this idea about the actual sheet spelling it out. I think the greater the clarity and the greater the transparency, the better we are. But, on the other side, when they go off the remediation plan, they should also be praised for going back on the regular track. "That's an incredible accomplishment. You've really made real strides, excellent!" Not that you're not going to be watching them.

Anything else? I wish you all the very best of luck in supervision. It's a great pleasure, so thank you all.

[Applause]