

SUPERVISEE EXPERIENCES OF POOR AND HARMFUL CLINICAL  
SUPERVISION

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## ABSTRACT

The overall purpose of this research was to build on existing discipline understanding of clinical supervision perceived by probationary psychologists as less than positive. Bernard and Goodyear's (2004) definition of clinical supervision was used as a framework to analyse contemporary theory and research and facilitate conceptualisation of levels of clinical supervision effectiveness from the supervisee's perspective. Constructs of bad (poor) and harmful supervision proposed by Ellis and his colleagues (e.g., Ellis, Swagler & Beck, 2000) were used to investigate the nature, incidence, causes, and impacts of less than positive supervision. Extant theory and research were combined to build a preliminary model of variables hypothesised to predict poor and harmful clinical supervision.

Two complementary studies were used to investigate supervisee experiences of less than positive supervision. In Study 1, 91 Victorian probationary psychologists completed an Internet questionnaire on their least positive past supervision experience. Quantitative data was collected on the incidence of poor and harmful supervision and supervisee selected explanations for its occurrence. Using Mann-Whitney U tests, rank scores on measures of the supervisory relationship, role conflict and ambiguity, evaluation within supervision, and supervisor self-disclosure, were compared to investigate whether poor and harmful supervision might be distinct constructs.

Approximately 28 % of participants described their least positive supervision experience as poor and 11% as harmful. Relative to poor supervision, supervisees reporting harmful supervision were more likely to select multiple explanations for the experience. Scores on measures of the emotional bond between supervisor and supervisee, and evaluative feedback within supervision, were found to differentiate participants reporting poor and harmful supervision.

In Study 2, 10 volunteer probationary psychologists from Study 1 participated in telephone interviews pertaining to a past poor or harmful supervision experience. Stages of the human phenomenological scientific method (Giorgi, 1997) were used to describe poor and harmful supervision experiences. Common

themes in supervisee descriptions of poor and harmful supervision were deduced using N Vivo 2.0. Concerns pertaining to unethical supervisor behaviour and evaluative feedback were evident in most accounts of poor and harmful supervision. Deleterious impacts arising from dual supervisor roles and supervisee role conflict were more evident in descriptions of harmful supervision.

A mixed methods research design was applied to assess the preliminary model of variables predicted to underlie poor and harmful supervision experiences. Findings from Study 1 and 2 were combined to critique the exploratory model predictions and make suggestions for future model development.

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experiences two years on. From my perspective, one of the defining features of the qualitative component of the research was the preparedness of probationary psychologists to explore the likely contributing factors to their experiences of less than positive clinical supervision. This prompted early consideration of poor and harmful clinical supervision within its context rather than from the more limited focus of who was responsible for its occurrence.

I would like to thank my partner, David MacFie who accepted the many weekends spent on this research. Undertaking research is a long-term commitment, often taking chunks of time out of other parts of life. On the other hand, there were immeasurable rewards along the way, and perhaps one of the most poignant moments for me came when one of the research participants wrote: "...it is sad to know that there are people just like me who have been exposed to such terrible supervision, but on a final note, there is life after harmful supervision!"

## **DECLARATION**

I declare that this thesis contains no material which has been accepted for the award of any other degree or diploma, except where due reference is made in the text. To the best of my knowledge, this thesis contains no material previously published or written by another except where due reference is made in the text. I declare that the ethical principles of the Australian Psychological Society and the codes, guidelines and principles of Swinburne University of Technology in relation to research have been adhered to during the course of this research project.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## QUOTATION

“An overemphasis on generic models of clinical supervision may obscure ways in which the meaning of supervision and its possible practice is contingent on the specific setting in which it is conducted.” (Davy, 2002, p. 231)

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## **CHAPTER 1: OVERVIEW**

Clinical supervision has been defined as an intervention where experienced psychologists (supervisors) perform a monitoring, supportive, and educative role for probationary psychologists (supervisees) in their work with clients (Bernard & Goodyear, 2004). In Australia, as in many other countries, supervision of the clinical work of students on field placements forms an integral component within training courses for psychologists (Australian Psychological Society [APS], 2006; Bernard & Goodyear, 2004; Gabbay, Kiemle & Maguire, 1999; Holloway & Neufeldt, 1995; Johnson & Stewart, 2000; Psychologists Registration Board of Victoria [PRB], 2005). Support for the use of clinical supervision as a training tool rests on the premise that therapeutic skills and professional learning can be effectively passed on from more experienced to less experienced or trainee psychologists (Bernard & Goodyear, 2004; Holloway, 1995).

Although there is extensive professional opinion recommending clinical supervision as a key intervention for training psychologists (Bernard & Goodyear, 2004; Holloway, 1995; PRB, 2005), empirical support for its effectiveness, as currently practiced for supervisees and their client work, is noticeably sparse (Bickman, 1999; Davy, 2002; Ellis & Ladany, 1997; Freitas, 2002; Ladany, 2004). Recent research, exploring supervisees' experiences of clinical supervision, has indicated that the impacts of supervision may depart from expectation in a significant minority of supervisory relationships (Gray, Ladany, Walker & Ancis, 2001; Ladany, 2004; Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002). Experiences of clinical supervision have been described negatively by some supervisees (Ramos-Sánchez et al., 2002), and involved harmful conflict for others (Nelson & Friedlander, 2001). While the effectiveness of clinical supervision cannot be evaluated solely on the basis of supervisee perceptions, it is of professional concern that an intervention generally perceived as a principal learning tool may have negative or even harmful impacts for some probationary psychologists (Ellis, 2001; Ellis, Swagler, & Beck, 2000; Gray et al., 2001; Ladany, 2004; Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002).

Currently, the profession of psychology has limited empirical knowledge of what constitutes clinical supervision perceived by supervisees' as less than positive (Ellis, 2001). This includes its nature, the potential causes and prevalence of such experiences, and the consequences for supervisees over time. Whilst a small number of recent studies have provided empirical support for the existence of counterproductive (Gray et al., 2001), negative (Ramos-Sánchez et al., 2002), and harmful supervision (Nelson & Friedlander, 2001), the lack of a unified nomenclature for defining less than positive clinical supervision, combined with use of different research designs, has impeded the comparability of such findings (Ellis, 2001; Ellis et al., 2000). Thus, it is unclear whether there are different levels or types of ineffective clinical supervision, and on what basis any such differentiation might occur (Ellis, 2001).

In the current climate of strong disciplinary support for clinical supervision as a training method, without substantive empirical validation as to its impacts, the overall aim of the current study was to further understanding of supervisee experiences of less than positive clinical supervision. Two complementary studies were designed with this overall purpose in mind. The first study sought to attain a broad understanding of the nature and incidence of less than positive supervision experiences amongst a population of probationary psychologists in Victoria, Australia. By obtaining quantitative data on a range of clinical supervision experiences, it was expected that some indication of the prevalence of less than positive supervision within this population could be determined. Concepts of poor (bad) and harmful supervision proposed in recent clinical theory (Beck & Ellis, 1998) were provided to supervisees as the basis for classifying their less than positive supervision experiences. Measures of the supervisory relationship (Bahrnick, 1990), role conflict and ambiguity (Olk & Friedlander, 1992), evaluation within supervision (Lehrman-Waterman & Ladany, 2001), and supervisor self-disclosure (Ladany & Lehrman-Waterman, 1999) were used to investigate the possibility that poor and harmful clinical supervision are conceptually and empirically different constructs.

The second study sought to obtain rich in-depth descriptions of poor and harmful clinical supervision from a small number of volunteer probationary psychologists who described their least positive supervision experience in the first study, as poor or harmful. In addition to gaining pertinent information on the nature, causes, and consequences of these supervision experiences, it was anticipated that any relevant criteria that potentially differentiate poor from harmful clinical supervision might be elucidated.

This thesis examines extant theory and empirical research on the effectiveness of clinical supervision within the discipline of psychology, with particular emphasis on the perspective of the supervisee. Chapters 2 through 6 provide the theoretical basis to the research, examining how clinical supervision has been conceptualised within existing theory and research and endeavouring to identify gaps in our knowledge base. Empirical research (in Chapters 7 and 8) is used to undertake some preliminary assessment of a proposed model of variables to predict poor and harmful clinical supervision (Chapter 9). Suggestions in terms of future research directions are provided in Chapters 7, 8 and 9. Some concluding comments on the nature of clinical supervision are provided in Chapter 10.

## CHAPTER 2: THE CONSTRUCT OF CLINICAL SUPERVISION

The purpose of this chapter is to describe and examine how clinical supervision has been defined within the discipline of psychology, with particular emphasis on delivery of counselling services. The dominant perspective, conceptualising clinical supervision as a multi-purpose intervention implemented by supervisors to train supervisees, is evaluated using contemporary research and theory. It is asserted that performance of a gate-keeping function, as to who enters the profession of psychology, is a pivotal supervisor function that interacts with and impacts on all other functions of clinical supervision.

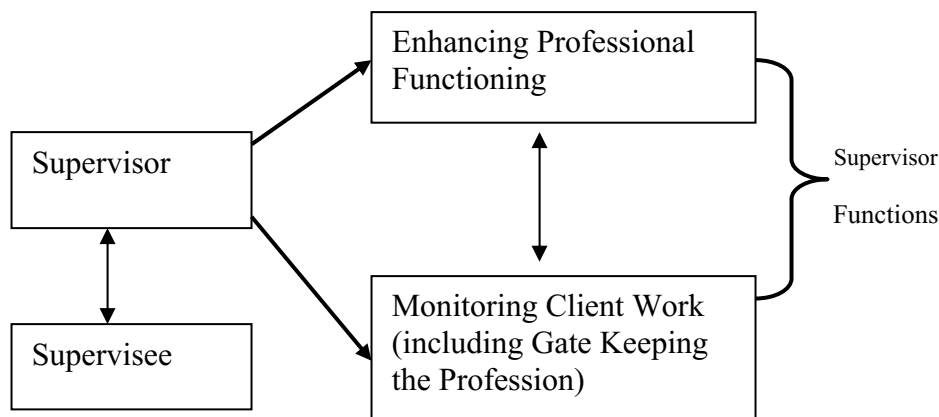
### 2.1 Defining Clinical Supervision

There is an extensive body of literature describing clinical supervision from the perspective of psychologists, educationalists, professional associations, and regulatory bodies (e.g., APS, 2004; Barletta, 2002; Bernard & Goodyear, 2004; Bradley & Kottler, 2001; Davy, 2002; Holloway, 1995; PRB, 2005). Principally, definitional focus has been placed on the role of supervisors to monitor or oversee the client work of supervisees, and to enhance their capacity to become ethically responsible and therapeutically competent professionals (Bernard & Goodyear, 2004; Bradley & Kottler, 2001; Davy, 2002; Holloway, 1995). Congruent with this approach, Bernard and Goodyear (2004) offered the following definition of clinical supervision:

An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional function of the more junior person(s), monitoring the quality of professional services offered to the client(s) she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession. (p. 8)

Depicted in Figure 1 are the components of Bernard and Goodyear's (2004) definition of clinical supervision. At least two purposes are sought to be achieved by dissecting this definition: firstly, the components can be used as a framework for presenting and evaluating some of the current literature and research on clinical

supervision, and secondly, the framework provides a useful starting point for building a theoretical model to reflect supervisee experiences of clinical supervision with respect to its effectiveness.



*Figure 1.* A diagrammatic representation of Bernard and Goodyear's (2004) definition of clinical supervision.

## 2.2 Components of Bernard and Goodyear's Definition of Clinical Supervision

Using a contemporary frame of reference and an Australian context, the key elements of Bernard and Goodyear's (2004) definition can be depicted as:

### *2.2.1 An Intervention Provided by a Senior Member of the Profession to a More Junior Member*

Within the profession of psychology, clinical supervision commonly occurs within a relationship between a supervisor (a registered psychologist) and supervisee (a probationary or another registered psychologist). As the focus of the current research is on the supervision experiences of probationary psychologists, it is usual for clinical supervision of this nature to occur within a one to one relationship. However, it is worth noting that clinical supervision is a diverse practice that can occur where the supervisor and supervisee are of relatively equal professional standing, within the context of a group of peers, and within multidisciplinary teams (e.g., including social workers and psychologists) in a workplace (Davy, 2002; Milne & Oliver, 2000). It is not uncommon for group and individual supervision to occur concurrently for some supervisees.



In Victoria, there are two main systems for probationary registration (PRB, n.d.). A person is eligible for probationary registration as a psychologist if he or she has:

- a) completed an accredited four year sequence of study in psychology and is engaged in work of a psychological nature under the supervision of a registered psychologist; or
- b) completed an approved four year sequence of study in psychology and is currently enrolled in an accredited higher degree in psychology.

The first group of probationary psychologists a) must complete at least 480 full-time days (or part-time equivalent) of supervised work, substantially psychological in nature, to attain full registration (PRB, 2005). For these probationers, registration as a psychologist occurs without a higher degree qualification and supervised psychological work can occur as part of paid employment. The second group of probationary psychologists must complete an approved research or course work Masters or Doctoral qualification. To obtain full registration, probationers who have undertaken an accredited research degree complete at least 240 days of supervised psychological work in addition to their research, and course work students working towards a Masters or Doctoral qualification at least 120 days of supervised psychological work. For all probationary psychologists, additional requirements must be met for full registration, including evidence of good character and competency in English (Psychologists Registration Act, 2000; PRB, 2005).

### *2.2.2 Clinical Supervision Occurs Over Time*

Clinical supervision may be a unitary event, perhaps occurring as one session. However, it commonly occurs more than once, on an ongoing basis, over a period of weeks, months or years. Supervisory relationships are thus temporal in nature (Bernard & Goodyear, 2004), with individual supervision experiences usually differentiated by the involvement of a different supervisor.

### *2.2.3 Clinical Supervision Occurs Within an Ongoing Relationship*

Theoretically, clinical supervision occurs within an evolving, dynamic relationship where a person's skills in delivering counselling services, and his or her identity as a counsellor, are enhanced through interaction with another (Hess, 1987).

This relationship between supervisor and supervisee has frequently been depicted as the core of clinical supervision (Holloway, 1995; Ladany, 2004; Nelson, Gray, Friedlander, Ladany & Walker, 2001; Ronnestad & Skovholt, 1993). It has been postulated that the initial stages of relationship development are crucial to the overall effectiveness of a supervision experience (Chen & Bernstein, 2000; Ladany, Ellis, & Friedlander, 1999; Magnuson, Norem, & Wilcoxon, 2000; Nelson et al., 2001). Thus, what is initially set up in supervision influences how difficulties and ethical dilemmas are dealt with later on within the supervisory relationship (Magnuson et al., 2000; Nelson et al., 2001). A growing body of theory and research indicates that the supervisory relationship must be able sustain the inevitable conflicts that arise as the supervisee progresses towards professional competence and autonomy (Bordin, 1983; Gray et al., 2001; Nelson et al., 2001).

#### *2.2.4 The Supervisor has a Number of Critical Functions to Perform*

##### *2.2.4.1 Enhancing Professional Functioning*

Bernard and Goodyear (2004) delineated two primary functions of clinical supervision. The broad role of enhancing the professional development of the supervisee is described as comprising of educative and supportive components (Bernard & Goodyear, 2004). As part of the educative function, it is anticipated that multiple concrete goals will be negotiated collaboratively by supervisor and supervisee, including the supervisee working towards attainment of specific therapeutic competencies, exploring the tenets of professional practice, and being exposed to a range of therapeutic interventions (Holloway, 1995; Talen & Schindler, 1993). It is also expected that such goals will be documented in a formalised supervision agreement to be reviewed and revised on an ongoing basis (APS, 2006; Bernard & Goodyear, 2004; Magnuson et al., 2000).

In addition to educating, the clinical supervisor is engaged in supporting the supervisee's efforts to become an effective psychologist. Ideally, clinical supervision affords the supervisee a secure base for working on limitations in knowledge and skill, confronting concerns and fears, and developing professional competence (Bradley & Kottler, 2001; Talen & Schindler, 1993). Holloway (1995) has described clinical support as comprising of empathic attention, encouragement,

and constructive confrontation. The provision of support and feedback is part of a collaborative, interactive process (Holloway, 1995; Lehrman-Waterman & Ladany, 2001), where the supervisee's perceptions and beliefs about the supervisor (e.g., as to trustworthiness) underpin how such clinical support will be interpreted (Allen, Szollos & Williams, 1986; Holloway, 1995).

The Psychologists Registration Board of Victoria [PRB] (2005), in its "Guidelines for Probationary Psychologists and Supervisors," [Guidelines] has essentially articulated the educative and supportive functions of clinical supervision within 5 of their 7 general objectives. The supervision program is used to:

1. Give probationary psychologists experience in, and instruction about, the practice of psychology;
2. Assist probationary psychologists to develop knowledge about the practice of the profession;
3. Support the professional development of probationary psychologists in ways that will increase their effectiveness as psychologists;
4. Create an awareness of the role of continuing professional development and ongoing supervision; and
5. Educate about and promote ethical and professional standards of conduct.

While these guidelines were purposely written for probationary psychologists undertaking supervised psychological work after completing 4 years of accredited studies, their content appears equally pertinent to clinical supervision occurring within higher degree qualifications.

#### *2.2.4.2 Monitoring Client Work*

According to Bernard and Goodyear (2004), the second key function of the clinical supervisor, monitoring client work, is integral to overseeing the well being of the clients of supervisees. The clinical supervisor is actively involved in ensuring that the supervisee is responding to client needs in an appropriate and timely manner. It has been noted that effective performance of this function is salient to minimising any potential supervisor liability for wrongdoing or neglect by a supervisee (Magnuson et al., 2000). The PRB Guidelines (2005) essentially incorporate monitoring client care in two goals. These are:

6. To protect clients, employers and probationary psychologists while professional tasks and roles are being learned;
7. To assist probationary psychologists to apply their professional knowledge in current work situations.

The sixth goal notably extends the protective function of the clinical supervisor to probationary psychologists and employers, as well as clients. This provision appropriately recognises that how a supervisor performs the monitoring function has implications not only for clients, but also for the well being of other involved parties such as supervisees and employers.

#### *2.2.4.3 Gate-keeping the Profession*

Bernard and Goodyear (2004) have not delineated professional gate keeping as a separate supervisor function, incorporating it under the umbrella of ensuring client well being. Owing a responsibility to the profession of psychology and future clients, the supervisor is charged with the duty of assessing the professional competence of the supervisee against designated criteria and professional standards (Bernard & Goodyear, 2004; PRB, 2005). Given that competencies indicative of readiness to professionally practice as a psychologist are multiple and interconnected (APS, 1996), and levels of competency to be demonstrated by supervisees not always easy to operationalise (Gould & Bradley, 2001; Magnuson & Wilcoxon, 1998), this function is not a straightforward one. Interestingly, there is little empirical evidence about how this gate-keeping role is performed, with some concern that subjective factors rather than objective criteria, may underpin this function for some supervisors (Gould & Bradley, 2001; Robiner, Saltzman, Hoberman, & Schirvar, 1997).

Within the Victorian context, clinical supervisors do appear to perform a key gate keeping function, adding weight to the proposition that this is a critical supervisor function that warrants separate consideration. For probationary psychologists outside the higher degree system, the clinical supervisor must complete a declaration stating that the supervisee has reached a level of skill commensurate with what would be expected from a registered psychologist (PRB, 2005). In the case of higher degree probationers, supervisors complete a written

report, verifying that the supervisee has satisfactorily completed placement requirements. Whilst the supervisor is not the sole gatekeeper for the profession of psychology (e.g., there are course work and research requirements for most probationary psychologists), supervisors do perform an integral part of this role.

Although supervisor functions within clinical supervision are commonly described separately, they are interconnected and are likely to be implemented concurrently. Theoretically, successful completion of placement requirements is dependent on both the supervisee's professional functioning and his or her capacity to attend to client welfare. However, the emphasis given to each function, and the potential for inclusion of other supervisor functions (e.g., attending to supervisee well-being), is likely to depend, to some unknown degree, on a range of contextual factors within a particular supervision experience, such as the nature of the client group (Bernard & Goodyear, 2004).

#### *2.2.5 Evaluation Can be Viewed as the Nucleus of Clinical Supervision*

Clinical supervision has been defined as comprising of clinical and evaluative components (Bernard & Goodyear, 2004; Holloway, 1995). The clinical role of supervision has been depicted as encompassing the supervisee's work with his or her clients (Bradley & Kottler, 2001), including building the therapeutic relationship, understanding client history, assessment of presenting problems, treatment planning, and appropriate referral (Holloway, 1995). Underlying the practice of clinical supervision is the notion that the accumulation of knowledge and skills by the supervisee is one aspect, but the opportunity to practice those skills in a clinical context under professional supervision is critical (Bernard & Goodyear, 2004).

The evaluative component of clinical supervision entails assessment by the clinical supervisor of the developing clinical skills and evolving professional identity of the supervisee. This evaluative element has been depicted as comprising of two components: the setting of standards of proficiency in relation to specific supervisee competencies (goal-setting), and providing feedback on the supervisee's progress towards meeting these goals (Ladany, 2004; Lehrman-Waterman & Ladany, 2001). Ideally, supervisee progress is assessed using a pre-determined mix

of common competencies such as discipline knowledge, communication skills, and proficiency in framing, measuring, and solving client problems (APS, 1996). To facilitate valid and reliable evaluation, use of a range of methods is recommended, including audio/videotape review, reflective self-reports, and process notes (Gould & Bradley, 2001). Effective feedback in supervision should be collaborative, timely, ongoing, clear, concrete and credible (Bordin, 1983; Ladany, 2004; Lehrman-Waterman & Ladany, 2001).

While evaluation is often conceptualised as a unitary experience, it has been proposed that there are two interactive aspects to evaluation (Robiner, Fuhrman & Ristvedt, 1993). Formative evaluation involves ongoing feedback to supervisees about their developing clinical competencies (e.g., strengths and weaknesses) and professional capabilities (e.g., application of ethical principles) (Bernard & Goodyear, 2004). This aspect appears to closely align with the definition of evaluation provided by Lehrman-Waterman and Ladany (2001) as comprising of goal setting and feedback.

A second facet of evaluation within clinical supervision, summative evaluation, may relate more to the gate-keeping function of supervisors. Typically near the end of a supervisory experience the supervisor objectively assesses the supervisee's clinical competence and professional integrity (Robiner et al., 1993). At this point in time, a decision is made about the supervisee's competence and readiness to practice as a fully registered psychologist, or in the case of higher degree students, to progress to the next placement.

The recognition that evaluation is multifaceted and relates differentially to key supervisor functions is important from the standpoint of compatibility in supervisor roles. While compatibility may be evident where supervisees are making good progress, attending to client welfare, and approaching readiness for professional practice, there will be some supervisory relationships where the outcomes of formative and summative evaluation may be less clear-cut. Conceivably, a particular supervisee may be progressing towards professional competence but still be perceived as not yet ready to enter the profession. Notably, there is limited

research on how supervisors deal with evaluation in supervision, particularly when the outcome for the supervisee is not positive (Robiner et al., 1997).

While evaluation straddles all supervisor functions, it is the summative function of evaluation that is significant in determining who enters the profession. It is notable that our system of registration affords the clinical supervisor primary responsibility for evaluating the clinical learning of the supervisee within a particular placement experience. For supervisees in Victoria seeking psychology registration outside the higher degree system, attaining full registration may hinge on evaluation by one person. It seems reasonable to suggest that evaluation in clinical supervision is likely to be anxiety provoking for some supervisees (Bernard & Goodyear, 2004) and supervisors (Gould & Bradley, 2001), and that this may be intensified where there are no effective processes in place for evaluation of the supervision experience itself or the supervisor. Concerns about this monopoly in evaluation has led to some questioning of the current process, with the credible proposal that client and third party expert evaluation should also be incorporated (Ladany, 2004).

### 2.3 The Complexity of Clinical Supervision

Clinical supervision is a complex training tool that serves multiple functions some of which are clearly articulated such as monitoring client care. Other functions such as gate-keeping the profession have been less overtly considered within theoretical and empirical writings. Evaluating the performance of supervisees is a critical supervisor function, particularly where concerns exist with respect to whether a particular supervisee has attained levels of competency commensurate with those expected of a fully registered psychologist. It is important for the discipline of psychology to learn more about how clinical supervisors perform this evaluative function.

### **CHAPTER 3: BROADENING THE CONSTRUCT OF CLINICAL SUPERVISION**

While Bernard and Goodyear's definition of clinical supervision provides a useful construct for understanding the main functions of clinical supervision, a broader theoretical structure is important for considering clinical supervision from the supervisee's perspective. This chapter examines the broader context of clinical supervision, and it is proposed that whether a particular supervisory experience is perceived as effective by a supervisee depends to some unknown degree on the wider context of supervision, including other parties involved, the placement context, and the compatibility of roles that the supervisee must perform within a specific clinical supervision experience.

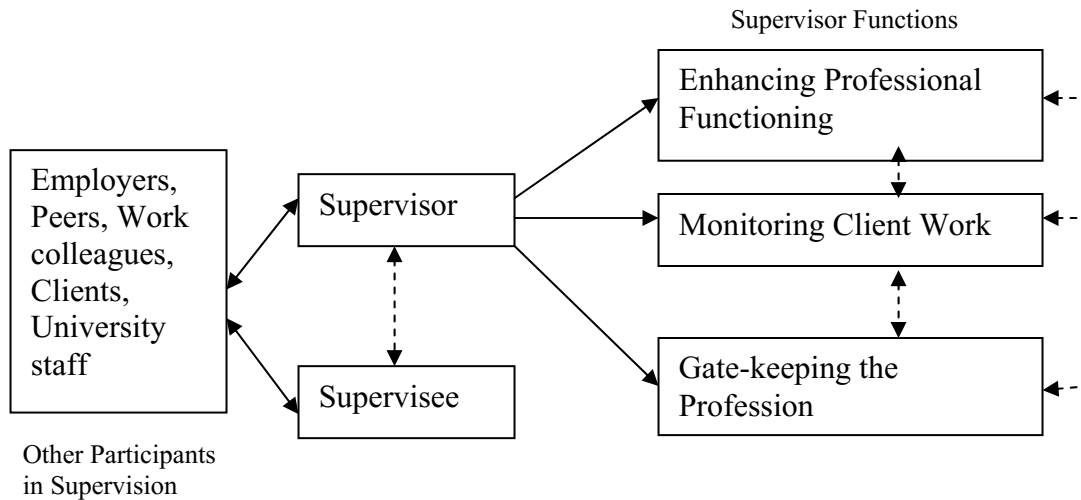
#### **3.1 Other Relationships in Clinical Supervision**

Broadening the construct of clinical supervision to incorporate additional participants within the supervisory experience offers a window into the interrelationships, both covert and overt, that potentially affects and is affected by clinical supervision from the supervisee's perspective. Arguably, the most important are the clients who may be the mainstay of discussions between supervisor and supervisee. However, directors of training programs, other supervisors, teachers, peers, ancillary staff and employees of outside organizations, amongst many may also affect the quality of the supervisory experience for both supervisor and supervisee.

The broader relationships within clinical supervision present professional, legal and ethical responsibilities for supervisor and supervisee, many of which are now delineated within ethical and professional codes of conduct (e.g., APS Code of Ethics, 2003; APS Ethical Guidelines, 2006). However, a plethora of dynamic interrelationships and ensuing issues may present for supervisees in university, work, and fieldwork contexts. Such experiences may lie outside guidelines, be uncertain in nature, and afford challenges some supervisees may struggle to deal with. Moreover, broader relationships may encompass associations that clinical supervisors have with clients, university staff, and placement personnel who can potentially affect a supervisee's experience of clinical supervision. In order to



recognise this broader relational context, Figure 2 incorporates some additional participants of potential influence into Bernard and Goodyear's (2004) original conceptualisation of clinical supervision.



*Figure 2.* A diagrammatic representation of Bernard and Goodyear's (2004) definition of clinical supervision, incorporating gate-keeping as a key supervisor function and including other participants of potential influence.

### 3.2 The Organisational Context

Clinical supervision cannot be isolated from the environment in which it occurs and thus is not a pure activity. It is contextual, affected by the culture and structure of the organization (Davy, 2002). Clinical supervision occurring within a psychological facility in a university is conceivably very different from supervision occurring within an outside organization, which may include multi-disciplinary teams, diverse services and different organisational goals (Bernard & Goodyear, 2004). In the same way, supervisory experiences within the same organization may vary in perceived quality for different supervisees based on variables such as supervisor and supervisee characteristics, the program area and structure, and the client group. In theory, an experience of supervision may be evaluated as ineffective by a supervisee as a result of pressures or experiences unique to a particular setting. Factors such as service demands, staffing levels, and organisational goals, culture

and politics, may impact on professional development and the client work of supervisees (Davy, 2002; Holloway, 1995).

### 3.3 Tasks and Roles within Clinical Supervision

Bernard and Goodyear's (2004) definition of clinical supervision offered a depiction largely construed from the supervisor's perspective. Yet clinical supervision is clearly an interactive process (Efstation, Patton & Kardash, 1990; Holloway, 1995), where the supervisee and supervisor work collaboratively to enhance the supervisee's therapeutic skills and build a professional identity (Holloway, 1995). Within supervision, the supervisee must learn complex tasks and assume multiple roles (Nelson & Friedlander, 2001). Holloway (1995) has conceptualised the process of supervision as consisting of a dynamic interplay between supervisor functions and the tasks of supervision; that is, what is to be taught and how this will be accomplished.

In her description of the collaborative tasks of clinical supervision, Holloway (1995) delineated the following key tasks: the development within the supervisee of counselling and case conceptualisation skills, the development of a professional role, the growth of intra- and interpersonal emotional awareness, and the development and facilitation of self-evaluative skills. Using Holloway's taxonomy, Appendix 1 presents a definition of each task and examples of the sub-tasks that may be involved. Arguably the tasks of clinical supervision are the shared responsibility of supervisor and supervisee and should relate to what is evaluated in clinical supervision.

The tasks of clinical supervision are interactive and translate into multiple supervisee roles. These include the roles of psychologist, student, client, supervisee and colleague (Olk & Friedlander, 1992). In learning counselling skills, the supervisee is the student; in applying those skills in a counselling session, the supervisee is the (trainee) psychologist. In its Guidelines on Supervision, the APS (of which over 14,000 Australian probationary and fully registered psychologists are members) delineated that supervisees are both a recipient of a psychological service (through supervision) and the provider of a psychological service (in

working with clients) (APS, 2006). In this respect, supervisees have to learn to manage multiple roles, including that of client as well as psychologist.

The varied roles that a supervisee performs may not fit together comfortably and afford significantly different levels of power (Nelson & Friedlander, 2001; Olk & Friedlander, 1992). As a counsellor with a client load during placement, the supervisee may be afforded more power than in a supervision session where the focus is on learning counselling skills. Managing the shifts in power embedded in different roles is part of the learning experience of clinical supervision for the supervisee. Factored into this must be the actuality that supervisees and supervisors bring to a particular clinical supervision experience different skill levels and personal characteristics that impact on how power is managed and distributed within the supervisory relationship (Olk & Friedlander, 1992, Nelson & Friedlander, 2001). The placement context is also likely to impact on role performance and affect the exercise of power within clinical supervision.

#### 3.4 The Construct of Clinical Supervision from the Supervisee's Perspective

Clinical supervision is a dynamic interactive experience, where the interplay of many variables has the potential to influence each supervisee's perception of a particular supervision experience. While the supervisor is charged with the responsibility for performing a number of critical functions, the broader context of clinical supervision is a reminder that whether a supervision experience is perceived as effective or otherwise, is likely to be related to a range of factors that are not all contained, or containable, within the dyadic relationship between supervisee and supervisor. Thus, clinical supervision from the supervisee's perspective is arguably a broader construct, incorporating additional influences on its effectiveness than evident in the supervisor functions conceptualised by Bernard and Goodyear (2004).

## **CHAPTER 4: EFFECTIVE CLINICAL SUPERVISION**

This chapter examines how the construct of effective clinical supervision has been defined in theory and operationalised within empirical research. It is noted that at this point in time there is no unified conceptualisation within the discipline of psychology as to what constitutes effective clinical supervision. With respect to empirical research, primary emphasis to date has been focused on the correlation between specific supervisory styles and behaviours, the quality of the supervisory relationship, and effective clinical supervision. This empirical focus has essentially placed primary responsibility for effective clinical supervision on the clinical supervisor.

### **4.1 Defining Effective Clinical Supervision**

Effective clinical supervision can be defined in many ways using a range of supervision variables. To date, effective supervision have generally been linked to specific supervisor styles (Allen et al., 1986; Friedlander, Siegel & Brenock, 1989; Friedlander & Ward, 1984) and behaviours (Worthington & Roehlke, 1979), the quality of the supervisory relationship (Bambling, 2000; Ellis, 1991; Holloway, 1995; Ladany, 2004; Nelson et al., 2001), the developmental level of the supervisee (e.g., Ronnestad & Skovholt, 1993; Stoltenberg, 1981), effective evaluation practices (Lehrman-Waterman & Ladany, 2001), and ethical supervisor behaviour (Ladany, Lehrman-Waterman, et al., 1999). Little of this research has clearly defined the construct of effective clinical supervision with some recent empirical studies forging new areas of inquiry to facilitate better understanding of what factors might underpin effective clinical supervision for supervisees (Ladany, Lehrman-Waterman, et al., 1999; Lehrman-Waterman & Ladany, 2001).

Recognising the importance of a theoretical base for understanding effective clinical supervision, Nelson et al. (2001) have suggested that effective supervision may hinge on two critical competencies: firstly, the ability of the clinical supervisor to establish strong and effective working alliances with supervisees, and secondly, their ability manage interpersonal conflicts in supervision. Whilst some studies have directly investigated the relationship between the quality of the working alliance on the one hand, and supervisee perceptions of self-efficacy (Efstation et al., 1990;

Ladany, Ellis, et al., 1999) and their satisfaction with supervision (Ladany, Ellis, et al., 1999) on the other, few studies have examined the rupture-repair process in supervisory alliances (Rose Burke, Goodyear & Guzzard, 1998). For the most part, the importance of managing interpersonal conflicts for effective supervision has been extrapolated from qualitative studies examining negative or conflictual events within clinical supervision (Nelson & Friedlander, 2001).

#### 4.2 Measuring Effective Supervision from the Supervisee's Perspective

An early study undertaken by Worthington and Roehlke (1979) operationalised effective clinical supervision from the supervisee's perspective as comprising of three elements: satisfaction with supervision, supervisor competence, and contribution of supervision to improved counsellor ability. In a similar vein, more recent studies of effective clinical supervision have generally used measures of perceived satisfaction with supervision (Ladany, Ellis, et al., 1999; Ramos-Sánchez et al., 2002), and self-efficacy (Ladany, Ellis, et al., 1999) to compare supervisee experiences as to supervision effectiveness. Whilst reasonable concerns have been expressed about reliance on supervisee satisfaction as a measure of supervision effectiveness (Borders, 1989; Fernando & Hulse-Killacky, 2005; Kavanagh, Spence, Wilson & Crow, 2002), use of supervisee satisfaction levels, in combination with other measures, arguably provide a valid means for supervisees to contribute to our understanding of effective clinical supervision.

#### 4.3 The Supervisor's Style and Characteristics as the Basis of Effective Supervision

Clinical opinion and some empirical findings have indicated that the style or manner that a supervisor adopts may be important to effective clinical supervision (Carifio & Hess, 1987; Friedlander et al., 1989; Friedlander & Ward, 1984; Leddick & Dye, 1987). Friedlander and Ward (1984) constructed the Supervisory Styles Inventory [SSI] to assess the supervisor's manner of approach and response within clinical supervision. The SSI comprises of three sub-scales: the Attractive subscale which assesses the degree to which the supervisor adopts a collegial approach to supervision (friendly, flexible, supportive, positive, warm, open); the Interpersonally Sensitive subscale which measures use of a therapeutic approach with attention to the relationship (perceptive, committed, reflective, creative,

intuitive), and the Task-Oriented sub-scale which estimates use of a practical, instructive approach (goal oriented, explicit, evaluative, focused). Using an in depth case study approach, Friedlander et al. (1989) indicated that a high Attractive, high Interpersonally Sensitive, and moderate Task-Oriented supervisor profile may be conducive to effective supervision. Chen and Bernstein (2000) reported a similar style profile within a dyad exhibiting a strong working alliance. In a recent study, Fernando and Hulse-Killacky (2005) reported that emphasis on Attractive and Interpersonally Sensitive styles increased supervisee satisfaction with supervision, whilst a more Task-Oriented style influenced supervisee perceived self-efficacy. While a balance in styles appears important to effective supervision, research to date suggests that most supervisees may prefer relatively greater emphasis on Attractive and Interpersonally Sensitive styles.

Using discriminant analysis to differentiate worst and best supervisory experiences, Allen et al. (1986) found that better quality supervision was associated with higher levels of supervisor expertise (skill) and trustworthiness (reliability). In terms of supervisor characteristics associated with best supervisory experiences, more than 60% of respondents characterised best supervisors as those who provided and sought feedback in a straightforward manner, accepted mistakes, and encouraged supervisees to experiment and take reasonable risks. One area that may be worthy of further consideration is the extent to which these qualities are outcomes of a strong supportive supervisory alliance, in contrast to being qualities that need to be considered in isolation.

#### 4.4 The Supervisory Relationship as the Basis of Effective Supervision

Employing a diversity of research designs and measures, empirical research has consistently highlighted the importance of the supervisory relationship to supervisee experiences of effective supervision (Ladany, Ellis, et al., 1999; Patton & Kivlighan, 1997; Worthen & McNeill, 1996; Worthington & Roehlke, 1979). Using qualitative methodology, Worthen and McNeill (1996) asked students in their 3<sup>rd</sup> to 7<sup>th</sup> year of graduate psychology training ( $N = 8$ ) to describe an experience when they felt they received good psychotherapy supervision. From the supervisee's perspective the most critical component of good supervision experiences was the

quality of the supervisory relationship. All supervisees described the supervisor as displaying an attitude that manifested itself in empathy, a non-judgemental stance, a sense of validation and affirmation, and encouragement to supervisees to explore and experiment. For most supervisees, an identified sense of inadequacy preceded the good supervision event (e.g., feeling of discomfort with therapeutic role) with the supervisor responding in an affirming or validating manner to the supervisee's experience (e.g., by displaying genuine support and empathy).

Ladany and his colleagues (e.g., Ladany, 2004; Nelson et al., 2001) have persuasively argued that the quality of the supervisory working alliance is the cornerstone of effective clinical supervision. Using Bordin's (1983) conceptualisation of the working alliance (originally developed as the client-therapist relationship), the supervisory working alliance has been defined as comprising of three components: (a) a mutual agreement between supervisee and supervisor about the goals of supervision (e.g., about how to improve counselling skills); (b) a mutual agreement about the tasks of supervision (e.g., supervisee responsibilities); and (c) an emotional bond between supervisor and supervisee (e.g., reciprocal feelings of trust and liking). Attention to building a strong supervisory alliance may be particularly pertinent to the earlier sessions of supervision (Ladany, Ellis, et al., 1999; Ramos-Sánchez et al., 2002). Recent research has indicated that a strong supervisory working alliance is significantly related to supervisee satisfaction (Ladany, Ellis, et al., 1999), increased self-disclosure by supervisees (Ladany & Lehrman-Waterman, 1999), and enhanced supervisee multicultural competence (Ladany, Britain-Powell, & Pannu, 1997).

#### 4.5 Effective Evaluative Practices in Clinical Supervision

There is some research indicating that effective goal setting and feedback are important to clinical supervision effectiveness (Lehrman-Waterman & Ladany, 2001). Effective goal setting involves the collaborative setting of goals that are explicit, achievable, challenging, task specific, flexible, prioritised, and set early in the supervisory experience (Lehrman-Waterman & Ladany, 2001). Effective feedback is systematic, timely, clear, balanced, credible and mutual (Lehrman-Waterman & Ladany, 2001). In research used to develop the Evaluation Process

Within Supervision Inventory (EPSI), Lehrman-Waterman and Ladany (2001) reported that effective goal-setting and feedback practices (measured by the two sub-scales of the EPSI) were predictive of greater supervisee satisfaction with supervision, supervisor influence on supervisee self-efficacy, and a stronger working alliance.

#### 4.6 Effective Clinical Supervision as Ethical Supervision

Within Australia and elsewhere, the last decade has seen development and elaboration of guidelines and standards pertaining to ethical practice of clinical supervision (e.g., APS Ethical Guidelines, 2006). Underlying greater regulation of supervisory practices is the notion that effective clinical supervision must be ethical (APS Ethical Guidelines, 2006). For instance, attention has been directed towards the need for supervisors to have competency in the areas they are supervising and to maintain clear boundaries in their relationships with supervisees (APS Code of Ethics, 2003; APS Ethical Guidelines – Guidelines on Supervision, 2006 [Supervision Guidelines]). Within Australia, guidelines accompanying the Code of Ethics are generally worded to encourage rather than prescribe ethical practice. For instance, supervisors *should* (author's emphasis) be competent in the areas they are providing supervision (Supervision Guideline 7.1), *should* consider explaining to the supervisee the process of supervision (Supervision Guideline 7.2), *can* assist supervisees by explaining the model of supervision or type of theories they will follow, and how they propose to provide feedback (Supervision Guideline 7.3). Where probationary registration occurs outside an accredited Masters or Doctoral degree, more specific and prescriptive guidelines are provided through the Psychologists' Registration Board of Victoria (PRB, 2005).

Few empirical studies have investigated the impact of a range of ethical and unethical practices of supervisors on the clinical supervision experiences of supervisees (Ladany, Lehrman-Waterman, et al., 1999; McCarthy, Kulakowski, & Kenfield, 1994). An American study undertaken by Ladany, Lehrman-Waterman, et al. (1999), involving 151 therapists in training (predominantly in counselling and clinical psychology graduate programs), explored a range of research questions including the relationship between supervisor ethical practices, the supervisory



working alliance, and supervisee satisfaction with supervision. Using the Supervisor Ethical Behaviour Scale (created for the study) to measure whether supervisees perceived supervisors to engage in specific ethical and unethical behaviours, and the Supervisee Satisfaction Questionnaire to measure supervisees' perception of the overall quality of supervision, Ladany, Lehrman-Waterman, et al. (1999) found that lower frequencies of supervisor unethical behaviours were associated with greater satisfaction with supervision.

#### 4.7 Effective Supervision Needs to Match the Developmental Level of the Supervisee

There has been substantial theoretical and empirical interest within the discipline of Psychology on how to foster a clinically developed, reflective and professional practitioner by matching the nature and type of clinical supervision with the developmental level of the supervisee (see Bernard & Goodyear, 2004, for a detailed discussion of supervision models). According to one set of models, the supervisee is conceptualised as passing through a series of developmental stages, facing certain issues and concerns at each stage, with the techniques and approaches of the clinical supervisor tailored to the developmental stage of the supervisee (Watkins, 1995; Worthington, 1987). Such developmental models tend to support a more structured, task-oriented approach to supervision for new supervisees, with a more interpersonally sensitive, relationship oriented style as trainees advance through clinical supervision (Goodyear & Bernard, 1998; Lochner & Melchert, 1997; Worthington, 1987).

Whilst developmental models afford a useful framework (Bernard & Goodyear, 2004), a number of factors have the potential to influence the learning needs of an individual supervisee. The cognitive style of the supervisee, and the manner in which they prefer to conceptualise therapy (Lochner & Melchert, 1997), may affect the supervisee's preferred supervision style. Age, life events and experiences, and previous clinical experience are potential factors that may impact on supervisee needs from clinical supervision (Nelson & Friedlander, 2001). Recognising that clinical supervision is often only one component within a comprehensive training

program, the nature of other aspects of the training course may also impact on the supervision needs of supervisees (Holloway, 1987).

Whilst evidence in support of developmental models is inconsistent (Bernard & Goodyear, 2004), it is notable that most research in this area has reported at least partial support for supervisee development with training and experience (Stoltenberg, McNeill & Crethar, 1994; Worthington, 1987). Bernard and Goodyear (2004) have stated that perhaps there is a developmental process for the supervisee, but it is yet to be fully explicated. Less sure of the worth of applying a developmental approach, Ladany (2004) has argued against use of generic models of development to guide supervisor behaviour, stressing that many supervisee and supervisor factors that account for effective clinical supervision are still less than well understood.

#### 4.8 Effective Clinical Supervision and Supervisor Self-disclosure

A recent area of research within clinical supervision relates to the impact of supervisor self-disclosures on the supervisory alliance and supervisee perceptions of clinical supervision (Ladany & Lehrman-Waterman, 1999; Ladany & Walker, 2003). Supervisor self-disclosure of information can take a variety of forms including disclosure of therapeutic experiences (e.g., struggles and successes), discussion of administrative or site-related matters, disclosure of reactions to the supervisee's clients, and the sharing of personal issues such as current stressors (Ladany & Walker, 2003). Disclosures can vary in their relevance to the supervisee, their level of intimacy, and whom they most benefit, supervisor or supervisee (Ladany & Walker, 2003). More frequent self-disclosures have been associated with supervisee perceptions of a stronger working alliance (higher agreement on the goals and tasks of supervision, and stronger emotional bond) within clinical supervision (Ladany & Lehrman-Waterman, 1999).

Whilst it is unclear how the level and type of supervisor self-disclosure impact on supervisee perceptions as to the effectiveness of clinical supervision, current theory and research affords tentative support for supervisor self-disclosure that is concordant with and relevant to supervisee needs (Hutt et al., 1983; Ladany & Lehrman-Waterman, 1999; Ladany & Walker, 2003). This proposition appears

somewhat supported in the study by Worthen and McNeill (1996) where supervisor feedback that affirmed the challenges experienced by supervisees was associated with effective clinical supervision. Although understanding of the role of supervisor self-disclosure within clinical supervision is at this time preliminary, it does appear that its impact on clinical supervision effectiveness is worthy of further examination.

#### 4.9 Current Understanding of Effective Clinical Supervision

Current empirical findings indicate that building and maintaining a strong, supportive working alliance, with attention to supervisor ethical behaviours and effective evaluative practices, is likely to be conducive to effective clinical supervision. From the perspective of the supervisee, there is also evidence to suggest that the manner and approach of the clinical supervisor impacts on the effectiveness of clinical supervision, whether directly or more indirectly through its effect on the quality of the working alliance. While evidence that favours tailoring clinical supervision to the developmental level of the supervisee is inconclusive at this time, there are some findings to support this approach.

#### 4.10 Measuring Effective Clinical Supervision

As the definition and measurement of effective clinical supervision is interconnected, the call by Nelson et al. (2001) for a theoretical underpinning to empirical research in this area is an important one. What constitutes effective clinical supervision is likely to be multidimensional, particularly given the number of variables that appear to correlate with it. Likewise, what is cause and effect is not always easy to differentiate. For instance, does a strong working alliance facilitate effective evaluative feedback and goal setting; or is it that effective formative evaluation builds the working alliance, and in turn effective clinical supervision? Use of model building and systematic empirical testing appear to warrant consideration in this area.

## CHAPTER 5: LESS THAN POSITIVE CLINICAL SUPERVISION

This chapter examines current understanding of less than positive clinical supervision. The subsequent analysis is undertaken in the light of a growing body of evidence within an American context that a significant minority of psychologists in training have and will experience less than positive clinical supervision on their pathway to full registration. It is argued that the theoretical foundation of our understanding of less effective supervision is relatively unexplored at this time. Thus, it is uncertain whether there are different types and gradations of ineffective clinical supervision.

### 5.1 Defining Less Than Positive Clinical Supervision

An examination of empirical research indicates the absence of a cohesive clear theoretical base for investigating the nature and incidence of less than positive clinical supervision (Ellis, 2001; Ellis et al., 2000). Definitions of less than positive clinical supervision vary in focus and context, with some empirical studies focusing on specific counterproductive events (Gray et al., 2001; Ramos-Sánchez et al., 2002) whilst others have explored harmful conflict and its impact on supervisory relationships (Nelson & Friedlander, 2001). In addition, different nomenclatures have been used to conceptualise supervision experiences that are less than positive (e.g., O'Connor, 2000; Gray et al., 2001; Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002), with constructs not always easy to compare or differentiate. This diversity is unsurprising given the multitude of different situations and explanations that may underpin clinical supervision that is experienced as ineffective by supervisees (Gray et al., 2001; Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002).

Ellis (2001) has argued for an accepted definition or unified framework for supervision that goes badly or harms supervisees. With this in mind, he proposed that a distinction be made between bad and harmful clinical supervision. This suggestion has not gone unchallenged. Nelson et al. (2001) have countered that such a distinction is difficult to make, and harmful clinical supervision could be best conceptualised as a subset of bad supervision. Without minimising the legitimacy of this argument, it appears reasonable to investigate whether less than positive clinical

supervision may vary in nature and context. A question for empirical consideration is whether bad and harmful clinical supervision are conceptually different phenomena or whether they lie alongside each other at the lower end on a continuum of clinical supervision effectiveness.

#### *5.1.1 Conceptualising Poor Clinical Supervision*

Recent attention has been directed to the possibility that supervisees' experiences of less than positive clinical supervision may differ in terms of their nature, causes and consequences (Beck & Ellis, 1998; Ellis, 2001; Ellis et al., 2000). With this proposition in mind, Ellis (2001) defined bad clinical supervision as potentially occurring when a supervisor is unable or unwilling to meet the supervisee's training needs. This might occur because the supervisor is over-committed, is not dealing with their workload, or has lost interest in the supervisor role. Alternatively, it might also arise from a poor supervisory relationship where supervisor and supervisee differ on what they perceive to be the goals and/or tasks of clinical supervision. It could involve a mismatch between the supervision styles or personalities of the supervisee and supervisor. It may arise from one event, perhaps a disagreement over a treatment plan for a client, or develop over time, where hasty half hour supervision sessions culminate in some frustration for the supervisee. What differentiates this type of supervision experience from harmful clinical supervision is that the impacts on the supervisee are relatively benign. Whilst it may be trying or disappointing, it does not result in psychological, physical or emotional harm to the supervisee and/or his or her clients (Ellis et al., 2000).

Also recognising the potential for different types or levels of ineffective clinical supervision, O'Connor (2000) differentiated less than ideal psychotherapy supervision from more overt forms of supervisor misconduct such as sexual exploitation. Less than ideal supervision, perhaps conceptually similar to Ellis' bad clinical supervision, may arise because supervisors do not seek direct verification of what happens in sessions between clients and supervisees, perhaps relying on indirect information such as self-report to evaluate supervisee competency (Allen et al., 1986; O'Connor, 2000). Supervision time in certain organisations may be

limited to brief administrative type meetings, with supervisees maintaining high case loads and assessed by their usefulness rather than competency or development. In this way, contextual factors as well as supervisor behaviours may underlie a bad or poor clinical supervision experience. O'Connor (2000) has theorised that inadequate supervision may present a pathway to blatant misconduct thereby leading to harmful clinical supervision.

### *5.1.2 Conceptualising Harmful Clinical Supervision*

Whilst harmful clinical supervision exists (Nelson & Friedlander, 2001), our understanding of its nature, causes, and consequences is limited. Ellis (2001) hypothesised that it arises from supervisory practices that result in psychological, emotional, or physical harm or trauma to the supervisee. Ellis et al. (2000) constructed a list of possible harms that may arise from harmful clinical supervision, including symptoms of psychological trauma (e.g., a prevailing sense of mistrust), functional impairment in work and home life, worsening mental health, diminished effectiveness in clinical work with clients, feelings of incompetence, exploitation, excessive guilt, shame or embarrassment, loss of self-esteem, and the presence of debilitating fears and anxieties. These effects may last for days, but conceivably the impacts may endure for months or years beyond the end of the supervisory relationship (Ramos-Sánchez et al., 2002).

Diverse and multiple factors may underpin harmful clinical supervision (Ellis, 2001), indicating a level of uniqueness to each experience. Types of unethical supervision, including sexual exploitation, arguably form a subset of harmful supervision (Ellis et al., 2000). Supervision that involves dual relationships (e.g., manager and clinical supervisor are the same person), or where the supervisor is critical, judgmental, sexist, or racist could also result in harm or trauma to supervisees (Ellis et al., 2000; Nelson & Friedlander, 2001). Power struggles between supervisor and supervisee may escalate into irresolvable conflict (Nelson & Friedlander, 2001). Supervisor impairment, including issues such as sexual contact or exploitation (Allen et al., 1986; Glaser & Thorpe, 1986; Pope, Schover, & Levenson, 1979; Pope, Tabachnik & Keith-Spiegel, 1987; Robinson & Reid, 1985), poor boundaries (Gray et al., 2001; Nelson & Friedlander, 2001), and

personal issues of the supervisor (Nelson & Friedlander, 2001), have also been reported to have deleterious effects on clinical supervision.

### *5.1.3 The Nature of the Relationship between Poor and Harmful Clinical Supervision*

There are inherent difficulties in differentiating supervision impacts on the basis of harm to the supervisee. It is conceivable that harmful supervision experiences may also involve impacts indicative of poor clinical supervision (e.g., feelings of disappointment or frustration). Additionally, it is well recognised that diversity in supervisees means that the same event may be perceived as harmful or poor depending on the particular supervisee in question. This overlap makes differentiating between poor and harmful clinical supervision potentially problematic. However, this division in the nature of less than positive supervision has not been empirically tested, and the suggestion presented by Nelson et al. (2001) that poor and harmful clinical supervision may exist on a continuum, remains untested. Additionally, it is conceivable that variables other than supervisee differences may account for the differential impacts of poor and harmful clinical supervision. Certain events or factors may be particularly evident in supervisee experiences of poor or harmful clinical supervision.

### *5.1.4 A Temporal Aspect to Less than Positive Clinical Supervision*

The relationship between time and poor or harmful clinical supervision is currently undetermined. It is plausible that harm to a supervisee could arise from one event such as a boundary violation. However, the actual process of harm may build over the time period that follows that event (Nelson & Friedlander, 2001). Impacts associated with poor supervision, due to lack of skill or attention from the clinical supervisor could also conceivably increase over time. While Ellis and his colleagues (Ellis, 2001; Ellis et al., 2000) hypothesised relatively benign effects from poor clinical supervision, it is plausible that at least some of the issues highlighted (e.g., supervisor disinterest or lack of feedback) may affect supervisee well being and professional development at least for some period of time.

## 5.2 The Incidence of Less Than Positive Clinical Supervision

Little empirical research to date has investigated the incidence of less than positive clinical supervision (Ellis, 2001; Nelson et al., 2001). Ellis et al. (2000), reviewing the few studies that exist in this area, reported that conceivably 33 to 50% of training psychologists might experience harmful clinical supervision, with perhaps 7 to 10% likely to change their career as a result. The restricted nature of much of the research in this area (e.g., limited to investigation of sexual intimacies) suggests that this is a rough estimate at best. In a recent American study, Ramos-Sánchez et al. (2002), from a sample of 126 respondents (54% pre-doctoral interns and 46% practicum students), found that 21.4% of respondents indicated they had a current negative event in supervision. Thus, while less than positive clinical supervision exists as a phenomenon, its prevalence remains unclear.

## 5.3 The Impacts of Less than Positive Clinical Supervision

A range of both positive and negative impacts has been reported from supervisees' experiencing less than positive clinical supervision (Nelson & Friedlander, 2001). Many negative impacts have been global in nature, affecting multiple areas of functioning, and have long-ranging effects on career choice by supervisees and their relationships with others (Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002). Some supervisees have reported negative impacts on their clinical work with clients and pervasive feelings of inadequacy in their role as therapist (Ramos-Sánchez et al., 2002). Health problems, excessive rumination and self-blame about the experience, loss of trust, and feelings of violation, self-doubt, and powerlessness have also been reported (Nelson & Friedlander, 2001). Such impacts suggest that the field of psychology itself has the potential to lose from less than positive clinical supervision (Ramos-Sánchez et al., 2002).

Unlike the negative impacts that appear to flow naturally from less than positive clinical supervision, supervisees reporting positive consequences often sought self-directed and insightful ways of moving forward from such an experience (Nelson & Friedlander, 2001). Some supervisees reported seeking assistance from training institutions, friends and family, and peers. Use of self-reflection, putting the experience into perspective by examining the contextual factors such as site



characteristics, and talking to previous supervisees of that supervisor, have also been used as coping strategies when harmful conflict has arisen within clinical supervision (Nelson & Friedlander, 2001). Some supervisees confronted their supervisors in an endeavour to resolve issues and impasses, with a number of reporting positive outcomes (Nelson & Friedlander, 2001).

#### 5.4 Current Discipline Knowledge of Less than Positive Clinical Supervision

At the present time, the discipline of Psychology has some empirical evidence verifying the occurrence of poor and negative clinical supervision for some supervisees. This knowledge base has been extended by recent qualitative studies that have alerted us again to the existence of conflictual clinical supervision and its associated negative impacts. Despite this, it still remains unclear whether there are different types or gradations of ineffective clinical supervision, and if so, how they differ. Given the range and magnitude of negative impacts reported by supervisees participating in research studies, it is important that the discipline of psychology acquire further knowledge and understanding of the prevalence, nature, causes, and consequences of less than positive clinical supervision.

## **CHAPTER 6: VARIABLES THAT MAY PREDICT SUPERVISEE EXPERIENCES OF POOR AND HARMFUL CLINICAL SUPERVISION**

While poor and harmful clinical supervision may exist on a continuum, whereby the factors that lead to poor supervision are similar but present with greater intensity in harmful clinical supervision experiences, it may also be that there are etiological differences between poor and harmful clinical supervision. According to this proposition, different types or mix of underpinning variables may be implicated. With this notion in mind, this chapter examines extant theory and research on clinical supervision, seeking both differences as well as similarities with respect to the factors that might underlie poor and harmful clinical supervision experiences.

### **6.1 A Weak Working Alliance**

Clinical supervision is both relationship and process (Chen & Bernstein, 2000; Hess, 1987). There exists a strong consensus amongst theorists and researchers as to importance of the supervisory relationship to the process of clinical supervision (Bernard & Goodyear, 2004; Muse-Burke et al., 2001; Nelson et al., 2001; Pearson, 2001). Thus, rather than being distinct facets, relationship and process interact within each supervision experience.

Recent theory and research also indicates that supervisory relationships are both multi-faceted and dynamic, alternating through periods of strength and weakness like any other human relationship (Bernard & Goodyear, 2004; Rose Burke et al., 1998). This proposition is reflected within Bordin's (1983) conceptualisation of the working alliance as comprising of a collaborative change process involving three interrelated aspects: a) mutual agreement and understanding of the goals of supervision; b) mutual agreement and understanding of the tasks of supervisor and supervisee; and c) an emotional bond between supervisor and supervisee. Applying Bordin's construct of the working alliance, there is potential for different and interactive aspects of the working alliance to be uncertain, lacking, fractured, or unresolved within poor and harmful clinical supervision. However, factored in this must also be the dynamic nature of supervisory relationships. There is potential for the quality of a supervisory relationship to vary over its duration, and likewise for

the effectiveness of clinical supervision to be perceived differently by a supervisee over time.

While clinical supervision is not just the relationship, it is difficult to envisage effective learning occurring where there is a weak working alliance. Using qualitative techniques ( $N = 6$ ), Chung, Baskin and Case (1998) reported that most of the themes for a negative supervisory experience pertained to the supervisory relationship; for instance, the supervisor being impersonal or distracted during supervision. In a similar vein, Ramos-Sánchez et al. (2002) found that respondents who reported negative supervisory experiences ( $n = 27$ ) tended to have weaker supervisory alliances relative to those who did not, indicating that these relationships were characterised by incongruent tasks and goals and by the absence of mutuality, trust, and confidence in the relationship.

It is important to consider how the working alliance might be different in poor and harmful clinical supervision, in the early as well as ongoing and terminating phases of the supervisory relationship. In their qualitative study of harmful or conflictual clinical supervision, Nelson and Friedlander (2001) asked the 13 participants (doctoral and masters trainees) to describe the early initiating aspects of their supervisory relationships. To facilitate adequate time for reflection without too much distance, supervisory relationships in question occurred six months to three years prior to the interviews. The most typical descriptions (7 or more cases) of early supervisory relationships involved supervisors perceived as remote and uncommitted to establishing a strong working alliance. Another relatively frequent initiating pattern (4 to 6 cases) involved supervisors who engaged in a friendly and overly close manner with supervisees.

In Nelson & Friedlander's (2001) study, a number of factors were described as leading to an impasse in the supervisory relationships. Power struggles (e.g., supervisee having considerable clinical experience which was perceived as threatening by the supervisor), role conflicts (e.g., supervisee acting as confidant for supervisor), dual roles (e.g., clinical supervisor was also director of training), and sexual matters (e.g., flirting behaviour by a supervisor) were amongst issues raised by interviewees. Less frequent, but of equal concern, were supervisees who reported

misunderstandings based on differing views about gender or cultural issues (e.g., one supervisor was described as making inappropriate comments about the supervisee's ethnicity).

Examining the impact of these impasses on the supervisory relationship affords a window into the ongoing nature of the working alliance after the rupture stage. For interviewees within Nelson and Friedlander's study, the most common supervisor reaction described by supervisees was ongoing, pervasive anger. One supervisee described how working through the supervisor's anger became the material for a number of subsequent supervision sessions. Many supervisees reported raising the problems for discussion but finding supervisors unwilling to discuss the issues in an open, non-judgemental manner. Most supervisees reported many of the negative impacts described by Ellis and his colleagues (Ellis, 2001; Ellis et al., 2000) as emanating from harmful clinical supervision. This included loss of trust, lack of safety, feelings of powerlessness, extreme stress, development of health problems, excessive rumination, and feelings of self-doubt.

In their investigation of counterproductive events in clinical supervision, Gray et al. (2001) examined the ensuing impacts on the supervisory relationship ( $N = 13$ ). Defining a counterproductive event as any experience perceived by trainees as hindering, unhelpful or harmful to their growth as therapists, a typical event (8 or more cases) involved the supervisor dismissing trainee's thoughts and feelings or being unempathic. Events in this category included a supervisor inappropriately self-disclosing, a supervisor intervening with a difficult client and taking the case over from the supervisee, a supervisor dismissing the supervisee's conceptualisation of a client, a supervisor critiquing the supervisee's therapy tape when the supervisee was feeling positive about the demonstrated skill level, and a supervisor shutting off the supervisee's therapy session tape and asking why the supervisee was showing it. Less frequent events included supervisors denying supervisee requests for the door to be closed during discussion of confidential information, and another refusing a request for more positive feedback within supervision. Perhaps because the focus was on a specific event in a supervision experience, it is notable that the nature of events depicted in Gray et al's (2001) study appears somewhat different from those

raised in the more alliance-focused study by Nelson and Friendlander (2001). How less than positive clinical supervision is conceptualised does appear to impact on the context and nature of the phenomenon revealed in research of this kind.

Post-rupture impacts on the supervisory relationship reported in the study by Gray et al. (2001) were considered in both the shorter and longer term. Impacts described by supervisees in the short-term included the supervisee trying to be conciliatory and non-defensive, the supervisor not listening or responding to supervisee concerns, the supervisor disputing or challenging supervisee, and the supervision work becoming stilted as a result. The counterproductive event was perceived as weakening the supervisory relationship, in some cases permanently. In the longer term, relationships typically did begin to recover, often gradually. In most cases, supervisees did not directly address their counterproductive event and it remained unresolved.

It is difficult given the different nomenclatures for less than positive clinical supervision to hypothesize how working alliances might be different in poor and harmful clinical supervision. In the studies by Nelson and Friedlander (2001) and Gray et al. (2001), the typical outcome was that the conflicts were never resolved. However in the study by Gray et al. (2001), most supervisory relationships did slowly recover. This outcome may provide an indicator to a potential difference between poor and harmful clinical supervision. Conceivably in poor clinical supervision, there is at least potential for partial repair to the supervisory relationship after rupture. In contrast, in harmful clinical supervision, the damage to the working alliance may be beyond repair, at least from the perspective of supervisee. Thus it may be in the stages beyond rupture that poor and harmful clinical supervision may be most effectively differentiated.

## 6.2 An Imbalance in the Supervisor's Manner of Approach with Supervisees

While supervisors need to utilise a balance of styles in their work with supervisees, some empirical research has suggested that a relatively higher focus on collegiality (Attractiveness) and relationship-building (Interpersonally Sensitive), with a moderate emphasis on content (Task-Oriented) may be most beneficial for building and maintaining strong supervisory relationships (Chen & Bernstein, 2000;

Friedlander et al., 1989). Also important for consideration in the balance of styles is the developmental level of the supervisee and the possibility that a relatively more task-oriented approach may be appropriate for beginning-level supervisees (Lochner & Melchert, 1997; Worthington, 1987). In recognition of diversity, it is also reasonable to propose that each individual supervisee is unique, and this should be factored into the selection of styles appropriate for a particular supervisee (Ladany, 2004).

The relationship between the supervisor style and less than positive clinical supervision is not well understood. One possibility is that where the manner of approach does not match the developmental level and unique characteristics of the supervisee (e.g., taking into account previous clinical experience, ability to conceptualise client problems, supervisee preference for style), the potential for less than positive clinical supervision may be greater. However, it is also likely that a range of other variables have the potential to interact in this relationship and Ladany's (2004) caution against applying a developmental cookie-cutter approach to treatment of supervisees appears a salient one. For instance, an advanced supervisee might benefit from relatively greater emphasis on a highly structured, task oriented approach where the client work is complex.

While there is some evidence to indicate that an imbalance in supervisor styles (e.g., insufficient attention to the relationship) may be associated with less than positive clinical supervision (Allen et al., 1986; Nelson & Friedlander, 2001), it is unknown how this impacts specifically on the experience of poor and harmful clinical supervision. Moreover, the interactive nature of supervisor style and the supervisory relationship cannot be overlooked. The emphasis taken by a clinical supervisor in terms of particular styles of approach to the supervisee may be an outcome of the nature of the working alliance and not a consciously selected strategy.

### 6.3 Dual Roles of the Clinical Supervisor and Supervisee

For probationary psychologists in Victoria who undertake supervised psychological work on completion of a 4-year accredited sequence of study in psychology, there is a high likelihood that they will seek paid employment whilst

completing their 480 days of supervised practice. In this case, learning occurs within an organised work structure that usually involves payment for labour supplied. While there appears little if any research or literature in this area, it is conceivable that supervisory relationships may come under different pressures when organisational employment needs interact with supervision needs. From the supervisee's perspective, the position of paid employee adds another role to the existing repertoire of trainee psychologist, colleague, client, and learner.

In all placement contexts, it is conceivable that on occasions organisational priorities may not fully align with the developmental needs of a particular supervisee. However, where the clinical supervisor and line manager are the same person, the interaction between clinical supervision needs and organisational requirements may be more direct and multifaceted. Moreover, when payment for labour interacts with learning needs, perhaps where a supervisee feels she or he is not ready to take on a full client load, potential for conflict between the different roles for supervisor and supervisee may be greater.

Other dual roles may arise for supervisors of probationary or trainee psychologists. Nelson and Friedlander (2001) discussed a number of these in their research on non-productive conflict and impasses in clinical supervision. Dual roles described by supervisees included where a clinical supervisor was also director of the clinic, and another where the supervisor was director of training. It is plausible that performance of dual roles by a clinical supervisor is not necessarily problematic in itself, but perhaps vulnerability to issues arising may be greater, particularly where little attention has been paid to the potential for conflicts early on in the supervisory relationship.

Supervisees have also been found vulnerable to assuming dual roles and/or experiencing role conflict. In Nelson and Friedlander's (2001) study, three supervisees reported feeling pressure to provide support and understanding to their supervisors. Quite a tangled web of interrelationships was noted in the supervisory relationships. For example, in two cases the primary supervisors would complain to supervisees about the supervisees' secondary supervisors, who were also supervising the primary supervisors. Lack of boundaries or clarity around roles may

make supervision a complex contextual experience, conceivably more likely to be problematic in outcome for supervisees.

As the nature and context of dual roles is diverse for both supervisor and supervisee, it is difficult to theorise how such relationships may be different in poor and harmful clinical supervision. It does seem plausible to propose that where due consideration is not explicitly given within the framework and process of supervision to the possible ensuing impacts arising from dual relationships, the potential for harmful clinical supervision may be greater (Ladany, Lehrman-Waterman, et al., 1999).

#### 6.4 Evaluation and Inadequate Conceptualisation of the Goals of Supervision

A critical aspect of effective evaluation within clinical supervision is clear, timely, collaborative, and comprehensive specification of what is to occur in supervision, and how this will be evaluated (Lehrman-Waterman & Ladany, 2001). Interestingly, while the APS Ethical Guidelines (2006) state that the responsibilities and expectations of all parties should be clearly delineated within a collaboratively constructed supervision contract (Supervision Guideline 6.3) they also specify that it is the supervisee who is responsible for delineating specific, operationalised goals (Supervision Guideline 8.2). Thus, if goals are inadequately specified or inappropriate, these Guidelines suggest that it would be difficult to assert that this was unequivocally the clinical supervisor's responsibility. Yet it would seem crucial for the clinical supervisor to take a leadership role in ensuring that the goals set direct the supervision experience and are appropriate for the developmental level of the supervisee.

Earlier empirical studies on poor or negative clinical supervision have usually not reported that lack of clarity with respect to the goals of supervision, or differential expectations of supervisor and supervisee, as significant issues for supervisees reporting less than positive clinical supervision (e.g., Allen et al., 1986; Hutt et al., 1983; Kennard, Steward, & Gluck, 1987). However, disparate expectations within the supervisory dyad have been raised as a concern in more recent studies of less than positive supervision (Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002). In their study of non-productive conflict, Nelson and



Friedlander (2001) reported that the majority of supervisees indicated there was a disagreement about what should take place in supervision. For many, there were issues pertaining to lack of clarity about the supervision contract.

A supervision contract can give structure to both the content and relational context of clinical supervision (Holloway, 1995). Where there is incongruity between supervisor and supervisee expectations of clinical supervision, this may become evident when the supervision contract is negotiated. If there is no supervision contract or the contract is brief or poorly constructed, the potential for misconception, confusion, and unanticipated issues arising within supervision is arguably greater (Bernard & Goodyear, 2004).

Probationary psychologists in Victoria, whose probationary status derives from completion of 4 years of accredited studies and engagement in supervised psychological work, collaboratively set supervision goals with their clinical supervisors within a supervision plan to be reviewed and revised on a six monthly basis (PRB, 2005). Interim guidelines in place prior to this also required development and regular review of a supervision agreement to guide the process of clinical supervision. With these arrangements in place, inadequate conceptualisation of supervision goals would not be expected to be a common issue for this group of probationary psychologists.

Probationary psychologists undertaking higher degrees in Victoria complete placement agreements, some of which are likely to contain specific supervision goals to be reviewed on an ongoing basis. To a large extent, the nature and structure of such agreements is the responsibility of accredited universities. While the PRB does require the submission of placement reports, supervision contracts are not part of the requirements. Thus, whether inadequate conceptualisation of goals is an issue for some higher degree probationers is uncertain at this time.

While supervision agreements, contracts, or plans should theoretically minimise any lack of clarity in relation to the goals of clinical supervision, it is possible that even with this guidance, some goals may be poorly constructed, ill conceived, or not adequately addressed within supervision. While it is empirically unclear how lack of clarity pertaining to supervision goals may causatively impact on poor and

harmful clinical supervision, for new supervisees with few if any previous experiences of counselling and supervision for comparison, the potential for harmful impacts might be greater (Leddick & Dye, 1987; Worthington, 1984).

### 6.5 Evaluation and Ineffective Evaluative Feedback

Evaluation is a part of any relationship (Hess, 1987). Each supervisee and supervisor comes to clinical supervision with their past experiences of learning, relationships, and evaluation. Either supervisee or supervisor, or both, may feel uncomfortable with the evaluative aspect of supervision. Bernard and Goodyear (2004) contended that evaluation might be particularly difficult for counsellors who are taught to be non-evaluative in their relationships with clients. Moreover, evaluation is arguably a personal experience. It is processed through the filter of past and existing life experiences, and potentially impacts on achievement of future goals.

The evaluative nature of clinical supervision may limit the level of honesty and openness displayed by both supervisor and supervisee (Hoffman, Hill, Holmes, & Freitas, 2005; Ladany & Melincoff, 1999; Webb & Wheeler, 1998). Without trust in the supervisory relationship, conceivably the basis of a viable working alliance (Bernard & Goodyear, 2004; Magnuson et al., 2000), honesty about mistakes and issues may be difficult for supervisees. There appears to be a critical risk for supervisees within the supervision process: that the expression of difficulties, mistakes, thoughts, and feelings may be misconstrued as incompetence (Webb & Wheeler, 1998). Likewise, supervisors may also believe that providing direct feedback to supervisees on non-clinical issues (e.g., the supervisory relationship or the supervisee's personality or behaviour) might be perceived to be outside the boundaries of clinical supervision (Hoffman et al., 2005). Depending on the dyad in question and a range of contextual variables, the risk of providing honest and direct feedback may or may not be manageable.

From the supervisee's perspective, the nature of ineffective evaluative feedback from the clinical supervisor may take different forms. The timing of feedback is critical (Lehrman-Waterman & Ladany, 2001). If feedback is delayed, there is potential for what might have been useful formative feedback to become

accumulated and delivered as part of summative feedback. A supervisee denied regular formative feedback might be highly resistant to critical summative feedback. In recognition of the importance of the supervisory relationship as the foundation from which to feedback is conveyed, delivery of and response to constructive yet critical feedback may be difficult for supervisor and supervisee where the supervisory alliance is weak (Hoffman et al., 2005).

On the basis of the limited empirical research to date, it is difficult to hypothesise how ineffective evaluative feedback might be different in poor and harmful clinical supervision. Drawing on reported supervisor reactions described by participants in Nelson and Friedlander's (2001) study of non-productive conflict, there is some room for speculation. The predominant supervisor reaction perceived by supervisees in this study was ongoing, pervasive anger. Supervisor reactions described by participants included overt criticism of the supervisee in front of peers and colleagues, threats to withhold or withholding of evaluations, blaming of supervisees, denial of problems, unpredictable outbursts, and inappropriate supervisor disclosures. Given these findings, it is possible to tentatively posit that where feedback to the supervisee becomes personal, emotional, and/or predominantly judgemental, it may be more likely to lead to harmful clinical supervision (Nelson & Friedlander, 2001). Alternatively, when it is perceived as inadequate (an absence rather than an action or reaction) in terms of quantity and/or quality, clinical supervision may be more likely to be described as poor by supervisees.

## 6.6 Supervisor Impairment

Defining supervisor impairment is critical to considering its impact in poor and harmful clinical supervision. Yet attempts to define and measure it, at least in general terms, are few (Muratori, 2001). At this point in time, it is not well understood whether any difference exists between impairment as a practicing psychologist and impairment as a clinical supervisor.

Muratori (2001) has conceptualised supervisor impairment as involving a clinical supervisor who is unable to perform the required supervisory roles because of interference of some kind from something in their behaviour or environment.

This could be due to the effects of drug or alcohol addiction, or a mental health issue, impeding the supervisor's capacity to function competently. Impairment as described by Muratori (2001) leads to a diminution in ability to function effectively as a clinical supervisor. Implicit in this definition is relatively effective functioning at some previous point in the past. Thus supervisor impairment is differentiated from a lack of skills or training in clinical supervision, which could be more appropriately seen as a competence issue. Whether this differentiation is empirically useful, when the ensuing impacts from competence issues might also be harmful, is currently unclear (Guest & Dooley, 1999).

It is the power differential between supervisor and supervisee that makes supervisor impairment a salient area for empirical investigation, yet interestingly our knowledge in this area is at a preliminary stage (Muratori, 2001). Supervisees are in a one down position of power (Bernard & Goodyear, 2004; Nelson & Friedlander, 2001), something that needs to be acknowledged within the supervisory relationship (APS Ethical Guidelines [2006] Supervision Guideline 7.2). The power of the clinical supervisor arises not only from their greater status and expertise, but from their capacity to influence the supervisee's right to enter the profession (Holloway, 1995). How this power is managed, whether punitively (Nelson & Friedlander, 2001), or alternatively to construct a mutually empowering relationship (Holloway, 1995), is likely to be salient to a supervisee's experience of clinical supervision.

Misuse of supervisor power can take different forms (e.g., Nelson & Friedlander, 2001), most of which have not been the subject of empirical research. Some consideration has been undertaken of sexual contact between supervisors and supervisees, including sexual harassment and its impact on supervisees (Bartell & Rubin, 1990; Lamb et al., 2003). However, it is conceivable that not all cases of supervisor-supervisee sexual contact are attributable to impairment of the clinical supervisor. At this point in time, understanding of supervisor distress and impairment is minimal pinpointing these as areas requiring further conceptualisation and empirical investigation (Muratori, 2001).

The potential for abuse of power in the position of clinical supervisor is a real one (Lamb et al., 2003; Nelson & Friedlander, 2001) with possible short-term and longer-term personal and professional impacts for supervisees. When a clinical supervisor is impaired, the risk from abuse of power may be greater (Muratori, 2001) with possible repercussions for supervisees in meeting registration requirements. Moreover, if supervisees have not been informed of a range of strategies and options for dealing with supervisor impairment, individual efforts to resolve difficulties from a one-down position of power may of itself amplify the negative impacts.

A difficulty with understanding the contextual nature of supervisor impairment is that it is often conceptualised as internally situated, with little reference to interaction between person and environment. It seems important to consider that a clinical supervisor could become impaired because of the interplay of factors occurring internally and externally for that particular supervisor at a point in time. For instance, it is important to recognise that supervisors operate under a range of pressures that may be organisational, client-based, personally or interpersonally driven. The reasons underlying impairment may be multiple and dynamic, the level varying in accordance with what is happening for the clinical supervisor at a particular point in time. This suggests many clinical supervisors may, given the “right” circumstances, be vulnerable to impairment, a possibility that is disconcerting. Arguably, when supervisor impairment is perceived as internally determined, the dynamic aspects of impairment will remain less than well understood (O’Connor, 2001).

Ladany (2004) has stated that supervisor impairment is a primary source of harmful clinical supervision, with its incidence occurring more frequently than the discipline of psychology realises. While this may be the case, the limited research in this area makes this statement difficult to substantiate at this time. Accordingly, there is persuasive argument for qualitative and quantitative studies investigating supervisee and supervisor experiences of clinical supervision where a supervisor was impaired.

### 6.7 Contextual Factors

A particular clinical supervision experience may be perceived as less than positive, at least in part, due to a range of contextual factors related to the placement context or parties involved. This might include the inability to gain regular effective clinical supervision due to organisational pressures including too many supervisees per supervisor, funding constraints, requirements to meet client targets, and a range of time pressures within the supervisor's job role (Greer, 2002; O'Connor, 2000). Additionally, other parties inevitably impact on the supervisee's experience of clinical supervision, including clients, program managers and colleagues at placement settings, and directors of clinics and training.

As empirical studies investigating the impact of contextual factors on clinical supervision effectiveness are few (Davy, 2002), it is unknown whether they play potentially different roles in poor and harmful clinical supervision. It is plausible that contextual factors may be instrumental to poor clinical supervision. In addition, they may be part of a complex of factors that underpin harmful clinical supervision experiences. Arguably, where organisational pressures are major or where considerable organisational change is occurring, the impact on clinical supervision could likewise be significant. For instance, an organisation undergoing pressures to keep funding may place client numbers and outcomes above supervisee developmental needs.

There are risks in not perceiving clinical supervision as a contextual experience. For instance, a clinical supervisor and his or her perceived impairment may be seen as the primary or sole cause of poor or harmful clinical supervision. Yet conceivably supervisor impairment has a context in which it occurs. Likewise, supervisee competence may be called into question where the level of supervision is not sufficiently structured or nurturing to facilitate effective supervisee performance for complex client work. A range of matching factors, in addition to supervisee-supervisor characteristics, appears salient for effective clinical supervision to occur.

### 6.8 Role Conflict and Role Ambiguity

Role ambiguity has been described as a lack of clarity regarding the expectations for one's role and the methods for meeting those expectations, with

consequences for effective or ineffective performance (Nelson & Friedlander, 2001; Olk & Friedlander, 1992). As supervisees are called upon to perform the multiple roles of student, client, psychologist, and colleague, the potential for some role ambiguity is high. New supervisees may be particularly prone to experience role ambiguity as they try to learn about the expectations, implicit rules, and roles within the supervisory relationship (Olk & Friedlander, 1992; Vespia, Heckman-Stone, & Delworth, 2002). It is plausible that role induction and clear specification of the goals and tasks of clinical supervision may minimise the potential for role ambiguity (Olk & Friedlander, 1992; Vespia et al., 2002). Thus, how goals and tasks are constructed, monitored, and evaluated within a specific clinical supervision experience appears pertinent to the potential for role ambiguity. Moreover, the quality of the supervisory relationship may impact on how role ambiguity is managed as it presents over time within clinical supervision.

Role conflict has been conceptualised as arising when a supervisee has to fulfil expectations that require behaviour that is competing or divergent or conflicts with their personal judgement (Olk & Friedlander, 1992). When a supervisee reveals personal issues that are impacting on the therapeutic work with a client, this may position the supervisee in a client-like role. Such disclosure may sit uneasily with the therapist role where the supervisee is expected to manage client issues and is evaluated on this level. Role conflict may also arise when the clinical supervisor converses openly with his or her supervisee about another supervisor (Nelson & Friedlander, 2001). The supervisee may experience conflict stemming from competing loyalties congruent with the roles of colleague and student. How such conflicts are handled within the supervisory relationship potentially impacts on clinical supervision effectiveness.

Role conflict may be salient for more experienced supervisees who may reach a level of confidence in terms of their status or competency as counsellors (Nelson & Friedlander, 2001). Conceivably for some more experienced supervisees, greater supervisor emphasis on the role of learner over colleague may sit uncomfortably. By implication, it is plausible that supervisee experiences of role conflict are unlikely to be the unilaterally determined by the behaviour of the clinical

supervisor. As with supervisor styles, some supervisees will display a preference for supervisor emphasis on some roles over others. If this need is thwarted or remains unaddressed in the supervisory alliance, the potential for poor or harmful clinical supervision may be greater.

While there is scant evidence to differentiate the salience of role ambiguity and role conflict to poor and harmful clinical supervision, it is plausible that the potential for harmful clinical supervision is greater where there is significant role conflict (Nelson & Friedlander, 2001). Where a supervisee becomes a confidant for issues arising outside work such as the supervisor's sexual activities (Nelson & Friedlander, 2001), or where a supervisor attempts to befriend a supervisee (Ladany, Lehrman-Waterman, et al. 1999), the capacity to deal with such role dilemmas strategically from a one down position of power is a challenging one. It is plausible that where significant levels of role ambiguity and role conflict occur concurrently, the potential for harmful impacts may be greater. In addition, when the supervisee tries to deal with such issues in isolation without assistance from others, such as the university placement co-ordinator, the potential for harm may likewise be greater.

### 6.9 Unethical Supervisor Behaviour

There is diversity in what constitutes unethical supervisor behaviour from the supervisee's perspective (Ladany, Lehrman-Waterman, et al., 1999). However, the few studies in this area mean empirical knowledge is scant at best (Ladany, Lehrman-Waterman, et al., 1999; McCarthy et al., 1994). In an American study on the ethical practices of clinical supervisors, trainees reported that the most frequent ethical violations pertained to evaluation and monitoring of supervisee activities (e.g., giving inadequate feedback on supervisee performance), confidentiality issues within supervision (e.g., with respect to supervisee self-disclosures about counselling work), supervisor ability to work with alternative theoretical perspectives (e.g., supervisor not receptive to approaches other than their own), and issues pertaining to session boundaries and respective treatment (e.g., supervisor cancelling supervision sessions without rescheduling) (Ladany, Lehrman-



Waterman, et al., 1999). Fifty one per cent of supervisees reported at least one ethical violation by their supervisor ( $N = 151$ ).

The limited research that does exist indicates that greater frequencies of unethical supervisor behaviours have been associated with lower ratings of the working alliance within supervision, and less satisfaction with supervision (Ladany, Lehrman-Waterman, et al., 1999). Also attesting to the importance of unethical supervisor behaviours, ethical concerns have been reported in empirical studies of non-productive conflict in supervision (Nelson & Friedlander, 2001), worst psychotherapy supervision (Allen et al., 1886), and negative supervisory events (Ramos-Sánchez et al., 2002).

While the APS Code of Ethics (2003) contains few directives with respect to what constitutes unethical supervisor behaviour, the accompanying Ethical Guidelines (2006) highlight a general ethical principle to guide all supervisor behaviour: supervisors (as are all psychologists) are personally responsible for the decisions they make with their supervisees (Code of Ethics, General Principle 1 Responsibility). Perhaps more over-arching than an extensive list of prescriptive unethical behaviours, this principle emphasises that supervisors must be mindful to consider the ethics of all decisions they make with supervisees and the potential consequences. As supervisees are also clients (APS Ethical Guidelines, 2006), all guidelines pertaining to clients are theoretically also relevant to supervisor interactions with supervisees.

The APS Ethical Guidelines (2006) also provide an inventory of ethical considerations for supervisors. This includes the supervisor's obligation to clarify respective roles and responsibilities in supervision and to inform supervisees of their availability. To not do so may constitute unethical supervisor behaviour. Moreover, the Guidelines state that supervisors should consider informing supervisees of various aspects of supervision, including their model of practice, the nature and processes of supervision, and the potential for dual roles and conflicts of interest (Supervision Guideline 7). Arguably, omitting to attend to these requirements may constitute unethical supervisor behaviour, depending on the consequences for supervisees. There are also supervisee ethical considerations

(Supervision Guideline 8), signifying that behaving ethically in clinical supervision is not a one-sided affair, but requires the commitment, responsibility, and involvement of supervisor and supervisee, amongst other parties.

When a supervisor acts unethically it occurs within a dynamic context that includes the supervisee and quite possibly other parties (Ladany, Lehrman-Waterman, et al., 1999). Unethical supervisor behaviour may affect more than one supervisee, with potential repercussions at the placement site, the university, and elsewhere. Supervisees must not only determine what constitutes appropriate action when faced with unethical supervisor behaviour, but whether third party disclosure may have harmful impacts for them and others that outweigh the behaviour itself. For instance, it is conceivable that some supervisory relationships may be beyond repair once a decision to report is acted upon. Thus while unethical supervisor behaviour may lead to poor or harmful clinical supervision, supervisee response to that behaviour may intensify any negative impacts or initiate new impacts for supervisees and others.

Unfortunately the APS Code of Ethics and Ethical Guidelines are silent on what constitutes appropriate supervisee action when a supervisor behaves unethically. While appropriate action might on first thought be more the domain of employers, supervisors, registration boards, agencies and universities, evidence suggests that supervisees seldom report what they perceive to be supervisor unethical behaviour (Ladany, Lehrman-Waterman, et al., 1999). In light of this, the provision of some direction or guidance for supervisees, not only in relation to what usually constitutes unethical supervisor behaviour but also what procedures and processes might be appropriately implemented, would be a useful addition to the APS Ethical Guidelines.

The recent PRB Guidelines (2005) outline grievance procedures that may be enacted by a clinical supervisor or supervisee who is using the Board's supervision program for registration purposes. Behaviours that may be the subject of a grievance include breaches of professional codes of conduct or unethical behaviour. Thus probationary psychologists completing supervised practice after their four years of studies can implement these procedures when faced with unethical

supervisor behaviour. It is uncertain whether these procedures also pertain to probationary psychologists undertaking higher degrees who have an existing option of using university based grievance procedures.

While it is unclear how unethical supervisor behaviour feeds into poor and harmful clinical supervision, research indicates that they are likely to play a role. As the impacts of different unethical behaviours are likely to vary depending on a range of factors such as contextual variables, supervisor and supervisee characteristics, and whether any action is taken to remedy the behaviour, future in-depth research on the impacts of various supervisor unethical behaviours on supervision effectiveness appears pertinent. Moreover, exploration of any relationship between unethical behaviour and supervisor impairment may expand discipline understanding of the antecedents of unethical supervisor conduct.

#### 6.10 Inappropriate Self-disclosure

While the impact of supervisor self-disclosure on supervisee experiences of poor or harmful clinical supervision is unknown at this time, it is notable that the limited research to date suggests that more frequent self-disclosures have been associated with stronger supervisory working alliances (Ladany & Lehrman-Waterman, 1999). Applying this theorising in reverse, it is plausible to hypothesise that limited supervisor self-disclosure may impede development and maintenance of a strong working alliance. Factored into this proposed relationship must be the likelihood that the type of self-disclosure used (e.g., supervisor disclosure of intimate personal information vs. disclosure of own counselling struggles) has its own impact on supervisee perceptions as to the effectiveness of clinical supervision.

While limited supervisor self-disclosure may feed into a weak supervisory relationship and poor clinical supervision, it is likely that something different or more intense may be required to lead to the harmful impacts proposed by Ellis and his colleagues (Beck & Ellis, 1998; Ellis, 2001; Ellis et al., 2000). In Nelson and Friedlander's (2001) study of conflictual supervisory relationships, two supervisees described how they had to listen to their supervisors discussing difficulties in their personal and work relationships. Another supervisee explained how she had to listen to her supervisor discuss graphic details of his sexual activities. Not only do

these depictions exemplify the issue of dual supervisee roles and role conflict, they may also implicate inappropriate supervisor self-disclosures in more conflictual clinical supervision. It appears plausible to speculate that supervisor self-disclosures of a personal and/or intimate nature, that may place the supervisee in therapist-like role with their supervisor, would more likely to be associated with harmful clinical supervision experiences.

#### 6.11 A Multi-variable Model of Less than Positive Clinical Supervision

Research on clinical supervision has had to straddle the inevitable challenge of establishing the salience of individual variables that contribute to less than positive clinical supervision, and at the same time recognise that the causes are likely to be manifold and interactive. Variables such as supervisor impairment and role conflict and ambiguity do not operate in isolation, and the assertion by Davy (2002) of the need to recognise the contextual nature of clinical supervision is a critical one. It is likely that when supervisees experience poor and harmful clinical supervision that an interplay of factors initiates the experience. It is also plausible that the salient factors that contribute to the initial stages of poor and harmful clinical supervision may differ from those that maintain the experience through to its termination. For instance role conflict may be an initial critical issue for a clinically experienced supervisee, but failure for this to be addressed within the working alliance may be significant in maintaining the less than positive experience.

#### 6.12 Factors that may Predict Poor and Harmful Clinical Supervision from the Supervisee's Perspective

Using existing theory and research, it is possible to construct a diagrammatic representation or model of the possible factors that may predict poor and harmful clinical supervision experiences from the perspective of the supervisee. Figure 3 is in essence a pictorial representation of the theoretical and empirical formulations contained in this chapter. While emphasis has been placed on using extant theory and existing research to inform the model, in some cases tentative exploratory hypotheses with respect to possible etiology have also been included.

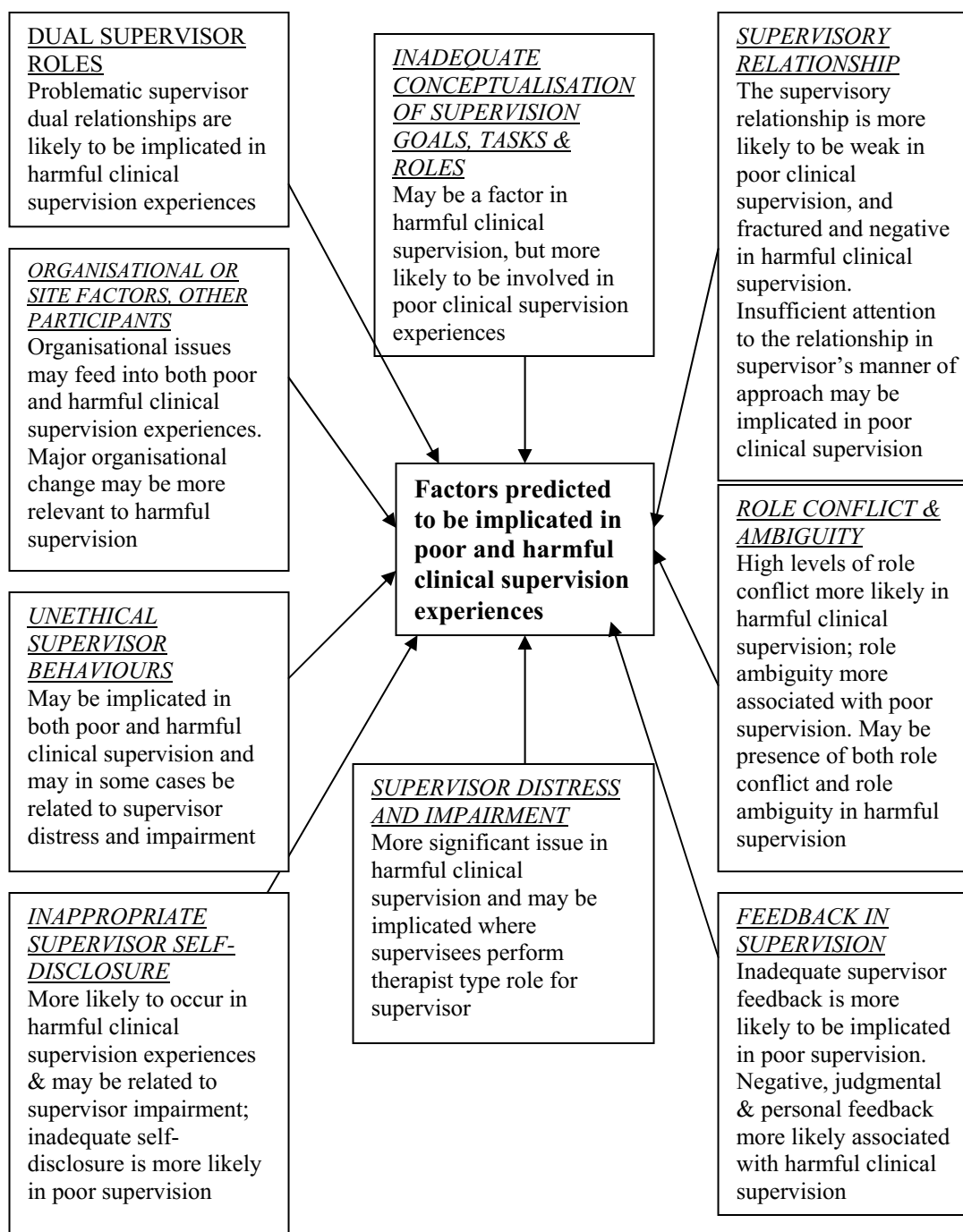


Figure 3. A diagrammatic representation of variables hypothesised to underlie supervisees' experiences of poor and harmful clinical supervision.

Factors that may account for effective clinical supervision are not necessarily the reverse of what accounts for less than positive clinical supervision (Hutt et al., 1983). Poor clinical supervision experiences may be due to the absence of factors that facilitate effective clinical supervision. This might include lack of clear identifiable supervision goals, the absence of regular ongoing evaluative feedback, the lack of disclosure of supervisor experiences and counselling struggles, or perhaps a lack of regular clinical supervision. According to this theory, poor clinical supervision is unlikely to arise from personal, judgemental, or critical feedback or behaviour by the clinical supervisor. Moreover, it is likely that contextual variables such as site factors and other participants in clinical supervision play a part in development and/or maintenance of poor clinical supervision.

In contrast, harmful clinical supervision may be due to action rather than inaction. It may be more identifiable by an excess of behaviour. This might include critical evaluative feedback, impaired supervisor behaviour (e.g., interpersonal violation), or a counterproductive dual supervisee or supervisor relationship. The harmful psychological, emotional and/or physical impacts for supervisees may principally arise from the nature of the interactions that ensue within the working alliance between supervisor and supervisee (e.g., Nelson & Friedlander, 2001). As with poor clinical supervision, harmful clinical supervision experiences may occur within a dynamic interplay of dyadic and contextual variables. For instance, it is hypothesised that significant organisational change within the placement context may causatively contribute to harmful clinical supervision experiences.

Although the factors hypothesised to underpin poor and harmful clinical supervision experiences have been represented separately, a critical precept of the model is the existence of interrelationships between variables. Rather than perceive less than positive clinical supervision as generally arising from one underlying cause such as supervisor impairment, this model endeavours to represent poor and harmful clinical supervision as contextual experiences that occur within a dynamic interplay between variables over time.

### *6.12.1 Criteria for Assessing the Usefulness of the Model*

While specific factors may be associated with poor and harmful clinical supervision experiences, it is arguable that each supervision experience is in some sense unique as it develops and persists over time. This model is a preliminary conceptualization of variables that appear implicated in less than positive clinical supervision. While it is used in this paper to provide an explanatory structure to evaluate quantitative and qualitative data on less than positive clinical supervision, it is intended to be more than purely descriptive. Through the process of developing the model, a set of testable predictions about poor and harmful clinical supervision experiences have been formulated. As research of this nature is still in its preliminary stage, the model's utility for researchers in the area of clinical supervision effectiveness is yet to be determined.

## **CHAPTER 7: STUDY 1 – THE NATURE AND INCIDENCE OF LESS THAN POSITIVE CLINICAL SUPERVISION**

Study 1 was designed to investigate the nature and incidence of less than positive clinical supervision amongst a sample of probationary psychologists in Victoria, Australia. To date, research on the effectiveness of clinical supervision has largely occurred within an American context and the transferability of such findings outside that environment is undetermined. In terms of research design, previous studies have employed varying conceptual structures to investigate less than positive clinical supervision (e.g., harmful supervision, negative supervisory events, counterproductive events in supervision), and measured less than positive supervision over different time periods (e.g., a negative event in supervision as opposed to a supervisory relationship over time). It has been somewhat unclear how findings from the different studies relate to each other and extend earlier research on less than positive clinical supervision.

The current study employed extant theory as the basis of empirical inquiry. Specifically, preliminary theory derived from Ladany and his colleagues (e.g., Nelson et al., 2001) and Ellis et al. (2000), was used to define different levels of supervision effectiveness (effective through to harmful). Categories of explanation, derived from a study by Ramos-Sánchez et al. (2002) on negative supervisory events, were extended to provide supervisees with a range of possible explanations for less than positive supervision experiences.

Measures of the supervisory relationship (Bahrack, 1990), evaluation within supervision (Lehrman-Waterman & Ladany, 2001), and supervisees' experiences of role conflict and ambiguity (Olk & Friedlander, 1992), previously found to have an association with less than positive clinical supervision, were used in this study as a basis of exploring whether poor and harmful clinical supervision are potentially different constructs. In order to increase understanding of how supervisor self-disclosure may relate to clinical supervision effectiveness, a measure of supervisor self-disclosure (Ladany & Lehrman-Waterman, 1999) was added to the questionnaire.



## 7.1 Study 1 Aims

Specifically the aims of Study 1 were:

1. To examine the incidence of less than positive supervision amongst a population of probationary psychologists;
2. To examine whether trends in American research on the nature and extent of harmful clinical supervision extend to an Australian context;
3. To explore whether less than positive clinical supervision is a unified concept or whether the constructs of poor and harmful clinical supervision may be potentially useful for differentiating types or gradations of supervision ineffectiveness;
4. To investigate whether ratings on measures of the supervisory relationship, role conflict and ambiguity, and evaluation in supervision, found to differentiate effective from less effective supervision may also differentiate poor from harmful supervision;
5. To explore the potential relationship between supervisor self-disclosure and poor and harmful clinical supervision.

## 7.2 Method

### 7.2.1 Participants

Participants comprised of 91 probationary psychologists registered in the State of Victoria who completed an Internet questionnaire titled “Supervisee Experiences of Clinical Supervision.” Of the 91 participants, 14% were male ( $n = 13$ ) and 86% ( $n = 78$ ) were female. Ages ranged from 22 years to 56 years, with a mean age of 31.68 years ( $SD = 8.78$ ; Mode = 26;  $N = 90$ ). The sample was predominantly self-described as Australian or Anglo-Australian (90%), with the remaining 10% drawn from a range of other ethnic groups.

To obtain probationary registration, 34% of participants ( $n = 31$ ) indicated that they were completing a four year accredited sequence of study in Psychology and were engaged in work of a psychological nature under the supervision of a registered psychologist. Of these, two participants volunteered that they had recently obtained their full registration at the time of completing the questionnaire. Fifty-six participants indicated that they were undertaking Masters or Doctoral

studies as the basis of probationary registration. The remaining four participants indicated that they were doing both of the above concurrently and were added to the Masters/Doctoral group, providing a total of 60 participants in this group (66% of the sample). In terms of current education, approximately 42% stated that they were studying for their Doctorate ( $n = 38$ ), 26% for their Masters ( $n = 23$ ), and 33% were undertaking no related study ( $n = 30$ ).

In terms of previous counselling experience, 65.9% of participants indicated that they had had two years or less counselling experience with individual clients ( $n = 60$ ), 24.2% between two and four years experience ( $n = 22$ ), and 9.9% had completed more than four years of individual client work ( $n = 9$ ). For probationary psychologists seeking full registration outside the higher education system, 61.3% indicated they had two years or less of counselling experience ( $n = 19$ ), 25.8% between two and four years ( $n = 8$ ), and 12.9% had completed more than four years of individual client work ( $n = 4$ ). Of probationers undertaking Masters or Doctoral studies, 68.3% indicated they had two years or less of counselling experience ( $n = 41$ ), 23.3% between two and four years ( $n = 14$ ), and 8.3% more than four years ( $n = 5$ ).

Approximately 86% of the sample had experienced less than five supervisory relationships in total ( $n = 78$ ), 10% between 5 and 9 ( $n = 9$ ), and approximately 4% of participants indicated they had been engaged in ten or more supervisory relationships ( $n = 4$ ). Comparing the two groups of probationary psychologists, only 3% of the sample outside the higher education system reported having five or more supervisory relationships ( $n = 1$ ), whilst 20% of the Masters/Doctoral group had had more than four supervisory relationships ( $n = 12$ ).

In describing their least positive supervision experience, participants indicated that 37.4% of supervisors were male and 62.6% female. Approximately 82.4 % of supervisors were described as Australian or Anglo-Australian, with 13% drawn from a range of ethnic groups. Four participants did not know or did not specify the ethnicity of their supervisor (4.4% of sample).

Participants indicated that there was a supervision contract, in addition to a placement contract, in just over half of their nominated least positive supervision

experiences (50.5%). Forty-two per cent of probationary psychologists outside the higher degree system ( $n = 13$ ) and 53% of the Masters/Doctoral group ( $n = 32$ ) indicated that there was no formal supervision contract guiding their nominated clinical supervision experience.

### *7.2.2 Measures*

#### *7.2.2.1 Preliminary Questions*

In order to obtain a snapshot of probationary psychologists' experiences of clinical supervision, 12 self-report questions and 4 existing supervision measures were combined into an Internet-based questionnaire to obtain supervisee ratings and assessments of their least positive supervision experience (Appendix 4). The resulting questionnaire required volunteer probationary psychologists to select their least positive clinical supervision experience occurring within the last three years and respond to the questionnaire with this supervision experience in mind. Based on the potential difficulties of evaluating a current supervisory experience, including ethical concerns pertaining to supervisees' relating a current harmful one, probationary psychologists whose only supervision experience was a current one were asked not to complete the questionnaire.

The 12 self-report questions were developed to serve two purposes. Firstly, questions 1 through to 7 were constructed to obtain background information on the sample of probationary psychologists, including age, gender, ethnicity, education and training, and previous experience of clinical supervision and individual client work. Supervisees were also asked to provide information on the gender and ethnicity of their nominated supervisor and to indicate whether a supervision contract had guided the supervision experience (Appendix 4, questions 9, 10, and 11).

A second purpose of the preliminary questions was to provide probationary psychologists with a set of uniform definitions for rating their least positive clinical supervision experience. With this purpose in mind, a literature review of poor, harmful and good clinical supervision events and experiences (e.g., Allen et al., 1986; Ellis, 2001; Ellis et al., 2000; Gray et al., 2001; Nelson et al., 2001; Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002) was used to select definitions for

“effective,” “somewhat effective,” “neither positive nor negative,” “poor,” and “harmful” clinical supervision (Appendix 4, question 8).

Effective clinical supervision was defined as supervision that involved development of a strong working alliance between supervisor and supervisee, and effective management of any supervision conflicts arising during the supervisory experience. This definition was derived from Nelson et al. (2001) who posited that the ability of a supervisor to establish a strong working alliance and manage interpersonal conflict was the basis for effective clinical supervision.

At the other end of the spectrum, harmful clinical supervision was defined as encompassing supervisory practices that result in psychological, emotional, or physical harm or trauma to the supervisee. Although the construct of harmful clinical supervision is yet to be clearly operationalised, Ellis (2001) has proffered persuasive argument for preliminary investigation of harmful clinical supervision as a phenomenon recognisable by its negative impacts on supervisees. Poor supervision was defined to occur when a supervisor is unable or unwilling to meet the supervisee’s training needs and can be differentiated from harmful supervision by its relatively benign impacts. Although it may entail a poor supervisory relationship, and/or fall short in meeting the supervisee’s training needs (Ellis et al., 2000), unlike harmful supervision it should not have lasting adverse effects on the supervisee (Beck & Ellis, 1998).

The central anchor points, somewhat effective, and neither positive nor negative clinical supervision, were operationalised to reflect the possibility that clinical supervision experiences lie on an effectiveness continuum. Thus, it was anticipated that some supervisees would have experienced clinical supervision where the nature of the working alliance and/or management of interpersonal conflicts reduced its effectiveness to some degree (somewhat effective). Likewise, some supervision impacts could also be described as relatively neutral (neither effective nor poor or harmful). All definitions were worded to reflect the proposition that a clinical supervision experience evolves over time and is not, for the purposes of this research, a discrete time-limited event such as a single session.

Where supervisees indicated that their least positive supervision experience was poor or harmful, they were asked to nominate what factors, or combination of factors, they perceived in retrospect were important to explain their ratings (Appendix 4, question 12). Of the six categories of explanations used, four were derived from research undertaken by Ramos-Sánchez et al. (2002). In their study investigating negative experiences in supervision, 24 negative events described by supervisees were subsequently coded into 4 categories of explanatory factors: interpersonal relationship and style (e.g., differing attitudes and personality conflicts), supervision tasks and responsibilities (e.g., issues about role or goals), conceptualisation and theoretical orientation (e.g., conflicts involving treatment decisions), and ethics, legal and multicultural issues (e.g., deficits in multicultural competence). A fifth explanatory category was added to the current study on the basis of a literature review conducted on supervisor impairment (e.g., Beck & Ellis, 1998; Ellis, 2001; Ladany, Lehrman-Waterman, et al., 1999; Lamb et al., 2003; Muratori, 2001; O'Connor, 2001). The resulting category, supervisor distress or impairment, was defined as including clinical supervision issues such as sexual contact or exploitation, poor boundaries, and the personal issues of supervisor intervening in the supervision process. An open sixth category provided the opportunity for probationary psychologists to specify other factors perceived as important that were not covered in the previous options. Recognising the possibility that multiple factors underpin poor and harmful clinical supervision, respondents were able to choose more than one category to explain their least positive supervision experience.

The wording of the 12 preliminary self-report questions was evaluated through feedback from four colleagues who completed the questionnaire online. Revisions to the wording and layout of some questions were undertaken on the basis of their recommendations.

*7.2.2.2 The Working Alliance Inventory-Trainee version (WAI-T) (Bahrnick, 1990)* was adapted from Horvath and Greenberg's (1986) Working Alliance Inventory, which was designed to assess the strength of the working alliance within a therapeutic relationship. Revised for a supervision context, the WAIT-T is a 36-

item self-report instrument that assesses supervisee perceptions of the 3 factors of the supervisory working alliance: Agreement on the goals of supervision, Agreement on the tasks of supervision, and an Emotional bond. The three subscales, containing 12 items apiece, correspond to the three supervisory working alliance factors (see Appendix 5). Items are rated on a 7-point Likert-type scale ranging from 1 (never) to 7 (always) with higher scores reflecting increased strength in each of the working alliance factors. An example from the Agreement on Goals subscale is the item, "The goals of these sessions are important to me." An item from the Agreement on Tasks subscale is "I am clear on what my responsibilities are in supervision." On the Emotional Bond subscale, one item is "(supervisor's name) and I trust one another." For the current study, the wording of items within all subscales were minimally altered to orient supervisees to a past supervision experience. For instance, using the examples above, "are" was amended to "were," "am" became "was," and "trust" became its past tense "trusted." Evidence for the validity of the WAI-T is indicated by its negative relationship with supervisee role conflict and role ambiguity (Ladany & Friedlander, 1995) and positive relationship with favourable supervisory racial identity interactions (Ladany, Brittan-Powell, et al., 1997). Regarding reliability, previous internal consistency estimates have exceeded  $\alpha = .91$  for all the subscales (Ladany, Brittan-Powell, et al., 1997; Ladany & Friedlander, 1995). For the current sample, the internal consistency coefficients for the three sub-scales were  $\alpha = .93$  (goals),  $\alpha = .94$  (tasks), and  $\alpha = .94$  (bond).

*7.2.2.3 The Evaluation Process within Supervision Inventory (EPSI)* is a 21-item self-report inventory (see Appendix 6), which examines evaluation practices within clinical supervision (Lehrman-Waterman & Ladany, 2001). Drawing on the clinical supervision literature, evaluation was defined as consisting of two primary functions: goal setting, and providing feedback to supervisees regarding progress on these goals (Lehrman-Waterman & Ladany, 2001). Items for the two sub-scales, Goal-setting (GS: 13 items) and Feedback (FB: 8 items), were constructed from extant literature on effective goal setting and feedback practices. Expert raters subsequently reviewed the suitability of items for each sub-scale (Lehrman-Waterman & Ladany, 2001). Examples of questions include, "My supervisor and I

created objectives that were realistic” (GS) and “The feedback I received was directly related to the goals we established” (FB). Items are rated on a 7-point Likert-type scale on the basis of level of agreement with each statement, ranging from 1 (strongly disagree) to 7 (strongly agree). The two factors were found to be highly correlated ( $r = .82$ ) but conceptually distinct. Evidence of the validity of the EPSI was indicated by theoretically consistent relationships between effective goal setting and feedback practices, and (i) a stronger working alliance, (ii) enhanced supervisee perception of supervisor influence on self-efficacy, and (iii) increased supervisee satisfaction with supervision (Lehrman-Waterman & Ladany, 2001). With respect to reliability, reported internal consistency estimates were  $\alpha = .89$  (GS) and  $.69$  (FB). Potential explanations for the relatively low alpha coefficient for feedback were provided including the possibility that providing feedback encompasses a diverse range of activities (Lehrman-Waterman & Ladany, 2001). The internal consistency coefficients in the current sample were  $\alpha = .91$  (GS) and  $\alpha = .81$  (FB).

*7.2.2.4 The Role Conflict and Role Ambiguity Inventory (RCRAI)* is a 29-item self-report instrument developed by Olk and Friedlander (1992) to measure role difficulties in past and present clinical supervision (see Appendix 7). The stated purpose of the RCRAI is to estimate supervisee perceptions within clinical supervision of role conflict (opposing expectations for their behaviour) and role ambiguity (uncertainty about expectations for their performance). It consists of two subscales, Role Conflict (13 items) and Role Ambiguity (16 items). Items were developed from the organisational psychology literature and from supervision theory and research (Olk & Friedlander, 1992). Examples of questions include, "I was not certain about what material to present to my supervisor" (Role Ambiguity subscale [RA]), and "My supervisor told me to do something I perceived to be illegal or unethical and I was expected to comply" (Role Conflict subscale [RC]). Items are rated on a 5-point Likert-type scale on the basis of level of agreement with each statement, ranging from 1 (not at all) to 5 (very much). Raw scores are summed and divided by the number of items in the subscale, so that both RC and RA range from 1 (low) to 5 (high). The two subscales were found to be moderately

correlated ( $r = .59$ ), reliable ( $\alpha = .89$  [RC] and  $.91$  [RA]), and predictive of work-related anxiety, general work dissatisfaction, and dissatisfaction with supervision (Olk & Friedlander, 1992). The RCRAI has been recommended as a psychometrically sound measure for use in supervision research (Ellis & Ladany, 1997). The internal consistency coefficients for the two subscales were  $\alpha = .94$  (RA) and  $\alpha = .91$  (RC) in the current sample.

*7.2.2.5 Supervisor Self-Disclosure Index (SSDI)* is a nine-item self-report inventory that was constructed from the types of self-disclosures described in the literature (Ladany & Lehrman-Waterman, 1999). Participants rate on a 5-point scale, ranging from 1 (not at all) to 5 (often), the extent to which their supervisor engaged in the various types of self-disclosures in supervision (see Appendix 8). Examples of items in the SSDI are "My supervisor self-discloses information related to her or his past experiences" and "My supervisor self-discloses information about herself or himself that is similar to the issues on which I am working." To orient supervisees in the current study to a past supervision experience, the tense of items was altered accordingly. For example, "self-discloses" became "self-disclosed." Scores on the SSDI range from 9 (no supervisor self-disclosure) to 45 (very frequent self-disclosure). Ladany and Lehrman-Waterman (1999) reported an internal consistency estimate of alpha of  $.88$ . Concurrent validity has been supported by a significant relationship between the SSDI and frequency and content of self-disclosures reported (Ladany & Lehrman-Waterman, 1999). The internal consistency coefficient for the current sample was  $\alpha = .86$ .

### *7.2.3 Procedure*

#### *7.2.3.1 Recruitment*

The Internet questionnaire used in Study 1 was publicised in the following ways:

1. Brief preliminary information on the research, including the web address for the Internet questionnaire, was published in "Dialogue" in December 2003. Dialogue is a newsletter of the Psychologists Registration Board of Victoria (PRB) and is distributed by post to registered psychologists in Victoria. The newsletter can also be viewed on line at the Registration Board's website.



2. Public addresses of probationary psychologists as at December 2003 were obtained from the PRB. Supervisees whose addresses were incomplete or who gave their professional address as a University were deleted from the system. This latter decision avoided large numbers of letters being sent to universities. From the database of 862 probationary psychologists with public addresses, a flyer providing information on the first stage of the research and the Internet address for the questionnaire was sent to the 612 probationary psychologists who met the criteria above. Ninety letters (14.7%) were returned to the researchers marked not deliverable.
3. As at December 2003, the PRB also had a database of 749 probationary psychologists without public addresses. Probationers within this database were divided into 2 groups on the basis of their length of probationary registration in months. Four hundred probationary psychologists (200 from each group) were randomly selected and sent a flyer on the first stage of the research. In order to comply with privacy requirements, these letters were sent directly from the Board and included a brief statement that the researchers had not been provided with private address information. Of these 400 letters, 5 were returned to the sender. As there was no return address on the outside of the envelopes, it is probable that a larger number did not reach the intended sender and would have been simply discarded.
4. As a strategy to increase the sample size and target probationary psychologists who may have only provided a university address to the PRB, it was decided to contact the Convenors and Directors of Victorian University Psychology Programs that were providing training to probationary psychologists. In a letter emailed in August 2004, 16 Convenors and Directors of Programs at 9 Victorian universities were asked to display or distribute a flyer providing concise information on the first part of the research. The letter and flyer are included in Appendices 11 and 12 respectively. Only one completed data set was obtained from this process.

### *7.2.3.2 Selection of Participants*

Participants were derived from 122 responses to an Internet questionnaire asking Victorian probationary psychologists about their experiences of clinical supervision. An additional set of data, obtained through an email request for a written copy of the questionnaire, was posted to the principal researcher and manually added to the data file. Of the 123 questionnaire responses, data from 8 participants were excluded because respondents had answered less than 5 questions. Of the remaining 115 data sets, 10 participants answered the first 11 questions but did not continue with the questionnaire beyond this point. As participants were asked to complete the remainder of the questionnaire using a past (and not a current) supervision experience, it is likely that most, if not all, 10 participants ceased participation in the study at this point because of this exclusion criteria. Of the remaining 105 participants, only 91 participants completed all instruments that formed part of the supervision questionnaire. For one participant, the last 4 responses (of 108 questions in total) were not recorded. These data were retained and the mean of completed items within the sub-scale (9 out of 13) used to compute values for these items. A final data set from 91 probationary psychologists was used to investigate the study aims.

### *7.2.3.3 Response Rate*

Use of an internet-based questionnaire targeting a specific population, in this case probationary psychologists within Victoria, generates data for calculation of response rates that are at best a rough estimate. Of the 612 letters sent to the public addresses of probationary psychologists, it was estimated that approximately 522 were received. Assuming a similar non-delivery rate for probationary psychologists at private addresses (14.7%), approximately 341 may have received the letter detailing the web-site address for the Internet-based questionnaire. It was unknown how many probationary psychologists became aware of the research as a result of contact by Program Directors, but only one questionnaire response was received. Out of a total population of 1611 probationary psychologists registered with the PRB as at 31/1/2004, it is likely that around 50% were provided with information on the research by mail. On the basis of these approximations, the 115 respondents

(including the 91 who provided the data for this study) could represent around 13% of those receiving information on the research by post.

### 7.3 Results

This section is divided into:

1. Preliminary analyses, which examine the association between respondents least positive supervision experience (effective through to poor/harmful) and a range of variables including age, gender, registration type and education, level of previous therapeutic experience, and presence or not of a contract to direct clinical supervision. Information on the age and gender of supervisor were also analysed.
2. Descriptive analyses of the incidence of the poor and harmful clinical supervision, and the number and categories of reasons that respondents chose as explanations for its occurrence.
3. Quantitative analyses of the association between categories of least positive clinical supervision and measures of the supervisory relationship, evaluation within clinical supervision, role conflict and role ambiguity, and supervisor self-disclosure.

The Statistical Package for the Social Sciences Windows Version 12.0.1 (SPSS Inc, Gary, NC: January, 2004) was used to conduct all statistical analyses and to calculate frequencies and percentages for questionnaire items.

#### *7.3.1 Preliminary Analyses*

Categories of least positive clinical supervision (effective, somewhat effective, neither positive nor negative, poor, and harmful) were reduced to 3 categories for the purpose of undertaking preliminary analyses. The decision to combine effective and somewhat effective clinical supervision into one category was made on the basis of their relative similarity in conceptualisation. From a theoretical standpoint, effective and somewhat effective supervision appeared gradations of the same construct and were defined to reflect this. In contrast, the decision to combine the categories of poor and harmful clinical supervision was made for statistical purposes. Given the small number of participants with harmful clinical supervision experiences ( $n = 10$ ), collapsing these categories into one cell for Chi square

analyses was not believed to impinge on the integrity of the research. Both poor and harmful clinical supervision, whether conceptually distinct or otherwise, appear to clearly form part of less than positive clinical supervision. Consequently, 3 categories of least positive clinical supervision experience, effective ( $n = 41$ ), neither effective nor ineffective ( $n = 15$ ), and poor/harmful ( $n = 35$ ), were used to investigate any association between respondents least positive clinical supervision experience and the demographic, educational and clinical experience characteristics of the sample.

Three variables were recoded to facilitate adequate cell frequencies to compute Chi square analyses. Ages of participants were divided into two groups ( $n = 45$ ) with 28.5 as the cut-off age separating the groups. Months of counselling experience was divided into two groups: 2 years or more, or less than 2 years. Number of previous supervisors comprised 2 categories: less than 5, and 5 or more. Variables that were not recoded were gender of supervisor and supervisee, registration type, education type, and presence or not of supervision contract. Chi Square tests of significance were used to examine associations between the categorical dependent variable (least positive supervision experience) and other variables of interest. Participants reporting effective, neither effective nor ineffective, and poor/harmful clinical supervision experiences did not differ significantly in terms of age, gender, gender of supervisor, number of supervisory relationships, months of counselling experience, or whether or not a contract was used to direct the clinical supervision experience. In contrast, the association between the type of least positive supervision experience and registration type (outside of graduate education or within a Masters/Doctoral program) was significant,  $\chi^2 (2, N = 91) = 8.42, p < .05$ . As represented in Table 1, participants reporting experiences of poor/harmful clinical supervision were more likely to be from Doctorate and Masters level programs than be undertaking probationary registration outside of the higher education system.

Table 1

*Registration Type of Probationary Psychologists as a Function of Type of Least Positive Clinical Supervision Experience*

Registration type	<u>Least positive supervision experience</u>		
	Effective	Neither positive nor negative	Poor or harmful
Four years of study	20	5	6
Masters or doctoral studies	21	10	29
Total	41	15	35

*Note.*  $N = 91$ .

### *7.3.2 Descriptive Analyses*

#### *7.3.2.1 Incidence of Less than Positive Clinical Supervision*

To explore the incidence of less than positive clinical supervision amongst the sample of Victorian probationary psychologists, the proportion of participants who categorised their least positive experience as effective, somewhat effective, neither positive nor negative, poor, and harmful, was computed. As indicated in Table 2, the majority of participants (62.5%) had not experienced clinical supervision that could be described as either poor or harmful. For those supervisees who had experienced poor or harmful supervision (38.5%), the incidence of poor clinical supervision (27.5%) was higher than that for harmful supervision (11%).

Table 2

*Percentage and Number of Participants as a Function of their Least Positive Clinical Supervision Experience*

Least positive clinical supervision experience	Number of supervisees	Percent
Effective supervision	17	18.7
Somewhat effective supervision	24	26.4
Neither negative nor positive supervision	15	16.5
Poor supervision	25	27.5
Harmful supervision	10	11.0

*Note.* N = 91.

### *7.3.2.2 Factors Selected to Explain the Occurrence of Poor and Harmful Clinical Supervision*

To investigate potential differences between poor and harmful clinical supervision, participants who nominated their least positive clinical supervision experience as poor or harmful were asked to select from a number of reasons, what they perceived to be underlying explanations for their rating of this experience. Either multiple or singular explanations could be selected from a prepared list. Table 3 provides a definition for each category of explanation provided to supervisees. Participants were able to add their own written explanation in addition to or as an alternative to the categories provided.

Table 3

*Reasons Provided to Supervisees for Explaining Poor or Harmful Clinical Supervision*

Reason	Description
1. Interpersonal relationship and style	Differing attitudes, personality conflicts, communication difficulties, including the supervisor being critical, disrespectful and unsupportive
2. Conceptualisation and theoretical orientation	Conflicts involving client conceptualisation, diagnosis, treatment decisions, and interventions, such as disagreements related to different theoretical orientations
3. Supervision tasks & responsibilities	Issues pertaining to activities, roles, goals, expectations and time spent in supervision, including lack of supervision, inadequate knowledge and/or skills of the supervisor
4. Ethics, legal and multicultural issues	Ethical and legal considerations pertaining to the professional practice of psychology, including multicultural competence, clinical issues, and case management
5. Supervisor distress or impairment	Issues such as sexual contact or exploitation, poor boundaries, personal issues of supervisor intervening in the supervision process
6. Other	To be specified by supervisee

*7.3.2.3 Reasons Selected to Explain Poor Clinical Supervision Experiences*

Eight per cent of supervisees ( $n = 2$ ) selected interpersonal relationship and style differences as a sole explanation for poor clinical supervision experiences (see Table 3 for a description of each reason). Issues pertaining to supervision tasks and responsibilities were nominated by 28% of supervisees as a sole explanation for

their poor clinical supervision experiences, and was the most nominated explanation for a poor clinical supervision experience ( $n = 7$ ). Interpersonal relationship and style differences in combination with issues pertaining to supervision tasks and responsibilities were the second most nominated explanation for poor supervision (24% of supervisees). Two supervisees selected interpersonal relationship and style differences, differences in relation to conceptualisation and theoretical orientation, and difficulties with respect to supervision tasks and responsibilities, as shared explanations for poor supervision experiences (8% of supervisees).

Table 4

*Reasons Chosen by Supervisees to Explain Poor Clinical Supervision Experiences*

Number of supervisees	Percentage of supervisees	Reasons
7	28	3
6	24	1, 3
2	8	1
2	8	1, 2, 3
1	4	1, 2, 3, 4
1	4	1, 2, 3, 4, 5
1	4	1, 3, 4
1	4	2, 3
1	4	2, 3, 4
1	4	3, 4
1	4	4
1	4	5

*Note.* Key for reasons chosen: 1 = Interpersonal relationship and style; 2 = Conceptualisation and theoretical orientation; 3 = Supervision tasks and responsibilities; 4 = Ethical, legal and multicultural issues; 5 = Supervisor distress or impairment.

$n = 25$ .

As indicated in Table 4, no other category or combination of categories was nominated more than once. With respect to the three participants who provided written explanations for their poor clinical supervision experience, in all cases their



comments were interpreted as supportive of their choice of category and did not offer a new or different reason for its occurrence. As regards the number of reasons chosen to explain poor clinical supervision experiences, 44% of respondents chose one reason (mode) and 32% two reasons (see Table 5).

Table 5

*Proportion and Number of Supervisees as a Function of the Number of Explanations for Poor Clinical Supervision Experiences*

Number of supervisees	Percent of supervisees	Number of reasons chosen
11	44	1
8	32	2
4	16	3
1	4	4
1	4	5

*Note.*  $n = 25$ .

Examining the frequency of each reason used as a partial or total description for poor clinical supervision experiences, difficulties in relation to supervision tasks and responsibilities was nominated by 84 % of supervisees, interpersonal relationship and style differences was nominated by 52% of supervisees, differences in relation to case conceptualisation and theoretical orientation was nominated by 24% of supervisees, ethical, legal and multicultural issues by 24%, and supervisor distress or impairment by 8%.

#### *7.3.2.4 Reasons Selected to Explain Harmful Clinical Supervision Experiences*

A total of 10 supervisees within the sample (11%) reported having had a harmful supervision experience. A range of reasons was chosen to explain these harmful experiences (see Table 6), with only two combinations selected by more than one supervisee. Two supervisees selected issues pertaining to interpersonal relationship and style, differences in conceptualisation and theoretical orientation, and difficulties in supervision tasks and responsibilities, as explanations for harmful clinical supervision. A further two supervisees nominated the combination of interpersonal relationship and style, supervision tasks and responsibilities, and

supervisor distress and impairment, as underpinning their harmful supervision experience. Only one participant offered a written explanation for the harmful supervision experience, which appeared to elaborate on one of the categories of reasons selected.

Table 6

*Reasons Chosen by Supervisees to Explain Harmful Clinical Supervision Experiences*

Number of supervisees	Percent of supervisees	Reasons chosen
2	20	1, 2, 3
2	20	1, 3, 5
1	10	1, 2, 4
1	10	1, 2, 3, 4, 5
1	10	2
1	10	1, 3
1	10	1, 5
1	10	3, 5

*Note.* Key for reasons chosen: 1 = Interpersonal relationship and style; 2 = Conceptualisation and theoretical orientation; 3 = Supervision tasks and responsibilities; 4 = Ethical, legal and multicultural issues; 5 = Supervisor distress or impairment.

*n* = 10.

With respect to the number of reasons selected by supervisees to explain harmful supervision experiences, 50% chose 3 reasons (mode) and 30% chose 2 reasons (see Table 7). This differs from the number of reasons chosen to explain poor clinical supervision experiences where the modal number of reasons provided by respondents was one. It was also noted that while 11 supervisees experiencing poor supervision chose one explanation for poor clinical supervision (44% of this

category), only one supervisee selected a unitary explanation for harmful supervision (10%).

Table 7

*Proportion and Number of Supervisees as a Function of the Number of Explanations for Harmful Clinical Supervision Experiences*

Number of supervisees	Percent of supervisees	Number of reasons chosen
1	10	1
3	30	2
5	50	3
0	0	4
1	10	5

*n* = 10.

Examining the frequency of each reason as a partial or total explanation for a harmful clinical supervision experience, interpersonal relationship and style differences was nominated by 80% of supervisees, difficulties in relation to supervision tasks and responsibilities was nominated by 70 % of supervisees, differences in relation to case conceptualisation and theoretical orientation by 50% of supervisees, supervisor distress or impairment by 50 %, and ethical, legal and multicultural issues by 20% of supervisees.

### *7.3.3 Quantitative Analyses*

#### *7.3.3.1 Relationship between Independent Variables*

Before investigating associations between the dependent variable (supervisees' least positive supervision experience) and the independent variables (measures of the working alliance, evaluation processes within supervision, supervisee experiences of role conflict and role ambiguity, and supervisor self-disclosure), correlation analyses were undertaken to examine whether the expected associations between the independent variables were supported in this study. Preliminary analyses to check any violations of the assumptions of normality, linearity, and homoscedasticity indicated that relationships between the measure of supervisor self-disclosure (the Supervisor Self Disclosure Index [SSDI]) and other variables

were not linear. In order to assess the impact of this violation, both Pearson product-moment and Spearman rank order correlation coefficients were computed for all measures. Analyses indicated that correlation coefficients were similar in strength and significance for both coefficient types, with the exception of some correlations involving the SSDI. In this case, while the strength of relationships was similar irrespective of the coefficient reported, some coefficients did not reach statistical significance when Spearman rank order correlations were computed. As a result, a decision was made to report Pearson product-moment correlation coefficients for associations between all measures of independent variables with the exception of the SSDI. Spearman's rank order correlation coefficients are reported for all analyses involving the SSDI (see Table 8).

As expected, supervisee ratings on the three sub-scales of the Working Alliance Inventory–Trainee Version (Goals, Tasks, Bond) were positively and strongly correlated (Table 8). With respect to associations between the three WAIT-T sub-scales and the Evaluation Process Within Supervision sub-scales (EPSI Goal-setting and Feedback), there were strong positive correlations between all WAIT-T sub-scales and effective goal-setting and feedback practices.

On the basis of previous research, it was anticipated that an inverse relationship would be revealed between higher ratings on the three subscales of the WAI-T and supervisee perceptions of role ambiguity and role conflict within clinical supervision. As predicted, higher ratings on all three WAI-T sub-scales were inversely associated with role ambiguity and role conflict (Role Conflict & Role Ambiguity Inventory sub-scales). Likewise, strong inverse relationships were also found between effective goal setting and feedback practices and supervisee perceptions of role ambiguity and role conflict.

Scores on the SSDI showed some significant associations of small to moderate strength with most other independent variables. Specifically, medium positive associations were found between scores on SSDI and WAI-T Bond and EPSI Feedback. Small significant positive associations were also found between scores on SSDI and WAI-T Task, WAI-T Goal, and EPSI Goal-setting. No significant

associations were found between scores on the SSDI and measures of role conflict and role ambiguity within supervision.

Table 8

*Means, Standard Deviations, and Intercorrelations of Working Alliance Factors, Supervisor Self-Disclosure, Evaluation Process within Supervision Factors, and Role Conflict and Role Ambiguity Factors*

	M	SD	1	2	3	4	5	6	7
WAI-T									
1. Goal	52.44	14.31							
2. Task	52.85	14.04	.94**						
3. Bond	54.34	16.44	.76**	.77**					
SSDI	24.53	7.71	.26*	.29**	.48**				
EPSI									
1. Goal-setting	58.53	16.20	.86**	.82**	.63**	.22*			
2. Feedback	32.21	9.17	.76**	.78**	.80**	.34**	.73**		
RCRAI									
1. Ambiguity	2.90	1.00	-.75**	-.70**	-.61**	-.13	-.70**	-.64**	
2. Conflict	1.93	.85	-.57**	-.62**	-.61**	-.19	-.53**	-.58**	.47**

*Note.* WAI-T Goal, Task, and Bond refer to the three subscales of the Working Alliance Inventory – Trainee Version (Bahrnick, 1990). SSDI refers to ratings on the Supervisor Self-Disclosure Index (Ladany & Lehrman-Waterman, 1999). EPSI Goalsetting and Feedback refer to the two subscales of the Evaluation Process Within Supervision Inventory (Lehrman-Waterman & Ladany, 2001).

RCRAI Ambiguity and Conflict refer to the two subscales of the Role Conflict and Role Ambiguity Inventory (Olk & Friedlander, 1992).

The sample size was 91 for all analyses.

\*\* $p < .01$ ; \* $p < .05$

### *7.3.3.2 Relationship between Categories of Least Positive Clinical Supervision and the Independent Variables*

Categories of supervisee least positive supervision experiences were collapsed into four categories for the purpose of this analysis. Effective and somewhat effective supervision were combined into one category of effective clinical

supervision on the basis, as stated earlier, that the constructs were not considered conceptually distinct. The proportion of participants falling into each group is displayed in Table 9.

Table 9

*Percentage and Number of Participants as a Function of their Least Positive Clinical Supervision Experience*

Least positive clinical supervision experience	No. of supervisees	Percent
Effective supervision	41	45.0
Neither negative nor positive supervision	15	16.5
Poor supervision	25	27.5
Harmful supervision	10	11.0

*N* = 91.

Prior to computing group differences with respect to the independent variables, careful consideration was given as to whether to apply parametric or non-parametric tests. As the aims of this study are exploratory in nature and the number of participants relatively small, it was difficult to make any clear assumptions about the population from which the data were derived. The small size of the harmful clinical supervision group ( $n = 10$ ), the unequal group sizes (varying from 41 for the effective supervision group to 10 for the harmful supervision group) and their potential effect on normality and homogeneity of variance, the presence of outliers on some measures for the groups (WAI-T Bond, SSDI), and the ordinal nature of the dependent variable (least positive supervision experience) were important considerations. Additionally results from Shapiro-Wilk normality tests indicated that scores on independent variables were not normally distributed for all groups. Consequently, non-parametric tests were used to explore group differences on the independent variables (Siegel & Castellan, 1988). As the selected tests use ranks (not raw scores) as the basis of computation, quartile values on measures of the independent variables for each group of probationary psychologists is reported in Table 10.

Table 10

*Quartile Values on Measures of Independent Variables for Four Groups of Least Positive Clinical Supervision Experience*

Measures of IVs	Effective (n = 41)	Neither pos nor neg (n = 15)	Poor (n = 25)	Harmful (n = 11)
WAI-T Goal				
Median	63.00	48.00	42.00	38.00
Q1, Q3	53.50, 72.00	47.00, 63.00	33.50, 49.50	33.00, 42.75
WAI-T Task				
Median	65.00	50.00	42.00	41.50
Q1, Q3	51.50, 71.00	44.00, 61.00	35.50, 50.00	36.25, 47.00
WAI-T Bond				
Median	65.00	62.00	45.00	30.00
Q1, Q3	54.00, 73.00	55.00, 65.00	38.50, 56.00	22.75, 46.25
SSDI				
Median	27.00	26.00	23.00	19.50
Q1, Q3	21.50, 31.50	20.00, 29.00	17.00, 28.00	13.50, 25.50
EPSI-Goalsetting				
Median	73.00	59.00	47.00	43.00
Q1, Q3	53.00, 78.00	47.00, 72.00	40.00, 59.00	37.25, 53.25
EPSI-Feedback				
Median	37.00	32.00	27.00	20.50
Q1, Q3	29.50, 42.00	28.00, 38.00	24.50, 33.00	14.75, 29.00
RCRAI- Ambiguity				
Median	2.63	3.19	3.31	3.53
Q1, Q3	1.72, 3.22	2.06, 3.88	2.41, 4.09	3.17, 4.28
RCRAI- Conflict				
Median	1.31	1.62	2.38	2.77
Q1, Q3	1.08, 1.81	1.38, 1.77	1.73, 3.19	1.90, 3.38

*Note.* WAI-T Goal, Task, and Bond refer to the three subscales of the Working Alliance Inventory – Trainee Version (Bahrnick, 1990). SSDI refers to ratings on the Supervisor Self-Disclosure Index (Ladany & Lehrman-Waterman, 1999). EPSI Goalsetting and Feedback refer to the two subscales of the Evaluation Process Within Supervision Inventory (Lehrman-Waterman & Ladany, 2001). RCRAI Ambiguity and Conflict refer to the two subscales of the Role Conflict and Role Ambiguity Inventory (Olk & Friedlander, 1992).

*N* = 91.

A Kruskal-Wallis Test was used to compare scores on measures of the independent variables for the four groups of least positive supervision experience. As reported in Table 11, the Kruskal-Wallis values were significant ( $p < 0.05$ ), indicating a significant difference between rank scores on all measures (WAI-T Goal, WAI-T Task, WAI-T Bond, EPSI Goal-setting, EPSI Feedback, RCRAI Role Ambiguity, RCRAI Role Conflict) for the four groups, excluding the SSDI. As data were analysed for exploratory purposes only, no adjustment was made to the significance level to control for the effects of multiple comparisons.

Table 11

*Kruskal-Wallis Test Statistics for Independent Variables as a Function of Supervisees' Least Positive Supervision Experience*

Measures of IVs	$\chi^2$	p
WAI-T Task	42.09	.00
WAI-T Goal	40.04	.00
WAI-T Bond	29.31	.00
SSDI	7.25	.06
EPSI Goal-setting	28.12	.00
EPSI Feedback	28.61	.00
RCRAI Ambiguity	16.04	.01
RCRAI Conflict	28.57	.00

*Note.* WAI-T Goal, Task, and Bond refer to the three subscales of the Working Alliance Inventory – Trainee Version (Bahrnick, 1990). SSDI refers to ratings on the Supervisor Self-Disclosure Index (Ladany & Lehrman-Waterman, 1999). EPSI Goalsetting and Feedback refer to the two subscales of the Evaluation Process Within Supervision Inventory (Lehrman-Waterman & Ladany, 2001). RCRAI Ambiguity and Conflict refer to the two subscales of the Role Conflict and Role Ambiguity Inventory (Olk & Friedlander, 1992).

$N = 91$ ,  $df = 3$ .

An examination of the mean ranks indicated that supervisees who classified their least positive supervision experience as effective displayed the highest mean rank on the WAI-T sub-scales (Goal, Task, and Bond) and the EPSI sub-scales (Goal-setting and Feedback). They also recorded the lowest mean rank on the RCRAI Role Ambiguity and Conflict sub-scales. In contrast, participants who



described their least positive supervision experience as harmful displayed the lowest mean rank on measures of the working alliance and evaluation within supervision, and also exhibited the highest mean rank on the measure of role ambiguity and conflict. As displayed in Table 11, this gradation in ranks was exhibited across all measures for the four groups.

#### *7.3.3.3 Relationship between Poor and Harmful Clinical Supervision and Independent Variables*

One of the key study aims was to investigate whether ratings on measures of the supervisory relationship, role conflict and ambiguity, and evaluation in supervision, that have been found to differentiate effective from less than effective clinical supervision, also differentiated poor from harmful clinical supervision. Data from participants reporting poor ( $n = 25$ ) and harmful clinical supervision ( $n = 10$ ) were compared on all independent variables. Due to small group numbers, the presence of outliers, and non-normal distributions, Mann-Whitney U Tests were used to compare the mean rank scores for the 2 groups (Siegel & Castellan, 1988). Mean ranks on all independent measures for the 2 groups are presented in Table 12.

Scores on the WAI-T Bond sub-scale were found to significantly differentiate the two groups ( $U = 58.5$ ,  $N_1 = 25$ ,  $N_2 = 10$ ,  $p < .05$ ). In addition, scores on the EPSI Feedback sub-scale were found to significantly differentiate the poor and harmful clinical supervision groups ( $U = 56.5$ ,  $N_1 = 25$ ,  $N_2 = 10$ ,  $p < .05$ , *two-tailed*). For both measures, the mean rank score for supervisees reporting harmful clinical supervision was significantly lower than the mean rank score for supervisees reporting poor supervision. As displayed in Table 13, no other measure was found to be significant in explaining group differences.

Table 12

*Mean Ranks on Independent Variables as a Function of Supervisees' Least Positive Supervision Experience*

Measures	Effective (n = 41)	Neither pos nor neg (n = 15)	Poor (n = 25)	Harmful (n = 10)
WAI-T Task	63.67	48.37	25.38	21.55
WAI-T Bond	59.15	51.33	33.06	16.45
WAI-T Goal	63.30	47.03	27.88	18.80
SSDI	52.33	50.13	38.30	33.10
EPSI Goal-setting	59.84	48.50	31.20	22.50
EPSI Feedback	58.99	50.30	33.94	16.45
RCRAI Ambiguity	35.16	47.80	54.02	67.70
RCRAI Conflict	31.60	44.23	61.36	69.30

*Note.* WAI-T Goal, Task, and Bond refer to the three subscales of the Working Alliance Inventory – Trainee Version (Bahrck, 1990). SSDI refers to ratings on the Supervisor Self-Disclosure Index (Ladany & Lehrman-Waterman, 1999). EPSI Goalsetting and Feedback refer to the two subscales of the Evaluation Process Within Supervision Inventory (Lehrman-Waterman & Ladany, 2001). RCRAI Ambiguity and Conflict refer to the two subscales of the Role Conflict and Role Ambiguity Inventory (Olk & Friedlander, 1992).

*N* = 91.

#### *7.3.3.4 Relationship between Poor and Harmful Clinical Supervision and Supervisor Self-disclosure*

Although the mean rank scores on the SSDI were in the expected direction, with a higher mean rank score on this index for the effective clinical supervision group in comparison with the neither positive nor negative group, graduating to a lower mean rank for the poor and then the harmful supervision group, the Kruskal-Wallis test score was not statistically significant ( $\chi^2 = 7.25, p > .05$ ). Additionally, scores on the SSDI did not significantly differentiate the poor and harmful clinical supervision groups ( $U = 107.5, p > .05$ ).

Table 13

*Mann-Whitney Test Statistics for Poor and Harmful Clinical Supervision Groups*

Measures of independent variables	U	p
WAI-T Task	117.5	.78
WAI-T Goal	92.0	.23
WAI-T Bond	58.5	.02
SSDI	107.5	.52
EPSI Goalsetting	96.0	.29
EPSI Feedback	56.5	.01
RCRAI Ambiguity	83.0	.13
RCRAI Conflict	96.5	.30

*Note.* WAI-T Goal, Task, and Bond refer to the three subscales of the Working Alliance Inventory – Trainee Version (Bahrack, 1990). SSDI refers to ratings on the Supervisor Self-Disclosure Index (Ladany & Lehrman-Waterman, 1999). EPSI Goalsetting and Feedback refer to the two subscales of the Evaluation Process Within Supervision Inventory (Lehrman-Waterman & Ladany, 2001). RCRAI Ambiguity and Conflict refer to the two subscales of the Role Conflict and Role Ambiguity Inventory (Olk & Friedlander, 1992).

*Note.*  $n = 35$ .

## 7.4 Discussion

### 7.4.1 Sample Characteristics

The sample for the current study was obtained through preliminary advertising of the research in a Psychologists' Registration Board of Victoria newsletter (Dialogue) and mailing of the web address for the Internet questionnaire directly to perhaps 800 or 50% of probationary psychologists in Victoria. It is plausible that choice of an Internet-based questionnaire may have affected the representativeness of the sample (e.g., some potential respondents may have felt uncomfortable with this type of responding), as well as contributing to a lowered response rate than what might have been expected (Granello & Wheaton, 2004). The current findings of this study also need to be considered in the light of the fact that little is known empirically about the psychometric effects of changing research from a hard copy questionnaire to a web-based electronic survey (Arnau, Thompson, & Cook, 2001).

Weighed against these potential limitations is the flexibility and ease of access that Internet questionnaires can offer respondents, as well as their potential for supporting anonymity. Such anonymity may encourage respondents to raise sensitive or difficult issues that they might be less likely to do in a pen and paper version of the questionnaire.

Due to the small number of participants in the harmful clinical supervision group ( $n = 10$ ), it was not possible to separately analyse the different sample characteristics of the poor and harmful clinical supervision groups. The preliminary analyses provided some indication of the demographic, educational and clinical experience characteristics of the sample across the effective, neither positive nor negative, and the less than positive clinical supervision groups. The only significant difference related to the greater proportion of respondents from Masters/Doctoral programs reporting poor and harmful clinical supervision experiences in contrast to probationary psychologists undertaking training outside the higher degree education system. The most parsimonious explanation for this would be that probationary psychologists within Masters and Doctoral programs undertake a greater number of clinical placements during their studies, exposing them to a larger number of supervisory experiences that may vary in effectiveness. This explanation is supported by the sample data, where only one probationary psychologist outside the higher education system reported having 5 or more supervisory relationships (3% of the sample). In contrast, 12 probationers undertaking Masters/Doctoral studies (20% of the sample) indicated having been engaged in more than 4 supervisory relationships.

For ethical reasons the focus of the current study was on the past clinical supervision experiences of the sample of Victorian probationary psychologists. Supervisees whose current supervisory experience was their only one were asked to discontinue responding to the questionnaire once they had completed the preliminary questions pertaining to sample characteristics. For probationary psychologists outside the higher education system, having one clinical supervisor during supervised practice is quite a probable scenario. If this was the case, they were requested not to complete the questionnaire. Consequently, the research

design, by excluding supervisees with only a current clinical supervision experience, limits the validity of drawing any inferences that might be obtained from comparing the incidence of poor and harmful clinical supervision for the two groups of probationary psychologists.

The current study included a high proportion of probationers undertaking doctoral studies (42% of the sample). It is unknown at this time how the expectations of probationary psychologists undertaking doctoral studies compare with those of masters students or those of probationers obtaining registration outside the higher degree system. It is quite possible that expectations of clinical supervision vary not only individually, but also as a function of the type of psychological training probationers are engaged in. It is not possible to know the impact of having a significant proportion of doctoral students participating in the current study.

The lack of a formalised supervision contract in approximately half of the supervisory relationships in this sample is a somewhat perplexing finding, particularly in light of the strong emphasis placed on their use by registration boards (e.g., PRB, 2005) and within the clinical literature (e.g., Bernard & Goodyear, 2004; Magnuson et al., 2000). While the current study did not find a significant association between the lack of a formalised supervision contract and less than positive clinical supervision, reliance on verbalised or tacit agreements to guide a supervision experience is not a recommended practice for clinical supervisors (Bernard & Goodyear, 2004; Magnuson et al., 2002; Watkins, 1997). As both the Interim Supervision Guidelines (pre-2005) and the recent PRB Guidelines for Probationary Psychologists and Supervisors (2005) specifically require written supervision plans for supervisees outside higher education programs (PRB, 2005, Guideline 2.6), the lack of a formalised agreement reported by 42% of probationary psychologists within this group ( $n = 13$ ) is a concern.

#### *7.4.2 Incidence of Less than Positive Clinical Supervision*

At this point in time, few empirical studies have investigated the incidence of poor and harmful clinical supervision (Ellis, 2001). As a result, comparison of current findings with earlier research is tentative at best. The 11% of Victorian

probationary psychologists reporting a harmful clinical supervision experience in the current sample is less than the 33 to 50% estimated by Ellis et al. (2000). Nonetheless, harmful clinical supervision was not a rare occurrence, adding further empirical support to qualitative studies from the United States reporting the existence of harmful clinical supervision as a phenomenon (e.g., Gray et al., 2001; Nelson & Friedlander, 2001). A limitation in assessing the incidence of less than positive clinical supervision across countries is that educational programs for probationary psychologists vary and this conceivably impacts on the comparability of the data.

For the same reasons as raised with harmful clinical supervision, it was difficult to compare the current estimate as to the incidence of poor clinical supervision with other empirical findings. Few studies have directly considered the incidence of less than positive clinical supervision, and few, if any, the existence of poor (bad) clinical supervision as defined in this study (Ellis, 2001). The current estimate that 27.5% of probationary psychologists sampled had experienced poor clinical supervision is slightly higher than the 21% reported by Ramos-Sánchez et al. (2002) in their study of supervisees' experiences of negative events in clinical supervision. As their study may have involved both poor and harmful clinical supervision, it is difficult to assess how these results compare.

Approximately 38% of probationary psychologists in the current study ( $n = 35$ ) reported that they had experienced poor or harmful clinical supervision. This compares with the estimate suggested by Ellis et al. (2000) for the occurrence of harmful clinical supervision. Until empirical research employs standardized nomenclatures, it will remain difficult to compare estimates on the incidence of less than positive clinical supervision. Consideration should to be given to conceptualising and operationalising different levels of clinical supervision effectiveness (Nelson et al., 2001).

If it is acknowledged that clinical supervision is both a contextual and individual experience (Davy, 2002), the current Victorian estimate should also be considered in light of the fact that many probationers experiencing less than positive clinical supervision would have (or will have) other supervision

experiences that were (or are) either effective or more neutral in their impact. Thus, less than positive clinical supervision should not be considered in isolation, and its impacts may vary as a consequence of the other experiences that supervisees have, as well as perhaps over time with the benefit of hindsight and distance. Arguably, more positive experiences of clinical supervision would provide a more balanced context for evaluating a less than positive supervision experience. While it is important to consider individual clinical supervision experiences, there also appears to be some argument for estimating the incidence of less than positive clinical supervision for probationary psychologists at the end of their training, and for this information to be periodically collected and reviewed by training institutions and registration boards.

#### *7.4.3 Reasons Used to Explain Poor Clinical Supervision Experiences*

Issues pertaining to supervision tasks and responsibilities were the most nominated unitary reason chosen to explain a poor clinical supervision experience within the current sample (chosen by 28% of supervisees). Included within this category of explanation were issues pertaining to activities, roles, goals, expectations and time spent in supervision, including lack of supervision, inadequate knowledge and/or skills of the supervisor (Ramos-Sánchez et al., 2002). As categories of reasons utilised in the current study were derived from Ramos-Sánchez et al. (2002), their findings provide some basis for comparison, bearing in mind that a different process for choice of categories was applied in the current study. Whilst negative events reported by supervisees were classified by the researchers in the Ramos-Sánchez et al. (2002) study, in the current project supervisees were asked to select their own categories of explanation for poor clinical supervision. Of the 24 negative events described by supervisees in the Ramos-Sánchez et al. (2002) study, approximately 50% were coded into issues pertaining to supervision tasks and responsibilities. In the current study, 84 per cent of supervisees nominated this category as a sole (28%) or partial (56%) explanatory factor for poor clinical supervision.

The interpersonal relationship and style category, (differing attitudes, personality conflicts, communication difficulties, including the supervisor being

critical, disrespectful and unsupportive) was nominated as a unitary explanation for poor clinical supervision by 8% of probationary psychologists in the current study ( $n = 2$ ). This explanation appeared more important in combination with other factors as an explanation for poor clinical supervision (nominated by 52% supervisees). As with the Ramos-Sánchez et al. (2002) study, issues pertaining to interpersonal relationship and style and supervision tasks and responsibilities were the most important dual explanations for poor clinical supervision experiences.

Difficulties pertaining to conceptualisation and theoretical orientation (conflicts involving client conceptualisation, diagnosis, treatment decisions, and interventions) were not chosen as a sole explanation for poor clinical supervision in the current study, although they were chosen by 20% of supervisees, in combination with other reasons, as a partial explanation for its occurrence. Ethical, legal and multicultural issues pertaining to the professional practice of psychology, including multicultural competence, clinical issues, and case management, was chosen by one supervisee as a unitary explanation of a poor clinical supervision experience, and a further 20% of supervisees as a partial explanation. Using data derived from Ramos-Sánchez et al. (2002) for comparative purposes, difficulties pertaining to conceptualisation and theoretical orientation and ethical, legal and multicultural issues were coded as important in 21% of the 24 negative events in supervision. These findings compare closely to the current study where 20% and 24% of supervisees respectively nominated these as reasons underpinning poor clinical supervision experiences.

On the basis of theory and research on clinical supervision (e.g., Beck & Ellis, 1998; Ellis, 2001; Ladany, Lehrman-Waterman, et al., 1999; Ladany, 2004; Lamb et al., 2003), the current study included an additional category, supervisor distress or impairment (issues such as sexual contact or exploitation, poor boundaries, personal issues of supervisor intervening in the supervision process) as a potential explanation for poor clinical supervision. While the content of this category in some ways straddles that of other categories (e.g., the interpersonal relationship and style category) it has been highlighted in the clinical supervision literature as a potentially important explanatory variable in less effective clinical supervision



(Beck & Ellis, 1998; Ellis, 2001; Ladany, 2004). In the current study, one supervisee chose this category as a unitary explanation, and another chose it as a partial explanation for poor clinical supervision experiences. Supervisor distress and impairment was not one of the major categories chosen by probationary psychologists in the sample.

The current study provided respondents with the option of including their own reasons to explain a poor clinical supervision experience. While three participants offered written responses on the questionnaire, these responses were interpreted to be elaborations on the actual reasons chosen and were not perceived as unique explanations. The four categories offered by Ramos-Sánchez et al. (2002), in combination with the additional category of supervisor distress and impairment, appeared to provide supervisees with a reasonable taxonomy for explaining what they perceived to be underlying causes for the occurrence of poor and harmful clinical supervision.

#### *7.4.4 Reasons Used to Explain Harmful Clinical Supervision Experiences*

A range of reasons were selected by probationary psychologists ( $n = 10$ ) to explain their harmful supervision experiences. Nine supervisees selected more than one factor to explain their harmful experience. Five supervisees chose three explanatory reasons, and three supervisees selected two reasons to explicate the occurrence of harmful supervision. The selection of multiple causative factors lends some tentative support to the proposition that harmful clinical supervision may occur for several reasons, with the potential for interacting effects amongst the factors. For instance, interpersonal relationship and style differences between clinical supervisor and supervisee could conceivably make it difficult to work collaboratively on supervision tasks and responsibilities.

While interpersonal relationship and style differences and difficulties in relation to supervision tasks and responsibilities were the most nominated categories used to explain harmful supervision for this group of supervisees (80% and 70% respectively), the remaining categories were selected by at least one supervisee as a partial or in one case total explanation for their harmful clinical supervision experience. This included the explanatory categories of differences in relation to

case conceptualisation and theoretical orientation (selected by 50% of supervisees), supervisor distress or impairment (nominated by 50% of supervisees), and ethical, legal, and multicultural issues (nominated by 20% of supervisees). Further investigation of these factors and others in future empirical research on harmful supervision may elucidate their relative contributory importance to studied experiences of less than positive clinical supervision.

#### *7.4.5 Differences in Nature and Number of Reasons Chosen by Supervisees to Explain Poor and Harmful Clinical Supervision Experiences*

Given the small sample size and reliance on descriptive data to investigate the factors underpinning less than positive clinical supervision, it was not possible in the current study to reach any substantive conclusion in relation to the comparative importance of various factors, singularly and multiply, to the experience of poor and harmful clinical supervision. While it did appear that supervisees reporting harmful clinical supervision made more use of explanatory categories such as differences in conceptualisation and theoretical orientation and supervisor distress or impairment relative to supervisees reporting poor supervision, it is unknown whether such differences would generalise outside this study.

The selection of multiple reasons to explain the occurrence of harmful clinical supervision ( $n = 9$ ) as evident in the current study appears worthy of further empirical inquiry. While currently unknown, it is possible that harmful clinical supervision may often present as a relatively more complex phenomenon than poor supervision and thus be more likely to occur when a greater number of concerns are present for supervisees.

#### *7.5.6 Measures of the Independent Variables used to differentiate Supervisees' Least Positive Clinical Supervision Experience*

The Kruskal-Wallis values computed indicated significant differences between the 4 groups of clinical supervision effectiveness on measures of the strength of the working alliance (WAI-T Goal, WAI-T Task, WAI-T Bond), use of effective evaluative practices (EPSI Goal-setting, EPSI Feedback), and levels of role conflict and role ambiguity present for supervisees within a supervision experience (RCRAI Ambiguity, RCRAI Conflict). These findings coincide with what may be expected

from extant theory and previous empirical research in this area. Both qualitative and quantitative studies have confirmed the importance to supervisees of a strong working alliance within clinical supervision (Ladany, Ellis, et al., 1999; Ladany, 2004; Patton & Kivlighan, 1997; Ramos-Sánchez et al., 2002; Worthen & McNeill, 1996). Likewise, although empirical studies on the evaluation process within supervision are still at a preliminary stage, higher ratings on the two factors of the EPSI (goal-setting and feedback) have been found to predict supervisee satisfaction with clinical supervision and their perceptions of their ability to perform specific counselling activities (Lehrman-Waterman & Ladany, 2001), both of which have been used as measures of supervision effectiveness (Lehrman-Waterman & Ladany, 2001; Worthington & Roehlke, 1979). With respect to role conflict and ambiguity as measured by the RCRAI, research to date indicates that supervisees who are uncertain about supervisory expectations or how to reach them, or experience opposing expectations as to how to perform different roles (e.g., student and counsellor), will be relatively less satisfied with a clinical supervision experience (Nelson & Friedlander, 2001; Olk & Friedlander, 1992).

The Supervisor Self Disclosure Index (SSDI) was not found to significantly differentiate groups as a function of their least positive clinical supervision experience. Higher scores on the SSDI represent greater engagement by the clinical supervisor in various types of self-disclosure within clinical supervision. A closer examination of the SSDI depicts nine questions, which ask the supervisee to rate the extent of supervisor involvement in different types of self-disclosure (e.g., intimate information about himself or herself [question 5]; non-intimate information about himself or herself [question 6]). As only certain types of supervisor self-disclosure may be pertinent to effective clinical supervision (or alternatively may influence less than positive clinical supervision) adding together or summing supervisee responses for this measure may obscure the impact of certain kinds of self-disclosure on supervision effectiveness. For instance, continual disclosure of personal material by the supervisor may have negative impacts on clinical supervision, whilst disclosure by the supervisor of his or her own previous failings or struggles may be conducive to effective supervision (Ladany & Walker, 2003).

Both scores are summed for this measure, indicating frequent use of self-disclosure by the clinical supervisor, yet their impact on clinical supervision effectiveness could conceivably be quite different. It is thus difficult to hypothesise how overall scores on this index relate to clinical supervision effectiveness.

An examination of the mean rank scores across the different groups of clinical supervision effectiveness indicates that scores on the SSDI were relatively higher for the effective, and neither positive nor negative groups, relative to the groups reporting poor and harmful clinical supervision. The SSDI may be an effective measure for differentiating effective clinical supervision from less than positive clinical supervision, in contrast to making the finer discriminations that may be needed to differentiate supervisee experiences of poor and harmful clinical supervision. It is difficult to make any firm inferences from the data, except perhaps to raise the possibility that aggregated global levels of supervisor self-disclosure may not have been a suitable measure for differentiating poor from harmful clinical supervision.

While measures of the independent variables were selected to operationalise different constructs in clinical supervision, it was noted that there were strong interrelationships between many measures in the current study. An example in point is the Goal and Task sub-scales of the WAI-T ( $r = .94, p < .01$ ). While this was not specifically considered a problem given the exploratory nature of the current study, more sophisticated statistical analyses would need to address the issue of multicollinearity. Using the WAI-T as a composite of the 3 sub-scales, or combining WAI-T Goal and Task sub-scales may be options worthy of consideration in future studies.

An additional and related issue was the conceptual similarity between some measures of the independent variables. This overlap was noted in relation to the WAI-T Goal sub-scale and EPSI-Goal-setting sub-scale. An examination of the questions forming the WAI-T Goal and the EPSI-Goal-setting sub-scales indicated some quite similar content (see Appendices 5 & 6). For instance, question 14 of the WAI-T Goal sub-scale (The goals of these sessions were important to me) and question 1 of the EPSI Goal-setting sub-scale (The goals my supervisor and I

generated for my training seem important) appear relatively similar. It is reasonable to hypothesize that how evaluation is handled will impact on the working alliance in clinical supervision, and vice versa. Nevertheless, the strong correlation in some measures does raise the matter of selecting independent variables and their measures carefully in research of this kind.

#### *7.4.7 Measures Distinguishing Poor from Harmful Clinical Supervision*

In the current study, Mann-Whitney U analyses indicated that mean ranks on the WAI-T Bond sub-scale and the EPSI Feedback sub-scale significantly differentiated supervisees reporting poor and harmful clinical supervision experiences. The WAI-T Bond sub-scale measures the feelings of liking, caring, and trust that a supervisee and supervisor share (Bahrack, 1990; Bordin, 1983). Questions on this sub-scale centre on the supervisee's perception of the existence of mutual respect within the working alliance, and genuine trust, care, honesty, and appreciation demonstrated by the supervisor to supervisee. Findings in the current study tentatively indicate that these qualities and characteristics were significantly less present in supervisory experiences that were harmful in nature, when compared to supervisees reporting poor clinical supervision. This finding is supported by previous research by Nelson and Friedlander (2001), which indicated that harmful clinical supervision was often associated with a loss of trust, the presence of conflict, and supervisee perceptions of a lack of respect for, and valuing of, the supervisee by the supervisor.

The EPSI-Feedback sub-scale measures the provision by supervisors of effective feedback to supervisees regarding progress towards achieving the stated goals of clinical supervision. Low scores on this measure tend to equate with supervisors who do not provide regular, impartial, clear, comprehensive, timely, direct, and goal-specific feedback to the supervisee. Effective evaluative feedback in clinical supervision has been related to higher ratings on the three sub-scales of the WAI-T Goal, Task, and Bond (Lehrman-Waterman & Ladany, 2001).

In the current study, supervisee ratings on bond (WAI-T Bond) and evaluative feedback in clinical supervision (EPSI-Feedback) were highly correlated ( $r = .80$ ,

$p < .01$ ). Examination of their respective questions suggests that on the face of it these measures are conceptually distinct, with the WAI-T Bond sub-scale concentrating on respect and care for the supervisee, while the EPSI –Feedback sub-scale is concerned with the nature and quality of supervisor feedback. While these measures may diverge in their focus, it is plausible that the nature of feedback provided by the supervisor would be closely related to the emotional bond between supervisor and supervisee.

One hypothesis to explain the joint significance of WAI-T Bond and EPSI-Feedback measures in differentiating supervision types requires consideration of the differential impacts arising from poor and harmful clinical supervision. The lasting psychological and/or physical harm emanating from a harmful clinical supervision experience may initially transpire because of lack of, or a significant breakdown in, emotional bond between supervisor and supervisee. This may in turn lead to an absence of effective evaluative feedback to the supervisee, specifically use of angry, negative and/or critical feedback (Nelson & Friedlander, 2001). If this proposition held true, the initiating force for harmful clinical supervision would be the absence of or breakdown of a strong emotional bond in the working alliance between supervisor and supervisee. It is possible that this pattern of proposed causality may become circular as harmful evaluative feedback in clinical supervision may lead to further breakdown of and lessening in the emotional bond between supervisor and supervisee. It is plausible that negative or critical feedback can become the destructive force that leads to psychological or physical harm for the supervisee.

The question arises as to how the emotional bond and evaluative feedback might be different where the clinical supervision experience is perceived as poor rather than harmful by the supervisee. A possible hypothesis is that ineffective evaluative feedback in poor clinical supervision experiences may be more in the nature of inadequate, irregular, or indirect feedback as opposed to negative feedback. While deficient feedback would in all likelihood also be a product of harmful clinical supervision, it is hypothesised that the more destructive aspects of critical evaluative feedback may be more a characteristic of harmful clinical supervision experiences.

Differences in the nature of evaluative feedback within poor clinical supervision experiences may arise because the emotional bond between supervisor and supervisee may be significantly less fractured and conflict ridden. This could be due to specific supervisor and/or supervisee characteristics. For instance, a more experienced or less threatened supervisor may be able to undertake strategies of repair that restore some of the emotional bond within the working alliance. As a result, feedback in poor clinical supervision may be less laden with negative emotionality and judgement. Arguably, this may result in the more benign impacts that Ellis and his colleagues (Beck & Ellis, 1998; Ellis, 2001; Ellis et al., 2000) have associated with poor (bad) rather than harmful clinical supervision.

In the case of harmful clinical supervision, the direction of hypothesised causality is from weak emotional bond to negative evaluative feedback. This is because it is hard to envisage a clinical supervisor providing negative or angry feedback without some initiating weakness or fracturing in the emotional bond between supervisor and supervisee. Nonetheless, it is arguable that a distressed or impaired clinical supervisor, perhaps under immense or protracted pressure due to personal or work-related factors, may be devaluing of a supervisee. This possibility does not closely equate with the small body of existing empirical research which indicates that harmful clinical supervision appears to become relatively personal in nature at least from the perspective of the supervisee (Nelson & Friedlander, 2001). However, additional research on supervisor distress and impairment and the role it might play in some harmful clinical supervision experiences may be a useful area of empirical inquiry (Ellis, 2001; Ladany, 2004).

While it seems more likely that the direction of causality is from emotional bond to negative evaluative feedback in the case of harmful clinical supervision, it is feasible that a bi-directional relationship may exist in poor clinical supervision. It seems plausible that a busy supervisor only able to find 5 or 10 minutes for quick clinical supervision or case management in a hectic timetable (O'Connor, 2000), may be an initiating factor in the absence or weakening of the emotional bond between supervisor and supervisee. In this regard, it is notable that the current study found difficulties in relation to supervision tasks and responsibilities (issues

pertaining to activities, roles, goals, expectations and time spent in supervision) was chosen by 84 % of supervisees as a partial or total explanatory factor for poor clinical supervision. While inadequate attention to the tasks and responsibilities of clinical supervision may underlie many poor clinical supervision experiences, it is also probable that a distant or undeveloped working alliance affords an inadequate basis on which to provide effective evaluative feedback in clinical supervision. Once again, it is likely that the relationship between emotional bond and evaluative feedback is an interactive one, where cause and effect are not always easily differentiated.

It has been proposed that the evaluative role in clinical supervision presents as a problem for many supervisors, standing as a counterpoint to their more therapeutic role (Bernard & Goodyear, 2004; Ladany, Lehrman-Waterman, et al., 1999). Yet little research has been undertaken in this area to obtain a detailed picture of evaluative decision-making by clinical supervisors (Hoffman et al., 2005; Robiner et al., 1997). The current findings indicate a need to learn more about evaluation in supervision generally and the impacts of different types of evaluative feedback on clinical supervision effectiveness. This is supported by a recent study reporting that supervisors do experience difficulty giving certain kinds of feedback, particularly when it may not be clearly within the bounds of supervision (Hoffman et al., 2005). At this time, little is known empirically about how clinical supervisors handle their evaluative role, especially when they have some concerns about the progress or competency of a supervisee (Robiner et al., 1997). It appears timely to learn more about clinical supervisors and their perceptions and experiences of clinical supervision.

### 7.5 Study Limitations

The study focused solely on the supervisee's perspective and should not be interpreted as an objective account of the events that happen within clinical supervision. While obtaining the perceptions of both supervisees and supervisors is a more balanced research design, the discipline's understanding of less than positive clinical supervision is at a preliminary stage (Ellis, 2001) and the implementation of



such a large-scale and resource-intensive project was beyond the scope of this exploratory study.

There are individual differences amongst supervisees which have the potential to impact on a supervision experience in a multitude of ways. Supervisees differ in terms of levels of previous client experience and competency, attachment styles, and their ability to handle different types of evaluative feedback. It is conceivable that individual supervisee and supervisor factors, and the interaction between such factors, have the potential to impact on the nature of a specific supervision experience.

This empirical study required probationary psychologists to look retrospectively at their least positive clinical supervision experience. Whilst it was regarded as ethically questionable to ask probationary psychologists to discuss current clinical supervision experiences particularly harmful ones, reliance on recall has limitations and pertinent information may have been forgotten. On the other hand, by not choosing current supervision experiences, respondents had the opportunity to reflect on events and their consequent impacts after the event.

As supervisees were asked to recall only their least positive clinical supervision experience, this study does not provide a complete picture of the incidence of effective clinical supervision. By targeting supervisees' least positive supervision experience, information was not obtained on the more positive experiences that many supervisees may have had. Thus some caution must be applied in interpreting results.

Probationary psychologists who took part in this study were at different time periods since the occurrence of their least positive supervision experience. It is possible that as time progresses experiences that may have been classified at different levels of supervision effectiveness change. For instance, harmful clinical supervision experiences may have less impact at later points in time. On the other hand, it is possible that the negative psychological impacts of a harmful clinical supervision experience may grow, particularly where there are opportunities for rumination over what occurred.

The findings of this study lack generalisability. They relate to a small sub-set of a particular population. As few studies of this type have been undertaken, it would be remiss to perceive the results as representative of clinical supervision experiences outside the context of this study. Replication of this research is needed to determine the generalisability of these findings to other localities and contexts.

The current study relied on self-report for measuring the independent variables and an ordinal self-report scale for differentiating levels of clinical supervision effectiveness. The development of a valid and reliable measure of clinical supervision effectiveness, which has as its basis extant theory, is needed. While the current study utilised existing theory, it is evident that such theory is incomplete, and less than positive clinical supervision continues to be investigated using different constructs (Ellis, 2001). Building on existing research affords the opportunity to verify findings and extend theory in this area.

Use of an Internet questionnaire to investigate the least positive clinical supervision experiences of probationary psychologists may be subject to sample bias. It is possible that some supervisees would not respond to an online questionnaire, particularly if they feel uncomfortable with this questionnaire response style. Another possibility is that use of an Internet based questionnaire may have led to the research being more accessible or attractive to higher education students. It is usual for research projects and theses to form a compulsory part of higher education psychology courses and not uncommon for these probationers to be exposed to the research of other students both within their university and other universities. Thus it is possible that research design may have favoured response from this group of participants.

The small number of participants in the current study provided a limit with respect to the nature of statistical analyses that could be performed on the data. For instance, the small number of participants in the harmful clinical supervision group limited the validity of making inferences about causal factors likely to underpin poor and harmful clinical supervision experiences.

Reliance on non-parametric tests has often been regarded as reducing the power of a test to reject a false null hypothesis of no difference between groups (Pallant,

2001). As the current study was exploratory in nature (we can assume little about the population), and some variables were distributed non-normally across the groups and included outliers, non-parametric tests were selected. It is hoped that future research with larger samples and more refined measurement techniques may favour statistical analyses such as multiple and logistic regression. Such analyses will be able to explore the interrelationship between variables and their predictive ability on less than positive clinical supervision.

## **CHAPTER 8: STUDY 2 – SUPERVISEE PERCEPTIONS OF THE NATURE, CAUSES, AND CONSEQUENCES OF POOR AND HARMFUL CLINICAL SUPERVISION EXPERIENCES**

Using qualitative techniques and small samples for in-depth investigation, recent empirical studies undertaken in the United States have explored supervisee experiences of counterproductive events within clinical supervision (Gray et al., 2001) and harmful conflict within supervisory relationships (Nelson & Friedlander, 2001). Building on existing research (e.g., Allen et al., 1986; Kennard et al., 1987; Ladany, Lehrman-Waterman, et al., 1999), these studies have added to a growing body of evidence documenting the existence of less than positive clinical supervision. In addition, they have provided detailed accounts of the factors that trainee psychologists perceived to underpin such experiences. Such factors have included the supervisor dismissing the feelings of the supervisee, or being unempathic (Gray et al., 2001), and the existence of power struggles or role conflict between supervisor and supervisee (Nelson & Friedlander, 2001).

Empirical research on less than positive clinical supervision exists within what Ellis (2001) has aptly termed a conceptual morass. Ellis (2001) has argued that there are almost as many concepts for less than positive clinical supervision as there are publications attesting to its existence. As a result, there remain unanswered questions about whether there are different types of ineffective clinical supervision, and if this is the case, how such types relate to each other.

Drawing on the constructs of poor and harmful clinical supervision provided to supervisees in Study 1 of this research project (Chapter 7), the current study asked for volunteer participants from Study 1 to provide information on their least positive supervision experience. The verbal content of their interviews was used to gain a detailed account of the nature, causes, and consequences of less than positive clinical supervision experiences perceived by this sample of probationary psychologists as poor or harmful. Responses of participants were explored individually to examine ideas and themes present in supervisees' experiences of poor and harmful clinical supervision. In addition, transcripts were analysed

collectively to consider whether poor and harmful clinical supervision might differ in terms of supervisee perceptions as to their nature, causes and consequences.

The current study also sought to obtain detailed information on conflict or relational impasses in supervision and how supervisees attempted to resolve these. In addition to endeavouring to build on the research by Nelson and Friedlander (2001) on conflictual supervisory relationships, this focus reflects the small body of research suggesting that repairs and ruptures are normal within the supervisory relationship (Bordin, 1983; Rose Burke et al., 1998), particularly as supervisees move towards greater autonomy (Ronnestad & Skovolt, 1993). By examining rupture or conflict processes within clinical supervision, it was hoped to obtain more information on their nature within both poor and harmful supervision experiences.

### 8.1 Study 2 Aims:

Specifically, the aims of the second part of the study were to investigate:

1. The nature of clinical supervision experiences described by supervisees as poor and harmful;
2. Supervisee perceptions of supervisor styles and behaviours in poor and harmful clinical supervision;
3. Supervisee perceptions of the nature of the supervisory relationship;
4. The underlying factors that supervisees believed might account for poor and harmful supervision experiences;
5. The consequences for the supervisee of this experience, personally and professionally, over time;
6. Supervisee awareness and use of conflict resolution processes;
7. Strategies supervisees used to help resolve the conflict for themselves;
8. Supervisee perceptions, retrospectively, as to whether anything could have been done to resolve the conflict;
9. What the supervisee believed they had learnt from the experience; and
10. From a collective standpoint, any similarities and differences in factors perceived by supervisees as underpinning their experiences of poor and harmful clinical supervision.

## 8.2 Method

### 8.2.1 Participants

Ten Victorian probationary psychologists participated in Study 2. All volunteers were drawn from Study 1. Ages ranged from 25 to 50, with a mean age of 33.2 ( $SD = 7.7$ ). Five participants reported that their least positive clinical experience from Study 1 was poor, and five classified it as harmful. One participant who classified their supervision experience as harmful in Study 2 was uncertain what classification level they had selected in the Internet questionnaire used in Study 1.

With respect to the length of time since the clinical supervision experience occurred, for participants reporting poor clinical supervision experiences, one occurred in 2002 and the remaining 4 occurred in 2003. For supervisees reporting harmful clinical supervision experiences, two experiences occurred in 2001, one in 2002, and two in 2003.

Of the five participants reporting poor clinical supervision experiences, one probationary psychologist was completing supervised psychological work after 4 years of accredited studies at the time of the experience, one was undertaking masters level studies, and three participants were undertaking doctoral level studies. Of the five reporting harmful clinical supervision, two participants were undertaking supervised psychological work after completion of 4 years of accredited studies, one masters level studies and two were completing doctoral level studies. Two participants were male and eight participants female.

With respect to the level of experience of supervisees reporting poor clinical supervision experiences, one interviewee was undertaking their first year of supervised psychological work after completion of a 4 year sequence of study, another was about half-way through masters level studies, with the other three interviewees undertaking first year, second year, and third year doctoral level studies respectively. Supervisees reporting harmful clinical supervision experiences were also spread in terms of experience levels, with one interviewee early on in supervised practice after 4 years of accredited studies, one later in supervised practice, one in first year and another in second year of doctoral level studies, and one in the latter part of masters level studies.

With respect to gender of supervisee and supervisor in poor clinical supervision experiences, two dyads were female-female, two dyads were female supervisee-male supervisor, and one dyad was male-male. For supervisees reporting harmful clinical supervision experiences, three dyads were female-female, one dyad was female supervisee-male supervisor, and one male supervisee-female supervisor.

For the five supervisees reporting poor clinical supervision experiences, two had no previous supervisor, one had one previous supervisor, and two reported two previous supervisors. With respect to the five supervisees reporting harmful clinical supervision, one supervisee had no previous supervisor, two reported having two previous supervisors, one supervisee reported three prior supervisors, and one supervisee reported six previous supervisors over a number of years at one work setting.

For participants reporting poor clinical supervision experiences, one was in paid employment working under the supervision of a registered psychologist after completion of 4 years of accredited studies. One participant undertaking doctoral level studies was at an external placement and being supervised by a university staff member. Another doctoral student was undertaking an external placement at an organization with close connections to the university where studies were being undertaken. Two participants (one doctoral, one masters) were at external placements with no direct connection to their universities.

With respect to the harmful clinical supervision experiences, in two cases the clinical supervisors were university lecturers. For one supervisee, the actual placement context was an external site and for the other a university clinic. Two participants were in paid employment having completed 4 years of accredited studies in psychology and were at the time of the experience undertaking psychological work under the supervision of a registered psychologist. The fifth participant was undertaking paid work whilst completing masters level studies.

Of the five supervisees reporting poor clinical supervision experiences, two were situated within hospitals, one within a community agency, one within a private company, and another within a corrections facility. With respect to supervisees reporting harmful clinical supervision experiences, one was within a community

agency, two were located in government agencies, one within a corrections facility, and another within a university clinic.

With respect to supervisees reporting poor clinical supervision experiences, two participants reported having a written supervision contract guiding the clinical placement, one supervisee indicated that some aspects of supervision were covered in the placement contract, and two participants reported no specific supervision contract to guide clinical supervision. Three supervisees reporting harmful clinical supervision experiences stated that there was no supervision contract, one interviewee stated that there was a contract constructed from supervisee input only, and one supervisee reported there was a supervision contract.

The mean interview length for the 10 participants was 47 minutes ( $SD = 16.21$ ). For participants reporting poor clinical supervision experiences, the mean interview length was 40 minutes ( $SD = 3.74$ ). The mean interview length for interviewees reporting harmful clinical supervision experiences was 54 minutes ( $SD = 21.33$ ).

### *8.2.2 Measures*

After consideration of literature and research on effective, negative, harmful and counterproductive clinical supervision (e.g., Gray et al., 2001; Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002), a semi-structured interview guide was constructed for the purpose of guiding qualitative phone interviews with supervisees on their experiences of poor and harmful clinical supervision (Appendix 9). The guide consisted of 8 specific background questions primarily about the participants' training and supervision experiences, and 20 questions pertaining to their least positive supervision experience. Questions were adapted and expanded from those constructed by Nelson and Friedlander (2001) for their American study on non-productive conflict in clinical supervisory relationships (Appendix 10). The general focus of the two interview guides appears relatively comparable, although the Nelson and Friedlander (2001) study focused on conflict in supervisory relationships whereas the current study investigated supervision experiences perceived by supervisees as within the defined nomenclature of poor or harmful clinical supervision. As with Study 1, harmful clinical supervision experiences in Study 2 were defined as encompassing supervisory practices that result "in



psychological, emotional or physical harm or trauma to the supervisee.” In contrast, poor clinical supervision was defined as occurring when the supervisor is unable or unwilling to meet the supervisee’s training needs, or it may entail a poor supervisory relationship. While disappointing or frustrating to experience, it leads to relatively benign impacts that do not harm the supervisee.

The current interview guide diverged from that constructed by Nelson and Friedlander (2001) by the inclusion of questions that focused on supervisee knowledge of procedures available for resolving conflict, and what they had learnt about resolving conflict from their nominated least positive supervision experience. For instance, supervisees were asked whether they were aware of any procedures in place to deal with less than positive supervision, and whether in retrospect, they believed there was anything that could have done to repair or improve the supervision experience. These questions were included to obtain both a broader and more detailed picture of supervisee knowledge of conflict resolution processes and their perceived appropriateness for use in less than positive clinical supervision. Supervisees were also asked whether a supervision contract guided the nominated supervision experience. Apart from the proposition that negotiated supervision agreements can offer necessary structure to a supervision experience, they are also mandated in Victoria when probationary psychologists seek to obtain registration outside the higher degree system (PRB, 2005).

### *8.2.3 Procedure*

#### *8.2.3.1 Recruitment and Informed Consent*

Participants in Study 1 were provided with detailed information relating to Study 2 on the last page of the Internet questionnaire used in Study 1 (see Appendix 3). A university e-mail address for the principal researcher was provided and interested participants were asked to initially make contact through this method. In responding, some potential participants provided a phone number for future contact while others elected to be recontacted via e-mail. In all cases, contact was made at the time and in the manner that the probationary psychologist preferred. Return contact by the principal researcher provided further details on Study 2 (e.g., whether

the interview could be taped, how the proposed taping would be done) and an opportunity for potential interviewees to ask questions.

All 10 inquiries from potential participants reporting poor or harmful clinical supervision experiences were followed through and all 10 participants agreed to participate in telephone interviews. The voluntary nature of participation was verified by a final e-mail from the principal researcher to all participants, stating that times for phone interviews would be arranged on receipt of their return e-mail verifying that they still remained interested in participating in an interview. All participants responded to the e-mail stating that they were still interested in participating in the phone interviews and provided possible times as to when they would be available. These times were finalised by telephone or e-mail depending on the preferred communication mode for each supervisee.

#### *8.2.3.2 Interviews*

All interviews were conducted by telephone by the principal researcher. Rather than perceive each interview as a building block within an overall theory of less than positive supervision, the researcher-interviewer endeavoured to conduct each interview from the perspective of it being a unique individual experience of the phenomena under investigation (Giorgi, 1997; Giorgi & Giorgi, 2003; Wertz, 2005). This partitioning away of existing theoretical and empirical knowledge was considered appropriate in light of the discipline's limited understanding of less than positive clinical supervision, whether there are different levels and types, and how they might be related.

The general approach to interviewing was to adhere to the semi-structured interview guide with some use of minimal encouragers (e.g., repeating a word), clarifying questions (e.g., asking the supervisee to clarify something that was unclear), and paraphrasing (e.g., rewording of a question where the supervisee's response did not clearly match the question asked) in order to obtain a clearer picture of the phenomenon under investigation. Probes were not employed interpretively to create or offer a different meaning with respect to the experiences explicated by supervisees. An opportunity was provided at the conclusion of

interviews for supervisees to provide any additional information they felt was useful to the investigator.

Of the ten participants, nine agreed to have their telephone interview taped. One participant did not feel comfortable with this process, and the interview was not taped. Responses for this interviewee were recorded using pen and paper during the telephone interview. Notes taken during this interview were typed up as a document file immediately on completion of the interview.

All remaining nine interviews were audio taped using the speakerphone option on the telephone and a microphone attached to a standard tape recorder. Tapes were labelled by interviewee number and securely stored in a locked cabinet. At later times, tapes were transcribed verbatim and the dialogue typed up into nine document files. On completion, transcripts and tapes were reviewed by the principal researcher as to their accuracy and small amendments made. The ten document files formed the basis of data analysis.

#### *8.2.3.3 Method of Transcript Analysis*

The approach to transcript analysis followed that proposed by Giorgi (1997) comprising what he described as applying a human scientific phenomenological method. The main steps involved can be summarised as: (1) undertaking detailed readings of all the data prior to commencing analysis; (2) obtaining a detailed concrete description of the individual's holistic experience; (3) breaking down individual data into units of or shifts in meaning; (4) using a psychological perspective to organize and express data on less than positive clinical supervision; and (5) summarising of group data to explicate interrelationships for purposes of communication to the scholarly community.

The ten transcripts were repeatedly read to obtain a holistic understanding of each context for less than positive clinical supervision, as well as to facilitate a level of familiarity required for identification of key themes. Units of meaning were initially isolated question by question and responses for each participant entered into a table. Responses were broadened by adding information contained elsewhere in the transcripts that was interpreted as relevant to each question. This approach recognised that participants build a picture of their experiences over the duration of

the interview, and the holistic nature of these experiences would be threatened if meaning was partitioned question by question without reference to the entire transcript (Giorgi & Giorgi, 2003).

The process of adding units of meaning was undertaken on a number of different occasions to aid greater familiarity with the transcripts. On completion of this, key phrases contained in the verbal data were selected from the ten transcripts as a means of conveying the unique experience of each supervisee. The selected phrases were entered into tables under headings that corresponded with each question in the semi-structured interview guide (see Appendix 9). In some cases, one or two words in the phrases were altered by the principal researcher/interviewer in order to aid reader understanding or to record an idea more succinctly. Separate tables of key phrases were constructed for interviewees reporting poor and harmful clinical supervision experiences.

After each transcript was explored in its entirety, responses to each question summarised, and key phrases selected, transcripts of experiences were compared for group similarities and differences in supervisee experiences of poor and harmful clinical supervision. Two methods were used to summarise group data for supervisees reporting poor and harmful clinical supervision experiences. Firstly, group data were summarised directly from the individual transcripts and reported for each question on the semi-structured interview guide. This provided a means of comparing interviewee responses to each question within the poor and harmful supervision groups.

A software package was also employed to assist with evaluating the preliminary model of variables predictive of poor and harmful clinical supervision experiences (see Figure 3 in Chapter 6). The ten transcripts were converted into text files and entered into N Vivo 2.0. N Vivo 2.0 is qualitative software that can be used for multiple purposes including the storage, coding, moving, editing, linking, and modelling of verbal data (Qualitative Solutions & Research Pty Ltd [QSR], 2000). In the current study, N Vivo 2.0 was used to organise and manage text and documents and to facilitate a context-free environment for the development of theme documents. It was anticipated that a second method for summarising and

analysing verbal data might generate some different themes in supervisee experiences of poor and harmful supervision.

Interviewee transcripts were read and re-read and themes elicited with respect to variables that interviewees perceived had contributed to their poor and harmful clinical supervision experiences. Theme documents were constructed in areas relevant to the psychological study of clinical supervision such as supervisor feedback, the supervisory relationship, dual supervisor roles, goals and tasks in supervision, and supervisee role conflict. Responses from supervisees experiencing poor and harmful clinical supervision were entered under each relevant theme and a summary document compiled for each theme. The theme documents were used as a basis for conveying group meaning on the variables that might predict poor and harmful clinical supervision experiences.

As part of group data analysis, the researcher-interviewer reviewed all transcripts seeking to make explicit some of the underlying psychological meanings implicit in the dialogues (Giorgi & Giorgi, 2003). For instance, where an interviewee stated that “my supervisor did not tell me how I was going in supervision,” this response has implications for many aspects of the supervision experience including evaluative feedback, the supervisory relationship, and communication. Accordingly, drawing out implied meanings and the relational aspects of each supervision experience was considered an important part of the group data analysis.

#### *8.2.3.4 The Auditing Process*

The first part of the auditing process was focused on whether the interviewer-researcher had accurately represented each interviewee’s subjective experience of poor or harmful clinical supervision. With this purpose in mind, a summary of phrases and passages used to represent the individual’s poor or harmful supervision experience was e-mailed to each original informant (still contactable and agreeable to engaging in the process) as a means of establishing whether the principal researcher had provided an accurate representation of their least positive supervision experience at the time of the interview. Accompanying the summary was a brief letter providing some guidance as to the type of feedback the principal

researcher-interviewer was seeking (see Appendix 13). This auditing strategy was timetabled to occur approximately two years after the original phone interviews, and interviewees were informed of this option at the time of interview.

On receipt of the instruction sheet and summary of findings, participants were invited to make comments and suggest amendments to responses chosen to represent their least positive clinical supervision experience. In addition, participants were invited to disclose whether and in what ways their perceptions of their supervision experience may have changed since the original interview and what might have been the reasons for any shift recognized. Thus, the auditing process served an additional purpose by providing a mechanism for obtaining further information from interviewees on their progress and any perceptual or attitudinal shifts since the interviews.

The second part of the auditing process was the responsibility of the principal researcher-interviewer. Adhering to the stages of human phenomenological scientific method, the principal researcher-interviewer endeavoured to integrate the meaning of actual individual experiences into key psychological concepts pertaining to less than positive clinical supervision. These encompassed the constructs described in Chapter 6 including supervisor feedback, the working alliance, supervisor impairment, and role conflict and ambiguity. It was through rigorous attention to both representing the individual experience and adhering to the philosophy and methodology of phenomenology that the researcher sought to objectively represent and, if structure(s) was present, reveal any unity in the meaning of poor and harmful supervision (Giorgi, 2002).

#### 8.2.3.5 *The Researcher-Interviewer*

As a prelude to analysing transcribed interviews, it is important for researchers to examine their biases and expectations in relation to the research (Nelson & Friedlander, 2001). The researcher-interviewer, at the time of data analysis, was a 48-year-old woman who undertook this research project as part of the requirements for completing a Professional Doctorate in Counselling Psychology from Swinburne University of Technology. She did not know any of the participants prior to their involvement in the current study.

The researcher-interviewer has previous experience of counselling amounting to about 10 years, predominantly in the areas of financial debt and gambling behaviour. These roles were designated for a counsellor, but her employment was not as a psychologist or probationary psychologist. During her employment, she experienced a range of clinical supervision with respect to effectiveness, including what she perceived as effective, poor and harmful clinical supervision. While registered as a probationary psychologist in the State of Victoria (for 4 years at the time of data analysis), the researcher-interviewer had experienced effective clinical supervision from three registered psychologists.

The belief of the researcher-interviewer, at the time of undertaking some initial reading in the area of clinical supervision, was that poor and harmful clinical supervision might be different constructs, the harm associated with harmful clinical supervision arising perhaps because of how the event(s) or issue(s) was dealt with. The nature of the interactions between supervisor and supervisee, both verbally and behaviourally, may be particularly important in this regard. After reading and completing a literature review, the researcher-interviewer attributed a much greater emphasis in this research project to the context of clinical supervision, perceiving that site factors (e.g., client group, organisational politics) and dual relationships (e.g., same person performing roles of clinical supervisor and manager, or lecturer and clinical supervisor) may be important contributors to or moderating factors in less than positive clinical supervision.

### 8.3 Results

A phenomenological approach (Giorgi, 1997) was used to guide the process of obtaining detailed information on each interviewee's experience of less than positive clinical supervision and to summarise group responses to each question on the semi-structured interview guide. N Vivo 2.0 (QSR, 2000) was used to group data into themes. Group responses and themes were used to deduce variables that might predict poor and harmful clinical supervision experiences.

*8.3.1 A Brief Description of the Less Than Positive Clinical Supervision  
Experiences Reported by Supervisees*

*8.3.1.1 Poor Clinical Supervision Experiences*

When asked initially to describe the nature of their least positive supervision experience, three out of the five supervisees reporting poor clinical supervision described experiences that could be encompassed within a general category of inadequate supervision. One experience involved a clinical supervisor who was unavailable for a couple of months during the placement (with the exception of some contact by e-mail). This was the supervisee's first placement experience and the level of supervision did not reflect his or her expectations for an initial placement.

Another supervisee depicted their poor clinical supervision experience as involving a lack of clarity about who actually was the accountable supervisor. In this placement, the site supervisor was described as lacking the required qualifications to supervise, and as a consequence staff members at the university were also overseeing the placement. As issues arose during placement, the university informed the supervisee that the site supervisor was to perform the supervisory role. The supervisee described the quality of the supervision as somewhat inadequate, highlighting the supervisor's large workload and the culture within the organisation which placed the needs of students at the bottom of the hierarchy. Clinical supervision was portrayed as lacking in clear goals and direction, requiring the supervisee to work in relative independence with minimal supervision, something perceived as difficult given the developmental level of the supervisee (second placement).

The third experience of poor clinical supervision involved a clinical supervisor who double-booked appointments and forgot a number of supervision sessions during the placement. Feedback on progress was intermittent and delayed. In this experience, the supervisee related how the supervisor raised concerns about the supervisee's motivation and suitability for entering the profession in one of the last supervision sessions, in what the supervisee described as "a lump sum" feedback



session. This supervisee built a picture of placement within an organisation driven to achieve client targets, with students the lowest on the pecking order.

The remaining two experiences of poor clinical supervision stood out as significantly different. In one case, an organisational decision had been made prior to the placement commencing, the impact of which was that the student was not able to work with most clients at the setting. This decision was not imparted to the supervisee until placement was underway. As a result, this interviewee did not work directly with clients during the placement. The supervisee believed that insufficient thought had gone into how to use him or her effectively. This poor supervision experience could be classified as involving an unsuitable placement.

The final experience described as poor involved multiple instances of the clinical supervisor discussing sensitive information about the supervisee in front of others at the placement site. Some of this information pertained to the supervisee's performance in the work role, while other disclosures related directly to the supervisee's personality. The supervisee described these experiences as breach of confidentiality, and may be best classified as supervisor behaviour involving direct ethical concerns.

#### *8.3.1.2 Harmful Clinical Supervision Experiences*

The nature of the harmful clinical supervision experiences was quite diverse. One experience focused specifically on one supervision session where the supervisor made speculations about the supervisee's physical characteristics and how a particular client might perceive these. The supervisee felt uncomfortable with the supervisor's speculations, questioned their accuracy, and additionally the motivations of the supervisor for making them. This supervisee raised the possibility that aspects of his or her own personality may have added to feelings of discomfort with the nature and content of the session. As a first year student, the nature of supervisor feedback may not have been appropriate to the developmental level of the supervisee.

Perhaps on a somewhat similar developmental theme to the first example, a second experience of harmful clinical supervision was described as involving a clinical supervisor whose expectations of the supervisee's clinical work paralleled

what might be expected from a fully registered psychologist. Describing the client work as highly complex and demanding, this supervisee found the supervisor to be both unsupportive and unhelpful. This supervisee expressed concerns about the clinical supervisor's emotional stability and suitability to perform the supervisory role.

A third experience of harmful clinical supervision was described as involving the supervisee overhearing the clinical supervisor speaking in a disparaging manner about another member of the work team to a work colleague within the organization. The supervisee's decision to pursue available avenues of complaint over the supervisor's behaviour led to a breakdown in the supervisory relationship and later supervision sessions being described as irregular and ineffective. This event occurred within a supervisory relationship described as disappointing, with the supervisor seeking a collegial supportive relationship from the supervisee rather than one offering clinical direction and support. This supervision experience occurred against a backdrop of significant organisational change affecting the entire team.

A fourth experience of harmful clinical supervision was described as arising from supervisor dual roles. In this case the same person performed the roles of clinical supervisor and manager. The supervisee described feeling unable to honestly and openly discuss feelings and ongoing progress in the workplace because of the potential for it to impact on the attainment of full registration. Clinical supervision was depicted as focusing too much on administrative and work related matters at the expense of clinical skills and the professional development of the supervisee. This supervisee perceived that the supervisor's dual roles underlay ensuing personality clashes and fed into the supervisor's growing perception that the supervisee was unfit to work as a psychologist.

The fifth experience of harmful clinical supervision also involved supervisee unease about supervisor dual roles combined with supervisor concerns about the supervisee's suitability to enter the profession. In this case, the supervisee related the experience of being unexpectedly told on the last day of a placement that he or she had not performed satisfactorily and perhaps needed to consider a different

career path. As well as being the clinical supervisor for placement purposes, this supervisor was also a lecturer at the university within the student's course program. Having the same person perform the two roles was described as leading to the supervisee feeling unable to entirely peel off the label of "student."

### *8.3.2 The Clinical Supervisor in Poor and Harmful Clinical Supervision*

Descriptions of clinical supervisors provided by interviewees experiencing poor (see Table 14) and harmful clinical supervision (see Table 15) did not support a portrayal of supervisors who were lacking in clinical competency. Many supervisors were perceived as skilled clinicians, at least on certain levels. Also of interest is the breadth of descriptions used by most supervisees and the diversity in supervisor qualities articulated. Notably, half the supervisees spontaneously reported supervisor strengths as well as weaknesses.

With respect to supervisees reporting poor experiences, two characterised their supervisors as negative and untrustworthy (see Table 14). However, these depictions were not consistent themes running across all five interviews. Descriptions from supervisees indicated that a range of supervisor qualities and behaviours were evident amongst the clinical supervisors. For instance, two supervisees depicted their clinical supervisors as competent. One supervisee perceived the supervisor as inappropriately personally disclosing. Two supervisees referred to the organisational skills of their supervisors (one described as efficient, another disorganised).

Table 14

*Supervisee Descriptions of their Clinical Supervisor in Poor Clinical Supervision Experiences*

Supervisee	Descriptions of the clinical supervisor
1	Distracted, abrupt, negative, moody, aggressive, rude, task focused, untrustworthy, unsupportive, lacked empathy, rushed, hyperactive
2	Strange, flirtatious, personally disclosing, uninvolved
3	High expectations, organised, competent, respectful, encouraging
4	Confident, intimidating, distant, scrutinizing, focused on the negative, overcommitted, not easy to trust or be open with, stressed
5	Probably very competent clinically, courteous, inadequate organisational skills, didn't feedback in a timely manner

Supervisees' descriptions of clinical supervisors within harmful clinical supervision experiences, while also diverse, appeared to contain a few more commonalities (see Table 15). In three out of the five transcripts, there was some reference to a theoretically knowledgeable supervisor who brought this focus into clinical supervision. Within three transcripts there were references to the supervisor being unsupportive, indicating supervisees perceived a deficit in the interpersonal approach their supervisors brought into clinical supervision. In two transcripts, references to power games or misuse of power suggested that these supervisees experienced some issues around how supervisor power was used within the supervisory relationships.

Table 15

*Supervisee Descriptions of their Clinical Supervisor in Harmful Clinical Supervision Experiences*

Supervisee	Descriptions of the clinical supervisor
6	Dogmatic, insecure, insensitive, opinionated, closed, superior, good thinker, knowledgeable of theory, insightful, kind-hearted
7	Not a natural leader, anxious, unsupportive clinically, friendly, open, approachable, humorous, self-effacing, academic, supportive in an administrative sense.
8	Jargonistic, unapproachable, closed, uncommunicative, theory focused, played power games, impaired, well qualified, superficial
9	Skilled, unsupportive, not encouraging, critical and blaming, demanding, high expectations
10	By the book, manipulative, unsupportive, uncommunicative, distant, aware of power, duplicitous

### *8.3.3 The Relationship between Supervisor and Supervisee*

Supervisees were asked to describe the nature of their relationship with their respective clinical supervisor. For supervisees reporting poor clinical supervision experiences, there was a range of descriptions of their supervisory relationships (see Table 16). Two of the five supervisees were able to spontaneously report positive aspects to the relationship. Of the remaining three supervisees, one reported that the relationship was marred by the lack of confidentiality with which any supervisee disclosure was treated. For another, the supervisor was portrayed as relatively disinterested in the supervisee. The third supervisee described the clinical supervisor's approach as intimidating and unsupportive.

Table 16

*Depictions of the Relationship between Supervisor and Supervisee in Poor Clinical Supervision Experiences*

Supervisee	Descriptions of the supervisory relationship
1	Just a person I had to see to get the supervision done. I wasn't comfortable talking to ____ about personal issues. What you told ____ wasn't treated seriously or went further.
2	____ was more interested in himself or herself than me.
3	We got on well together. ____ was encouraging, but there was lack of supervision and support for a period of time.
4	Hierarchical. ____ was in a powerful position and used it to advantage. I found ____ intimidating and I didn't trust ____.
5	A professional relationship with mutual courtesy and respect.

For supervisees reporting harmful clinical experiences, their descriptions indicated some of the many ways in which relationships can be unproductive or uncomfortable. While each relationship had unique features, supervisee descriptions of their supervisory relationships presented a picture of alliances that were unsupportive, unclear, and lacking in collaborative focus (see Table 17). For three supervisees, there was the sense that they were in a “no win” situation, where any action or approach would be misconstrued or misinterpreted.

Table 17

*Depictions of the Relationship between Supervisor and Supervisee in Harmful Clinical Supervision Experiences*

Supervisee	Descriptions of the supervisory relationship
6	There were too many times when I had been railroaded by ____ to have a good relationship.
7	Before the incident ____ treated me like a confidant, which I didn't feel comfortable about. Afterwards, it was just plain tense.
8	There were a lot of power games and if I didn't play, ____ would invite me into the office saying ____ was sensing a lot of resistance from me and we needed to get past it.
9	There was no trust, no rapport; no support or encouragement. It was criticism, it was blame. There was no acknowledgement that we both have to work through this.
10	I felt that I had to be careful not to do the wrong thing, to not show too much initiative. I felt like if I showed too much initiative that would displease ____, if I didn't that would also displease ____, so I didn't feel like I could really win.

#### *8.3.4 Similarities and Differences between Supervisor and Supervisee*

Supervisees were also asked to compare themselves with their clinical supervisors. As the only guideline supplied was for supervisees to explore similarities and differences between themselves and their clinical supervisors, this question was left relatively open to interpretation. This general approach was used as an indirect means for exploring personality differences and their role in less than positive clinical supervision.

Two supervisees reporting poor clinical supervision experiences focused on the less empathic approach of their respective supervisors. Another two interviewees reflected on the different ideas of clinical supervision that appeared to be held by themselves and their supervisors. While transcripts indicated that interviewees perceived significant differences between their work style and that of their supervisor in poor supervision experiences, three of the five supervisees were able to pinpoint similarities as well as differences (see Table 18).

Table 18

*Descriptions of Similarities and Differences between Supervisor and Supervisee in Poor Clinical Supervision Experiences*

Supervisee	Supervisee descriptions of supervisor and supervisee
1	I like to show and feel a lot of empathy for people. And ____ is very opposite, just straight down the line in a negative way. We did share similar ideas and commitment to the work.
2	I felt that I was more empathic towards clients, whereas the supervisor was focused on generating work as a business approach. I found myself focusing on client difficulties rather than what service provision we could negotiate with them.
3	We both were hardworking, motivated, perfectionist and able to see the funny side of things. ____ level of knowledge made us different. Perhaps different also around our valuing of the supervision experience and the role of supervisor.



Supervisee	Supervisee descriptions of supervisor and supervisee
4	I'm more personable in my approach and look at people as being more equal. ____ used that power to ____ advantage. Yeah, quite abrupt, very, I suppose what you'd call honest but not in a positive way.
5	Same gender, same theoretical orientation. Different in the work loads that we had. Probably different in our ideas about supervision. ____ was probably quite happy to go along and provide a bit of feedback here and a bit of feedback there.

Four of the supervisees reporting harmful clinical supervision experiences identified significant differences between their own approach and that of their supervisors. This included difference in level of openness to new ideas, in their orientation towards client work or theory, in the level of helpfulness and support they provided to others, and in work style (see Table 19). In contrast, one supervisee described a process of reactivity where he or she became drawn into the relationship dynamics and matched the supervisor in antagonism and lack of openness exhibited in the supervisory relationship.

Table 19

*Descriptions of Similarities and Differences between Supervisor and Supervisee in Harmful Clinical Supervision Experiences*

Supervisee	Supervisee descriptions of supervisor and supervisee
6	I am quite open to other people's ideas about things, about me and my work and I hope to learn from them. ____ seems quite closed and quite dogmatic, unwilling to reflect really about...
7	I'm perhaps more naturally a therapist, whereas I think my supervisor would have been good at putting academic documents together.
8	I think I probably got very caught up in it and I would go into meetings hostile and I closed down. I'm sort of reactive in that way I suppose; if ____ had been open, I would have been open but because ____ was closed I became quite closed and couldn't raise topics. I would always just work it out on my own.
9	I am helpful and supportive person. I will try to get something right, but realise I am learning. I found that this supervisor was not supportive or encouraging.
10	I think we certainly had a clash of personalities. I wasn't subservient enough perhaps, so we differed in that we had different expectations of what our relationship should be.

### *8.3.5 Personal Effects of Less Than Positive Clinical Supervision*

Interviewees were asked what their supervision experience was like for them personally. A range of personal effects were raised during the interviews with supervisees experiencing poor clinical supervision (see Table 20). Some of the impacts described included the experience of fear, isolation, stress, disappointment, and frustration. For four of the supervisees, the effects were depicted as wholly

negative. One supervisee was able to conceptualise the experience as a positive learning experience, despite the presence of some negative impacts.

Table 20

*Personal Effects of Poor Clinical Supervision*

Supervisee	Personal effects arising from poor clinical supervision
1	My own stuff was coming up and there was no one to discuss the issues with. I had to try to deal with things alone and find the tools to do it.
2	Emotionally stressful, frustrating, a lack of trust.
3	Frustrating, stressful. A great learning curve.
4	It knocked my confidence and I felt scared of counselling, the profession and the system. I felt flat about things. I was often very emotional and I didn't look forward to going to the placement.
5	Disappointing. It did nothing to help me want to stay in the profession.

Personal impacts of a physical and psychological nature were depicted by supervisees reporting harmful clinical supervision experiences (see Table 21). Most common in the dialogues were the emotional and psychological effects that the interviewees experienced, including loss of trust and self-confidence, shock, anger, distress, and emotional pain. One supervisee reported intense physical impacts associated with the harmful supervision experience. None of the interviewees spontaneously raised any positive effects from their nominated experiences.

Table 21

*Personal Effects of Harmful Clinical Supervision*

Supervisee	Personal effects arising from harmful clinical supervision
6	Confusion. I was quite upset. I had to see a client right afterwards. I was angry too. Self-doubt and painful self-reflection occurred later.
7	Upset, isolated, a lack of support, shocked, morally shaken. It raised my stress level. I felt I can't learn anymore. I can't trust this person who is supposed to be there for me.
8	It was costly. I developed psychological problems – insomnia, rumination. I was unhappy about going to work. I had to vent to my partner every day. I would wake 5am in the morning....
9	It affected me physically & mentally. I had recurring attacks... I would be getting to work and I would be holding back the tears.
10	It was really painful. I felt undermined, completely useless. It was crushing to my confidence. It was really harmful.

*8.3.6 Why the Supervision Experience Was Less Than Positive*

Interviewees were asked to elucidate why they thought their nominated supervision experience was less than positive. While the reasons perceived as underlying poor clinical supervision experiences were clearly diverse (see Table 22), they supported the perception of significant supervisor responsibility for and involvement in the occurrence of poor clinical supervision. Two supervisees spontaneously referred to some aspect of the organisational context as also contributing to their experiences of poor supervision.

Table 22

*Reasons Supervisees Chose to Explain Poor Clinical Supervision Experiences*

Supervisee	Reasons for poor clinical supervision
1	Multiple breaches of confidentiality by supervisor.
2	The supervisor did not put thought into how the placement might work.
3	Incongruent expectations about clinical supervision.
4	No set goals; no relationship in supervision; the large workload of the supervisor.
5	Sporadic supervision; untimely and critical feedback about suitability to enter field; organisational priorities unsupportive of students.

Supervisees reporting harmful clinical supervision experiences described a range of lacks in relation to their nominated supervision experience. As indicated in Table 23, this included lack of sensitivity, an absence of rich learning, inadequate supervision, lack of encouragement, and absence of formative feedback. For three of the five supervisees, there was evidence of their spontaneous recognition of contributory factors to harmful clinical supervision (for instance, supervisee factors, client factors, the demands of setting up a new service).

Table 23

*Reasons Supervisees Chose to Explain Harmful Clinical Supervision Experiences*

Supervisee	Reasons for harmful clinical supervision
6	Lack of attunement and a lack of sensitivity displayed by my supervisor; personality factors (of supervisor & supervisee).
7	Absence of rich learning; I wasn't getting the same things as in previous supervision, not from the relationship.
8	Lack of adequate supervision for undertaking complex client work.
9	A critical supervisor who provided no reassurance; it was also a new service without necessary infrastructure and procedures in place.
10	My supervisor didn't communicate with me about how I was going.

*8.3.7 Contributing Factors to Less Than Positive Clinical Supervision*

In order to obtain a broader picture of the nature and range of factors that might underpin poor and harmful clinical supervision, supervisees were asked to describe what factors seemed to contribute to their less than positive clinical supervision experience. The categories of personal factors, interpersonal factors, client factors, and institutional factors were mentioned by the interviewer as possibilities that interviewees might like to consider. None of these categories were clearly defined for supervisees, but instead were presented as possible areas that may be relevant to talk about in relation to their less than positive clinical supervision.

With respect to the poor clinical supervision experiences, a theme common to all experiences was the presence of contextual factors impacting on supervision and placement (see Table 24). One supervisee found the nature of the client work stressful, exacerbated by the lack of support he or she felt from the supervisor. Another supervisee completed a placement without undertaking direct client work

at all. Two supervisees reported comparable pressures of working within programs where the organisational needs impacted on their clinical supervision. In both cases, the supervisees also recognised that personality differences fed into the less than positive supervision. One supervisee reported pressure to stay at a placement despite the absence of the supervisor.

Table 24

*Contributory Factors Supervisees Chose to Explain Poor Clinical Supervision Experiences*

Supervisee	Contributing factors to poor clinical supervision
1	The job was stressful; I couldn't talk to my supervisor.
2	Even with the best supervisor in the world I still wouldn't have been able to see clients.
3	Supervisor's absence; pressure to remain at the placement for other reasons.
4	Probably institutional in the sense that my supervisor was overworked. There was a personality clash as well.
5	Institutional in that I worked in a program that was driven by numbers. There were personality differences as well, more with the program supervisor than the clinical supervisor.

The contributing factors to harmful clinical supervision experiences were multiple (see Table 25). For three supervisees, their placement experiences took place at a time of significant organisational change. For the remaining two supervisees, institutional factors were perceived as playing a part or contributing to their experiences of harmful clinical supervision. All supervisees perceived the style of the supervisor as being important in their experiences of harmful clinical supervision. Within harmful experiences, only one supervisee referred directly to the nature of the client work impacting on supervision effectiveness.

Table 25

*Contributory Factors Supervisees Chose to Explain Harmful Clinical Supervision Experiences*

Supervisee	Contributing factors to harmful clinical supervision
6	Personal factors (me not being able to protect myself well); the supervisor's interactive style (opinionated; not a listener); the institutional context meant __ was able to comment on me in that manner.
7	Personality and style of supervisor (I was disappointed); institutional changes were occurring at the time.
8	Complex client work requiring support; unsupportive institutional environment; supervisor style and supervisor psychological problems.
9	The dual relationship – the difficulties initiated from this; supervisor's style (no encouragement or mentoring); a new institution (e.g., lack of procedures and processes in place); an interaction between the needs of the workplace and clinical supervision.
10	The style of supervisor; a personality clash; the dual relationship; major changes were occurring within the organisation.

In two experiences of harmful clinical supervision, dual supervisor roles were described as the critical initiating factor for harmful clinical supervision. In one experience, the supervisee was employed by an organization where the clinical supervisor for registration purposes and the Manager was the same person. Confusion as to the nature and content of clinical supervision and supervisee disappointment with the continued focus on administrative matters was regarded as problematic. For the other supervisee, having a university lecturer as supervisor was perceived as constraining to the development of a professional identity. In a third experience of harmful clinical supervision, a dual supervisor/lecturer relationship,



while not necessarily presenting as an issue during placement, was perceived as an issue after completion of placement in terms of ongoing contact in the university context.

### *8.3.8 The Early Experience of Less Than Positive Clinical Supervision*

Interviewees were asked to recall their early experience of less than positive clinical supervision. With respect to the poor clinical supervision experiences (see Table 26), three supervisees found the early relationship in clinical supervision to be relatively positive, with little if any sign of difficulties. A fourth supervisee reported that the relationship seemed okay, although there were early indicators of the supervisor's unfriendly manner. In contrast to the experiences reported by the other supervisees in this study, one supervisee found that the placement started badly, but improved over time.

Table 26

#### *Supervisee Perceptions of Early On In Poor Clinical Supervision Experiences*

Supervisee	Early perceptions of poor clinical supervision
1	___'s rude personality was evident, but it seemed okay.
2	Positive, able to talk openly, full of positive expectations.
3	It was quite okay. She organised meetings, which were beneficial. My thinking was challenged.
4	It started badly, probably got better as I learnt something. It was unstructured. There wasn't really a role for me at the start.
5	I think it was fairly positive. We discussed the level of supervision expected. For the first month or so, I was able to get regular supervision, but it sort of changed.

Supervisee perceptions of the early stages of harmful supervision experiences were also varied (see Table 27). Two supervisees reported finding their initial experience of harmful clinical supervision positive. A third supervisee felt unable to classify it because of a lack of any previous experience to form a basis for comparison. Another supervisee described the experience as more managerial than

clinical in focus, less satisfying than the previous supervisory relationship. A fifth supervisee reported that issues were probably present from the beginning of supervision, describing the early experience as superficial and stilted, unclear and unsupportive.

Table 27

*Supervisee Perceptions of Early On In Harmful Clinical Supervision Experiences*

Supervisee	Early perceptions of harmful clinical supervision
6	The early part was good. I was open to learning. ___ was knowledgeable. We talked well. It felt reasonably comfortable.
7	It was a less satisfying relationship than with my previous supervisor. ___ was supportive, but in an administrative sense. I felt accountable. ___ wasn't so interested in professional development, what I was learning or experiencing with a client.
8	Superficial. Stilted. ___ wouldn't reassure, explain. ___ didn't refer back to the goals of supervision. It was bad from the beginning.
9	I had no previous supervisory experience to compare with. I thought this must be the way supervision goes. Then problems arose.
10	I felt it was good. I will be supported. ___ is interested in me. ___ is organised, experienced. I felt confident.

*8.3.9 One Incident or Many in Less Than Positive Clinical Supervision*

As a way of exploring the role of relational ruptures and repairs within the process of less than positive supervision, supervisees were asked whether one event or many accounted for their experiences of less than positive clinical supervision. With respect to poor clinical supervision experiences, four supervisees discussed a number of key events, with only one attributing the poor experience to one event. For two supervisees, there was a key event. In one case, the clinical supervisor

raised a number of critical issues (including the supervisee's suitability for entering the profession) in a supervision session just prior to ending of the placement. In the other, the supervisor's absence was considered to be the only salient reason for poor clinical supervision. For four supervisees, as expected in any rupture-repair process, a number of issues arose during the supervisory relationship (see Table 28).

Table 28

*Number of Incidents in Poor Clinical Supervision Experiences*

Supervisee	Number of incidents in poor clinical supervision experiences
1	A few incidents, with breach of confidentiality incidents most important.
2	There were a number of events. There was nothing much to talk about in supervision. One event was of paramount importance.
3	One event. The supervisor's absence.
4	Probably just a continuous struggling to get time to see my supervisor. So often ____ didn't want to even have supervision.
5	Multiple, although there was one session where the supervisor brought everything up.

For four supervisees reporting harmful clinical supervision experiences, looking back there was one key event, but it was encompassed within many others that were not always recognized at the time. As indicated in Table 29, for all supervisees harmful clinical supervision was not perceived as related to one negative or conflictual event in isolation, but instead was encompassed within a general experience that could be described as less than positive when viewed in its entirety.

Table 29

*Number of Incidents in Harmful Clinical Supervision Experiences*

Supervisee	Number of incidents involved in harmful clinical supervision experiences
6	It was the general experience. I would have got sick of ___ anyway. But one incident was critical.
7	There were a number of incidents.
8	Among many, many incidents, one really stands out.
9	A few, but one was really the catalyst for it all falling apart.
10	I felt set up to fail throughout the placement. There were these sorts of clashes of ideas, which I saw as differences of opinion at the time. But there was one key event at the end.

*8.3.10 Effect on Progress through Training*

As indicated in Table 30, the most common general effect on progress through training described by supervisees experiencing poor clinical supervision was the impact this experience had on the development of their professional and clinical skills. Four supervisees related professional impacts pertaining to clinical skill levels, some generally, with others pointing out specific deficits.

Table 30

*Effects on Progress through Training for Supervisees Reporting Poor Clinical Supervision Experiences*

Supervisee	Effects on progress from poor clinical supervision experiences
1	There was a lack of professional development needed to be an effective psychologist.
2	I was conscious of having to compensate for the lack of clients in this placement.
3	I felt behind others in my assessment skills.
4	It affected my progress in this particular placement, particularly in terms of my group skills.
5	Probably none.

For supervisees reporting harmful clinical supervision experiences, two of the five reported reduced learning or limited skill development. Two supervisees raised the impact of the experience on their chosen career path with one deciding not to pursue a career in clinical work and the other questioning the high regard with which they had previously held a career in psychology. Three supervisees mentioned some probable gain from the adversity they had experienced (see Table 31).

Table 31

*Effects on Progress through Training for Supervisees Reporting Harmful Clinical Supervision Experiences*

Supervisee	Effects on progress from harmful clinical supervision experiences
6	There is no ongoing learning that can occur from any contact with ____.
7	I was probably pushed to complete my registration requirements, so it may have actually aided my progress. It left a blemish on the whole experience of being a psychologist.
8	It probably helped in some perverse way as I became quite resourceful at thinking on my feet and not having any support. I think I could have picked up more useful skills.
9	No, with the hurdles you can sometimes get a better sense of who you are and the importance of standing up for issues of personal integrity.
10	It made me question myself and put me off working in a clinical setting.

*8.3.11 Professional Effects Arising from Less Than Positive Clinical Supervision*

Interviewees were also asked to consider the broader professional effects that may have arisen from their less than positive supervision experience. Supervisees reporting poor clinical supervision experiences highlighted a range of professional effects (see Table 32) including impacts on clinical skills (two supervisees), on future job prospects (one supervisee), and on their perceptions of what actually constitutes adequate clinical supervision (two supervisees).

Table 32

*Professional Effects Described by Supervisees Experiencing Poor Clinical Supervision*

Supervisee	Professional effects for supervisees reporting poor clinical supervision experiences
1	It affected the clinical work I was doing at the time.
2	I went for a job recently in the same area of work and I was unable to say anything about the placement.
3	My assessment skills were less than that of my peers.
4	If I ever supervise students, I will approach it in a completely different light having had that negative experience.
5	It has motivated me to ensure I have adequate supervision in my employment.

Likewise, supervisees reporting harmful clinical supervision also pinpointed a range of professional effects (see Table 33), including changes in their perceptions of and expectations from clinical supervision (two supervisees), negative impacts on clinical learning (one supervisee), some positive learning (one supervisee), and a change in career path (one supervisee).

Table 33

*Professional Effects Described by Supervisees Reporting Harmful Clinical Supervision*

Supervisee	Professional effects for supervisees reporting harmful clinical supervision experiences
6	It has made me more wary of supervision and of people who think they know you.
7	I am a bit more realistic about supervision, less idealistic about my expectations.
8	I hope I have made up some ground since then.
9	Out of adversity you take some really strong lessons.
10	It reinforced my interest in a different career path that uses my talents and abilities.

*8.3.12 Attempts at Direct Resolution of the Issues*

Interviewees were asked whether they endeavoured to directly resolve the issues that arose within less than positive supervision with their clinical supervisor. With respect to poor clinical supervision experiences (see Table 34), for three supervisees there was some direct attempt at resolution of the issues, although in two cases the clinical supervisor and not the supervisee initiated this. For two supervisees, there was no direct discussion of the issues arising.

Table 34

*Attempts at Direct Resolution with Clinical Supervisor in Poor Supervision Experiences*

Supervisee	Attempted direct resolution with supervisor
1	No. Lack of trust was an impediment to this.
2	Yes, the supervisor initiated the meeting.
3	We never discussed what happened.
4	Yes, both with the supervisor and the university.
5	I engaged in discussion about the feedback in the session.



For interviewees reporting harmful clinical supervision experiences, the most common response was there was no direct attempt at resolution of the issues (see Table 35). Four supervisees believed that they could not undertake discussion of their concerns with their clinical supervisors. For the only supervisee who did engage the supervisor in a discussion of feedback (in this case that the supervisee was not suited to clinical work), the supervisee reported that the supervisor would not engage in any discussion of the reasons underpinning this evaluative opinion.

Table 35

*Attempts at Direct Resolution with Clinical Supervisor in Harmful Supervision Experiences*

Supervisee	Attempted direct resolution with supervisor within harmful clinical supervision experiences
6	No. I didn't feel comfortable with ___ and I didn't want to.
7	I didn't feel comfortable talking directly with ___ at the time.
8	I didn't say anything about the resentment I was feeling and the little respect I had for ___.
9	No. ___ saw almost any interaction as a personal attack.
10	Yes, telling the supervisor that the feedback came as a real surprise. I said I was unaware of ___ feelings. The supervisor didn't want to explain these feelings and didn't.

*8.3.13 Final Resolution of Issues in Less Than Positive Clinical Supervision*

Interviewees were asked whether the matters of concern were ever resolved. In the case of poor clinical supervision experiences, matters remained unresolved in some areas for four supervisees (see Table 36). In contrast, one of the three supervisees who had engaged in a direct discussion with the clinical supervisor

about the negative feedback felt that matters were resolved from the perception of both supervisor and supervisee.

Table 36

*Achievement of Final Resolution of Issues in Poor Clinical Supervision*

Supervisee	Issues ever resolved in poor clinical supervision experiences
1	No...it got to the point where ____ lost my trust.
2	As much as it could be. We did consider how things would be done if we had the placement over again. But it wasn't enough.
3	It was resolved as far as ____ was concerned, but not as far as I was concerned.
4	I'd say it wasn't resolved. I accepted the fact that I was only going to get 10 or 15 minutes of supervision a week.
5	Yes, probably for both parties.

For all supervisees reporting harmful clinical supervision experiences, there was no final resolution of the issues of concern (see Table 37). For the supervisee who engaged in direct discussion about the issues, the issues also remained unresolved.

Table 37

*Achievement of Final Resolution of Issues in Harmful Clinical Supervision*

Supervisee	Issues resolved in harmful clinical supervision experiences
6	For me, within myself, yes. But not between ____ and me.
7	No ...there has been no response from the supervisor.
8	No, not at all.
9	No, it couldn't be resolved.
10	No, it was put under the carpet...

### 8.3.14 Awareness of Procedures in Place to Deal with Less Than Positive Supervision

Interviewees were asked about their awareness of procedures in place to assist them with dealing with less than positive clinical supervision. For supervisees reporting poor clinical supervision experiences, three supervisees believed they were adequately aware of actual procedures for conflict resolution in clinical supervision and investigated use of these procedures. Of these, two contacted the university but did not find this assisted in resolution (see Table 38). The other supervisee was relatively happy with the support provided by the university. Of the two supervisees who stated they were unaware of conflict resolution procedures, one was undertaking Doctorate studies and the other paid psychological work after completing 4 years of accredited studies. The first of these supervisees did try to take up concerns with a supervisor at the university, but was dissatisfied with the response received and was unaware of additional avenues to pursue.

Table 38

#### *Awareness of Procedures to Deal with Poor Supervision Experiences*

Supervisee and basis of registration	Awareness of procedures in poor clinical supervision experiences
1 (4 years study)	No. I thought you just changed supervisors.
2 (Doctorate)	Yes, you contact the university.
3 (Doctorate)	I was aware the Placement Coordinator would know the right action.
4 (Doctorate)	I had absolutely no idea. I went to the supervisor at the university and tried to discuss it. I still don't know of any actual procedures, anything that I could have done.
5 (Masters)	Yes, you could go to the Placement Coordinator.

For supervisees reporting harmful clinical supervision experiences, only one reported a lack of knowledge of conflict resolution procedures (see Table 39). For two supervisees who initiated complaint procedures (one through their university,

one through management), there was a sense of futility about their effectiveness, with one supervisee frustrated by the time it took for the issues to be taken up by the university. This supervisee ceased using these procedures feeling that to continue may have done more harm than good. A third supervisee initiated complaint resolution procedures, in this case through management, but found the processes contributed to a total breakdown in supervision.

Table 39

*Awareness of Procedures to Deal with Harmful Supervision Experiences*

Supervisee and basis of registration	Awareness of procedures in harmful clinical supervision experiences
6 (Doctorate)	I could have talked to the Course Coordinator and my other supervisor. But it was a bit of a grey area.
7 (4 years)	Not really. I was aware that I could ask or demand another supervisor at the time.
8 (Masters)	Yes, the manager (of the supervisor) would have been happy to talk about it. But it was too risky, and I didn't feel strong enough nor supported enough.
9 (4 years)	There were organisational procedures, but they didn't help.
10 (Doctorate)	Yes. I made a formal complaint, but it didn't assist in the short or long term.

*8.3.15 Resolution of Any Internal Conflict*

Supervisees reporting poor clinical supervision experiences generally perceived that they had resolved any internal conflict associated with their less than positive clinical supervision experience (see Table 40). They reported a general feeling of having learnt from the experience and having taken something from it for future reference.

Table 40

*Resolution of any Internal Conflict Associated with the Poor Clinical Supervision Experience*

Supervisee	Resolution of internal conflict in poor clinical supervision experiences
1	Yes, although this research brought up the issue again.
2	Yes, it's in the past.
3	Any conflict I have thought through and learnt from.
4	Yes, I think I have. I don't feel I have harboured it and taken it with me.
5	Yes.

As would be expected from the definitions of poor and harmful clinical supervision used to define supervisee experiences in this research, the extent of resolution of internal conflict appeared less where supervisees reported harmful clinical supervision experiences (see Table 41). Of the four supervisees reporting less than complete resolution, there were collectively still some residual feelings of anger, guilt, distress, and for one supervisee, recurrent physiological and flashback symptoms associated with the experience of harmful clinical supervision.

Table 41

*Resolution of any Internal Conflict Associated with the Harmful Clinical Supervision Experience*

Supervisee	Resolution of internal conflict in harmful clinical supervision experiences
6	I feel better about it, but still have the question do people see me like this and do clients I see, see this. I've still got some questions and still feel quite angry about the supervisor's manner.
7	Perhaps I have. It has left me with a sort of lingering feeling of guilt. Guilt about having taken the action I did and feeling sorry for the supervisor at the time.... I suppose it leaves me with a bit of a nasty feeling ...
8	Yeah, I think it's pretty resolved within me. I was wondering if this interview would bring stuff up, but I think I've moved on...
9	There is still some residual. I haven't run into ____ yet. I think I will probably go through a bit of re-triggering when I actually see _____. I have an uncomfortable feeling when I go past. I get that sour sort of physiological tightening of the stomach.
10	I thought I was pretty okay about it until I saw your study ...It still upsets me, but I've regained my confidence.

*8.3.16 Benefits Associated With Less Than Positive Clinical Supervision*

Interviewees were asked whether any benefits had arisen from their less than positive supervision. As illustrated in Table 42, interviewees experiencing poor clinical supervision took benefits into their future, including an awareness of the need to be actively involved in the planning of supervision (two supervisees), the development of skills they can use in the future (two supervisees), and an awareness that the feedback delivered, although belated, was pertinent (one supervisee).

Table 42

*Benefits Arising from Poor Clinical Supervision Experiences*

Supervisee	Benefits arising from poor supervision experiences
1	I now recognize that you need to predetermine the supervision agreement and confidentiality requirements.
2	You need to take part in the planning of placement and be alert to what is being said.
3	Being able to work relatively independently, use my initiative, take control, work with colleagues, work closely with others, seeing I was actually able to do things...
4	...just the whole experience of working with groups and working independently, so knowing that I can accomplish something... supervising students in the future is something that I'd like to do, and I think I could identify more positive aspects.
5	Some of the belated feedback from the supervisor was relevant. It was feedback of professional development relevance.

Four supervisees reporting harmful clinical supervision were able to describe benefits arising from their experiences (see Table 43). This included benefits derived from self-reflection and learning about the self, learning to work independently, a greater awareness of the realities of work and clinical supervision, and the ability to assist others experiencing parallel situations. In contrast, one supervisee felt little was learnt from the harmful supervision experience.

Table 43

*Benefits Arising from Harmful Clinical Supervision Experiences*

Supervisee	Benefits arising from harmful clinical experiences
6	Thinking about the issue; self-reflection. These are positive things.
7	A bit more realistic about what to expect from a supervisor. A bit more about the pushes and pulls of working in a large organization with management agendas.
8	I did learn to be independent and function in a high stress environment. Maybe I learned what my limits are and what I'm prepared to put up with.
9	When I have clients going through heavy work loads or stressful situations and management problems, I think that will certainly aid me to help them through the process.
10	Not really, certainly not in terms of career or any particular special skills that I learnt there.

*8.3.17 Strategies Used to Deal With Less Than Positive Supervision*

The wider network of supports seemed critical to supervisees reporting experiences of poor clinical supervision. Talking to someone else was considered a very important strategy, in three cases emphasis was placed on someone who might have an understanding of, or experience in, what had occurred. Two supervisees referred to using relaxation techniques. For all supervisees, there was a sense of needing to get what happened into some sort of perspective outside their own personal experience through talking to others or self-reflection (see Table 44).



Table 44

*Strategies Used to Deal With Poor Clinical Supervision*

Supervisee	Strategies used in poor clinical supervision experiences
1	Meditation; the perspective of time.
2	Talking to a friend; making the best of the opportunity.
3	A lot of talking to my colleague.
4	Talking to colleagues at the placement. Setting my own goals.
5	Relaxation strategies. Venting with university supervisors. Appropriate assertiveness.

For interviewees experiencing harmful clinical supervision a mixture of talking and thought techniques were used to deal with the experience (see Table 45). Once again, being able to see the experience within its broader context appeared significant to supervisees. In addition, the importance of personal support was raised by all interviewees.

Table 45

*Strategies Used to Deal with Harmful Clinical Supervision*

Supervisee	Strategies used in harmful clinical supervision experiences
6	My own therapy. Talked to close friends. Not taking it on totally as about me.
7	Supports. Deciding at some point to let it go. I don't tend to dwell on the negatives.
8	Talking to colleagues, friends, normalising the experience. I tried relaxation techniques. It didn't help. Avoiding contact with the supervisor. Drawing the line, deciding to leave.
9	Talking about it in a supportive environment. Challenging some of my beliefs.
10	Having friends going through the same thing. Recognising the differences between my supervisor and me was important.

### 8.3.18 *A Retrospective Perspective on the Experience of Less Than Positive Clinical Supervision*

Supervisees were asked to look back on their experience and reflect on anything they could have done to repair or improve the situation. For four supervisees reporting poor supervision experiences, there was a general sense that there was probably little they could have done to repair or change what happened (see Table 46). However, two of these interviewees did raise potential strategies that could have made a difference or could be used in future supervision, such as clarifying what the supervisor expects from supervision. Two supervisees articulated the need to be more assertive about their requirements from clinical supervision.

Table 46

#### *Actions That Could Have Repaired Poor Clinical Supervision Experiences*

Supervisee	Any actions that could have been taken to repair poor clinical supervision experiences
1	Probably not, but you need to set rules and clarify expectations. A paid external supervisor may have been different.
2	No. My input into the decision-making wasn't required.
3	Probably not. The situation was what it was.
4	Probably making more effort to make sure I had my hour of supervision per week; being strong about it. I didn't really know my entitlements.
5	I suppose I probably could have been more assertive. Basically demanding what was owed to me, reasonable supervision. But I don't know what that would have achieved anyway.

Supervisees reporting harmful clinical supervision experiences displayed a range of reactions in regard to potential actions that may have repaired their supervision experience (see Table 47). One supervisee believed there was nothing that could have been done to restore the relationship. Another supervisee felt that

someone else may have, in the same circumstances, been able to resurrect the supervision experience. Three supervisees were able to revisit the supervision experience and theorise about what could have been different if they had actually raised their concerns with their respective supervisors. In all cases, consideration was given to the value of being upfront with their clinical supervisor about their experiences in supervision.

Table 47

*Actions That Could Have Repaired Harmful Clinical Supervision Experiences*

Supervisee	Any actions that could have been taken to repair harmful clinical supervision experiences
6	No, probably not as the person I am. Someone else may have been able to take up the issue.
7	Perhaps next time I will have a one to one. I did try to repair the situation. A lot was unsaid and perhaps I could have said that I am aware of the tension here, do you want to talk about it.
8	I could have laid it all out saying the impact it was having on me, the needs I had in supervision. I don't think it would have had an impact...I did really get caught up in it. It might have helped if I'd been able to buy into it less, reframed it for myself.
9	Not to let it go on so long. Be upfront about what is important to you from the start.
10	I don't think I stood a chance. I don't think there was anything I could have done.

### *8.3.19 Additional Information from Supervisees Reporting Poor Clinical Supervision*

Four supervisees reporting poor clinical supervision experiences chose to provide additional information outside the confines of the interview guide. One supervisee voiced concern about inequities in placement contexts. This supervisee believed that the ethics of the particular clinical supervisor were fundamental to whether a supervisee actually experienced a professional placement. What the clinical supervisor was prepared to say on paper becomes important, in contrast to what actually occurred on placement.

Another supervisee also voiced ethical concerns, stating that the supervisor in question had not perceived being unavailable for a period of time during placement as a problem. Regular face to face supervision was something that the supervisee expected from clinical supervision and this was not provided for a period of time. This supervisee believed this highlighted a disparity in supervisor and supervisee expectations of clinical supervision.

A third supervisee expressed concern that supervision contracts were not drawn up at the start of placements but rather left until after placements were completed. As a result, supervisees often went to placements without a clear framework of how the placement would work. Options if placements are not functioning effectively were not spelt out at the beginning of placement when they were most needed. Meeting potential supervisors prior to placement and having more than one choice of placement context were mentioned as possibilities that may limit experiences of less than positive clinical supervision. Given the lack of contracts to structure supervision, this supervisee felt there had been an element of luck in having other supervision experiences that were effective.

A fourth supervisee stated that not having adequate clinical supervision is potentially risky. This supervisee reported that having supervision about supervision (depicted as “secondary supervision”), in this case from university staff in relation to the placement, was very important. This interviewee speculated that while in some external organisations students are low in the order of priority, at least from the university’s perspective students are likely to be important. When experiencing

difficulties, this supervisee indicated that it was critical for students to utilise the university as a resource and recognise the protective value of airing their grievances.

### *8.3.20 Additional Information from Supervisees Reporting Harmful Clinical Supervision Experiences*

Four supervisees reporting harmful supervision chose to provide information in addition to what was obtained through the semi-structured interview guide. One supervisee was able to reflect on the role they may have played in the experience. In this case, the supervisor had not been in the organisation as long as the supervisee, and may have experienced some difficulties adapting to the organisation. In addition, the supervisee recognised that they had carried into this supervisory relationship their own issues of grief and loss, having lost a supervisor to whom they had formed a close connection.

A second supervisee reflected on the power that a supervisor can have over an impressionable student and the lack of checks in place to monitor this type of situation. The interviewee believed there is inadequate monitoring of the use of power by clinical supervisors who are out in the field. This supervisee reflected on how this supervision experience was really horrific to go through, and the critical role that peer support played. It was important to this supervisee to find out that other people were struggling with the same supervisor. This interviewee wished to convey to other supervisees the importance of self-care, particularly if the placement context is punitive in nature.

Two supervisees perceived dual relationships played important roles within their harmful clinical experiences. Both supervisees wished to convey the difficulties associated with dual relationships and their potential to cloud the supervisory relationship. One of these supervisees raised the need for more guidelines in universities on what is to happen in a supervisory relationship and what supervisees should reasonably be able to expect from clinical supervision.

### *8.3.21 Themes Derived from Transcripts of Interviewees Reporting Poor and Harmful Clinical Supervision Experiences*

This section reports findings from N Vivo 2.0 theme documents. Interviewee transcripts were examined with particular attention to themes in supervisee experiences of poor and harmful clinical supervision.

#### *8.3.21.1 Key Themes of Interviewees Reporting Poor Clinical Supervision Experiences*

*8.3.21.1.1 Ineffective evaluative feedback.* The nature and delivery of evaluative feedback presented as a pertinent issue for four supervisees experiencing poor clinical supervision. Three supervisees raised lack of regular formative feedback as a matter of concern. For two of these supervisees the nature of feedback received was predominantly negative rather than encouraging. For another supervisee, summative feedback questioning the supervisee's motivation and choice of profession was not congruent with the content of irregular formative feedback that preceded it. One supervisee did not raise issues per se with evaluative feedback.

*8.3.21.1.2 A weak working alliance.* Interviewees experiencing poor clinical supervision did not invariably perceive their working alliances as weak or problematic. Two supervisees perceived their supervisory relationships as relatively positive. Common to the dialogues of the remaining three supervisees who depicted their working alliances as poor was the issue of lack of trust they felt in relation to their respective supervisors. All three also portrayed their clinical supervisors as distant or uninvolved.

*8.3.21.1.3 Interpersonal style of supervisor.* Three supervisees reporting poor clinical supervision experiences raised concerns in relation to the supervisor's interpersonal approach. For two supervisees, the clinical supervisor's inability to express empathy towards clients and others was a primary issue of concern. The other supervisee described a supervisor whose use of power in interpersonal interactions was problematic.

*8.2.21.1.4 The placement context.* In the current study, three supervisees experiencing poor clinical supervision reported feeling constrained by the realities of the placement context. For one supervisee, this meant a client base of nil and the

need to integrate into an organisational culture that did not comfortably fit with his or her value system. For another, it meant completing placement within a setting that positioned students at the bottom of the hierarchy. Obtaining regular clinical supervision was a fight rather than a right. A third supervisee described confusion as to who in fact was the accountable supervisor. Set adrift within an unfamiliar organisational context, this supervisee endeavoured to find support from allied professionals outside the profession of psychology.

*8.3.21.1.5 Different expectations from supervision.* A disparity in the expectations of the supervisee and supervisor with respect to what should be offered and obtained through clinical supervision was raised by three supervisees. In one instance, there was a difference in perceptions about what would be discussed in clinical supervision. For two supervisees, the degree of structure and support from the supervisor did not meet their expectations.

*8.2.21.1.6 Tailoring supervision to the developmental level of supervisee.* Supervisor matching of the level of support and direction to the developmental level of the supervisee was not achieved from the perspective of two supervisees (also mentioned above under different expectations from supervision). One supervisee with an absent supervisor indicated that supervisor and supervisee seemingly had different ideas and expectations of what constituted necessary support for a first placement. For a second supervisee, the level of direction, support and supervision provided did not match what the supervisee perceived was required in a second placement.

*8.2.21.1.7 Unclear goals.* Lack of clarity about the goals of the placement was identified by two supervisees as an issue in their less than positive clinical supervision experiences. One supervisee reported that the choice of placement had not been adequately thought out, and consequently did not facilitate skill development. For the other supervisee, the goals of the placement were unclear at the beginning and appeared to evolve as the placement progressed.

Figure 4 provides a diagrammatic representation of the key themes drawn from supervisees' descriptions of their poor clinical experiences. Supervisor feedback was raised as a common concern for four supervisees, with the nature of the

working alliance, the organisational context of supervision, the interpersonal style of the supervisor, and differential expectations of supervisor and supervisee, reported as issues by three supervisees respectively. Unclear goals of placement and supervision, and a mismatch between the level of direction and support provided by the supervisor and expected by the supervisee, were themes identified in interview dialogues of two supervisees respectively.



*Figure 4.* A diagrammatic representation of themes derived from interview transcripts of poor clinical supervision experiences using N Vivo 2.0.

#### *8.3.21.2 Key Themes of Interviewees Reporting Harmful Clinical Supervision Experiences*

*8.3.21.2.1 A weak working alliance.* All supervisees reporting harmful clinical supervision described their working alliances in supervision as less than satisfactory. Trust issues were raised as an issue of concern by all supervisees. Examining the styles of the supervisors, three supervisees indicated there was an underlying sense of hostility from their supervisors that manifested in lack of encouragement and support and closed thinking about the approach or the ideas the supervisee brought to the work. From the perspective of these supervisees, there appeared a lack of balance between critique and encouragement in their supervisor's approach to supervision, with a predominance of critique and judgement over support and nurturance.



*8.3.21.2.2 Differences in personality and work style.* All supervisees pinpointed differences in their style of approach relative to their supervisors. This included differences in level of openness to new ideas, in orientation towards theory or applied clinical work, and in the level of helpfulness and support they provided to others. Moreover, all supervisees reporting harmful clinical supervision experiences described personality differences between themselves and their supervisors. Descriptions provided by supervisees included a supervisor perceived as having a personality disorder, another exhibiting a high level of anxiety, and a third described as unreceptive to the views of others.

*8.3.21.2.3 Ineffective evaluative feedback.* The nature of the evaluative feedback was raised as an issue for all five supervisees experiencing harmful clinical supervision. While one supervisee received feedback in a supervision session described as inaccurate, troubling, and personal, it was the lack of effective evaluative feedback that presented as the core issue for the remaining four supervisees. One supervisee described a lack of clinically relevant feedback and three supervisees a lack of regular formative feedback. In one case, the nature of the summative feedback (lack of suitability for entering profession) was unforeseen in light of formative feedback received prior to that session.

*8.3.21.2.4 Communication difficulties.* While examples of dyadic communication difficulties were evident in all interviewee dialogues, four supervisees specifically raised communication as a significant concern. Different communication issues were pinpointed by each supervisee including a supervisor who failed to communicate, another who was unable to communicate with any level of depth, a third who discouraged supervisee communication, and a fourth supervisor depicted as misunderstanding supervisee communications.

*8.3.21.2.5 The placement context.* Three supervisees related harmful clinical supervision experiences occurring within organisational environments undergoing significant change. Organisational issues were raised by an additional supervisee who characterized the work environment as punitive and non-supportive.

*8.3.21.2.6 Dual supervisor roles.* Three of the five supervisees reporting harmful clinical supervision experiences raised dual supervisor roles as an issue of

concern. One supervisee depicted a clinical supervisor/manager who gave precedence to administrative issues over development of clinical skills. A second experience of dual supervisor roles involved a clinical supervisor who was also the supervisee's lecturer. This supervisee described feeling that the power differential was magnified by the student/lecturer relationship and impacted on the supervisory relationship. For a third supervisee, the dual relationship of lecturer/clinical supervisor was more problematic after the clinical placement as issues occurring within clinical supervision remained unresolved and continued to fester afterwards. A fourth supervisee discussed how the clinical supervisor appeared more at ease with administrative duties than the role and responsibilities of clinical supervisor, but did not specifically attribute this to a dual role conflict.

*8.3.21.2.7 Supervisee role conflict.* Three supervisees who experienced harmful clinical supervision were in paid employment and thus had to manage an additional role as part of their supervisory relationships. Two of these supervisees were employed whilst undertaking supervised psychological work. One described how role conflict arose as he or she was asked to be a confidant for the clinical supervisor in relation to a number of workplace issues. Both supervisees perceived that administrative concerns took precedence over clinical work. For a third supervisee undertaking paid work during Master level studies, the expectations of the clinical supervisor for supervisee clinical work were described as beyond the skill level of a probationary psychologist.

*8.3.21.2.8 Supervisor misuse of power and supervisor impairment.* Two supervisees raised misuse of power as being of concern in their harmful clinical supervision experiences. Both supervisees related experiences of feeling powerless to resolve issues as any endeavour to discuss concerns was negatively interpreted by their respective supervisors. For one supervisee, the dual supervisor/lecturer relationship was perceived as impeding his or her attempts to foster a collaborative collegial relationship. For the other, supervisor impairment was perceived as a causative factor within harmful supervision. This clinical supervisor was described as having mental health issues that impeded his or her capacity to supervise a number of people at the workplace.

Figure 5 provides a diagrammatic representation of some of the common themes drawn from supervisees' descriptions of their harmful clinical experiences. The nature and/or style of supervisor feedback, the nature of the working alliance, and personality and work style differences, were concerns for all supervisees. Communication difficulties with the clinical supervisor and organisational concerns were raised by four supervisees. Dual supervisor role impacts were described by three supervisees. It was noted that three supervisees reporting harmful clinical supervision were in paid work, adding an additional role to the repertoire of psychologist, student, colleague and client. Supervisor misuse of power was an identified theme in interviews with two supervisees, with supervisor impairment referred to in one of these interviews.



*Figure 5.* A diagrammatic representation of themes derived from interview transcripts of harmful clinical supervision experiences using N Vivo 2.0.

#### *8.3.22 Participant Feedback on Findings and Later Perceptions of Poor and Harmful Clinical Supervision Experiences*

Eight of the original ten interviewees responded to an e-mail sent 18 months to 2 years after their initial interviews asking supervisees whether they were willing to be involved in the auditing process and provide additional feedback. At the time of follow-up, one participant was not contactable due to a change in workplace and another did not respond to a preliminary e-mail or follow-up e-mail asking about

further participation. Four interviewees who reported poor clinical supervision experiences and four interviewees from the harmful clinical supervision group responded to the follow-up e-mail and expressed interest in participating in the auditing and follow-up process. A covering letter (see Appendix 13) and sections' 8.3.1 through to and including 8.3.18 of the Results section above were e-mailed to the 8 participants.

Approximately one month after e-mailing the sections for auditing, 6 of the 8 interviewees had provided written e-mailed feedback on the accuracy of the selected key phrases and an update on how they viewed their less than positive supervision experience 2 years on. A second e-mail was sent to the two remaining interviewees informing them that participation in the follow-up was voluntary and that if they would still like to respond, there was about 2 weeks remaining before I compiled this information. No response was received from these interviewees.

Of the six interviewees participating in the auditing process, five stated that their supervision experiences had been accurately represented in the key phrases selected by the principal researcher-interviewer. One interviewee (the first in the harmful group) stated that he or she may not have expressed clearly enough in the interview their belief that the clinical supervisor had based his or her whole theory and discussion of the therapy issue in question on the wrong end of the stick. This supervisee felt that at the time of the supervision session in question he or she had not had the confidence and presence of mind to say to the clinical supervisor that their perception was entirely wrong.

Tables 48 and 49 contain key phrases selected to represent where the respondents are now in terms of their least positive supervision experience. For the three supervisees reporting poor clinical supervision experiences, there appeared to be increasing awareness of the broader context of clinical supervision and placement. This included one interviewee's concern that students generally are not given the recognition they are due, another's growing awareness that the system rather than the individual supervisor may have been at fault, and the third supervisee's ensuing recognition that other supervisees had experienced negative impacts from the same clinical supervisor.

Table 48

*Supervisee Perceptions 18 Months to Two Years after the Poor Clinical Supervision Experience*

Supervisee	Current perceptions of the supervision experience
1	Not contactable.
2	I still get angry about what a waste of my time the placement was. I am amazed that such low value is placed on students and what they contribute, when they are the staff of the future.
3	Originally contactable. No response to auditing process.
4	I have more understanding that the supervisor most likely had no training or support in supervision and thus I blame this person less and see that the system failed me not the individual.
5	I am feeling vindicated after a recent discussion with another psychologist who also had a negative experience with the individual in question and news that ___ has been demoted.

Respondents reporting harmful clinical supervision experiences appeared to tailor their responses to what they had learnt from their experiences and perceptual or attitudinal shifts in the intervening 2 years (see Table 49). Despite still depicting the supervision experience as harmful, respondents were able to describe how their perceptions, understanding, or behaviour had altered since the first interview.

Table 49

*Supervisee Perceptions 18 Months to Two Years after the Harmful Clinical Supervision Experience*

Supervisee	Current perceptions of the supervision experience
6	I still see things the same. I still think it was inappropriate, but I might deal with it a bit more assertively now.
7	Not contactable.
8	I have a better understanding of the limits of supervision, and know that if my current supervision is not helpful I have the right and ability to change the situation to get what I need. I still keep in contact with other “victims.” I still feel bitter about ____...but there is life after harmful supervision.
9	No response.
10	I still feel the same way, however, in the intervening period, I've had some successes which have strengthened my confidence in myself and my ability to do good and useful work with clients. In terms of the actual supervisor, I see ____ from time to time but have no respect for ____.

Three supervisees responded directly to the question inquiring about what might have been responsible for any perceptual or attitudinal shifts that had occurred since their nominated least positive supervision experience. The passing of time, the development of an autonomous professional identity, further clinical experience, and maturity, were raised by supervisees as significant in explaining some of the changes that have occurred in their perceptions since the interviews. Participating in the in-depth interview was not considered as significant to this process by any of these interviewees.

## 8.4 Discussion

### *8.4.1 Participant Diversity*

The participants in this study were diverse in terms of age (a range of 25 years), in the nature of settings where their clinical supervision occurred (hospitals, prisons, community agencies, a university clinic, and private company), and in terms of their progress through probationary registration (at different stages within their studies and supervised psychological work). While diversity may impede attempts to generalise findings into a relatively unified structure, at the current preliminary stage of our understanding (Ellis, 2001) in-depth study of individual experiences does afford a constructive basis for seeking underlying factors that potentially contribute to less than positive clinical supervision. Moreover, varied manifestations of less than positive clinical supervision may broaden our present understanding of the phenomena under investigation.

### *8.4.2 Contracting for Clinical Supervision*

While many of the experiences discussed by interviewees occurred a number of years before (four of poor experiences in 2003, one in 2002; two harmful experiences in 2001 & 2003, one in 2002), it was still unanticipated to find an absence of supervision contracts in many supervision experiences described in this study. It is generally considered important for probationary psychologists to have some form of written contractual agreement to give both relational context and structure to clinical supervision (Bernard & Goodyear, 2004; Holloway, 1995). Moreover, the Psychologists Registration Board of Victoria Guidelines (both Interim and new 2005 Guidelines) require a supervision contract or plan to guide supervision, and APS Ethical Guidelines (2006) indicate that a collaborative supervision contract *should* be constructed and be regularly reviewed (Supervision Guideline 6.3). Yet most supervisees in this study stated that this was not the case in their nominated least positive supervision experience. Only two supervisees reporting poor supervision experiences and one supervisee reporting harmful clinical supervision stated that they had specific written contracts to guide clinical supervision. Although a further two participants had less structured agreements (one

was verbal, another covered some aspects of supervision in the placement contract), it is possible that such agreements did not cover key aspects of clinical supervision.

A possible explanation for the limited use of specific supervision contracts amongst supervisees in the current study is that some placement coordinators and clinical supervisors may have considered that placement contracts offer ample opportunity for coverage of the key aspects of clinical supervision. Yet whether multiple goals pertaining to areas such as therapeutic competencies, the tenets of professional practice, and therapeutic interventions can be documented in sufficient detail within a placement contract is uncertain. Moreover, ongoing review and refinement of supervision goals and tasks in turn require a living document available for perusal, discussion, and editing on a regular basis. It is doubtful whether this could be achieved solely through a placement contract which is often used in preliminary stages of placements to set up the parameters of the work to be undertaken by probationary psychologists. It is also worth noting that clinical supervisors are not necessarily directly involved in the programs in which supervisees undertake client work. Thus placement and clinical supervision are not automatically overlapping arrangements for all supervisees.

#### *8.4.3 The Nature of Supervisee Experiences of Less Than Positive Clinical Supervision*

A range of experiences were discussed by interviewees in this study highlighting the probability that had a larger or different sample of probationary psychologists volunteered, a somewhat different range of experiences of poor and harmful clinical supervision would have been revealed. This diversity may at least in part have been due to the inclusion in the current study of participants from the two alternate pathways to full registration, the 4 years of accredited study followed by 480 days of supervised psychological work, and the higher (masters or doctoral) degree options.

In terms of the rupture-repair nature of less than positive clinical supervision, nine of the ten experiences related by interviewees involved a number of events, indicating that less than positive clinical supervision (whether poor or harmful) appears most likely to occur as part of an ongoing process and not arise from a



single, adverse event. Even for the interviewee who attributed his or her poor supervision experience to one event the event in question occurred over a number of months with implications felt in a number of areas of supervisee performance. That less than positive clinical supervision appears often to be expressed through a number of events over a supervision experience lends some tentative support to the assertion by Nelson et al. (2001) that the clinical supervisor's ability to manage interpersonal conflicts within the supervisory relationship may be a critical competency necessary for effective clinical supervision to occur.

#### *8.4.4 Underpinning Variables in Poor and Harmful Clinical Supervision Experiences*

Participants in this research did not appear to experience difficulty articulating what they perceived to be the underlying causes and contributing factors to less than positive clinical supervision. Notably, in preliminary descriptions of less than positive clinical supervision, the style or behaviour of the clinical supervisor and the quality of the relationship between supervisor and supervisee (Tables 14 -17, 22 & 23) were perceived as significant underlying causes of three poor clinical supervision experiences and all harmful experiences. However, when asked to consider contributing influences to the experience (institutional, interpersonal, personal, client factors), a broader range of variables and richer descriptions of poor and harmful clinical supervision were obtained.

An interplay of influences were revealed in most interviewee descriptions of poor and harmful clinical supervision, with a relatively greater range of implicated variables common to supervisee descriptions of harmful clinical supervision (see Figures 3 & 4). Information derived from N Vivo theme documents indicated that the nature and timing of evaluative feedback, the quality of the working alliance, and supervisor work style and personality were concerns for all supervisees reporting harmful clinical supervision experiences. Communication difficulties with the supervisor and impacts from organisational change were raised by most interviewees. While no variable was found to be common to all poor supervision experiences, the nature and timing of evaluative feedback, the quality of the working alliance, organisational issues, the style of the supervisor, and unmet

supervisee expectations from supervision, were common themes in the majority of interviewee accounts of poor clinical supervision experiences. Some of the common variables derived from both detailed individual analysis of interviewee dialogues and N Vivo 2.0 theme documents are discussed below.

#### *8.4.4.1 The Working Alliance in Less Than Positive Clinical Supervision*

The early relationship in supervision was described as satisfactory or promising for about half the supervisees in this study irrespective of whether they reported poor or harmful clinical supervision. Only two supervisees clearly perceived early on in their nominated supervision experience that there were deficits in the supervisory working alliance. The current findings are not entirely consistent with those reported by Nelson and Friedlander (2001) in their study of conflictual supervisory relationships. In their study, early supervisory relationships were typified as involving supervisors perceived as remote and uncommitted to establishing a strong working alliance. In the current study, the majority of participants felt either positive or hopeful at the beginning of their supervisory relationships, which while also a relatively frequent pattern reported by participants in Nelson and Friedlander's study, was not the most typical.

A poor supervisory relationship was not a requirement for supervisees to experience poor clinical supervision. For two supervisees in the current study there was a collaborative working alliance between supervisor and supervisee that while not perfect comprised of positive characteristics. This was an unexpected finding in light of previous theory and research indicating that poor working alliances are likely to be critical to less than positive clinical supervision (Chung, Baskin & Case, 1998; Ramos-Sánchez et al., 2002). For both supervisees, factors perceived to be outside the quality of the supervisory relationship per se were raised as significant determinants of their poor supervision experiences.

Bordin's (1983) conceptualisation of the working alliance in supervision (mutual agreement and understanding of goals and tasks of supervision and emotional bond) provides a basis for considering supervisee descriptions of the supervisory relationship in poor clinical supervision experiences. For the three interviewees reporting poor working alliances, a common theme to their

descriptions was the lack of emotional bond (perceived mutual feelings of liking, caring, and trust) between supervisor and supervisee, with two also reporting lack of clarity about the goals and tasks of supervision. All three supervisees portrayed their clinical supervisors as distant or uninvolved.

Supervisees reporting harmful clinical supervision experiences all reported problematic working alliances. With the exception of one supervisee, issues within the working alliances did not appear to relate to lack of agreement or understanding of the goals and tasks of clinical supervision. Four supervisees presented a general feeling of not being heard by their clinical supervisors (e.g., see Table 17). For three of these, there was a sense of futility about making any attempt to reconnect with their supervisor or work to repair the supervisory relationship when differences of opinion or ruptures occurred. The fourth supervisee also felt cornered as the impacts of a dual supervisor role were perceived as undermining any attempt by the supervisee to discuss perceptions or issues in an objective, non-judgemental manner.

The impediments to open discussion of supervisee perceptions, issues, and concerns in clinical supervision reported in this study are reminiscent of those discussed by Nelson and Friedlander (2001). However, unlike their study, where ongoing pervasive anger was the most commonly reported supervisor reaction to an impasse, in the current study it appeared that supervisor resistance to frank non-judgemental discussion of supervisee perceptions and presenting concerns was the most frequent reaction reported. The inability of supervisees to find the space to have their say and interact openly, combined with the lack of trust felt towards their respective supervisors (see Table 35), affords some support for the existence of a fractured emotional bond as being critical to harmful clinical supervision. In this study, as in Nelson and Friedlander's, the supervisory relationships appeared to lack the necessary substance or structure to repair these ruptures.

#### *8.4.4.2 An Imbalance in the Supervisor's Manner of Approach to Supervisees*

Previous research has generally supported use of a balance of styles by the clinical supervisor to facilitate effective clinical supervision from the supervisee's perspective (specifically high Attractive, high Interpersonally Sensitive, and

moderate Task-Oriented). In the current study, supervisee descriptions of the style or manner of approach used by clinical supervisors appeared relatively diverse. However, a closer examination of supervisee dialogues and the responses contained in Tables 14 to 17 elicited some commonalities. For three of the five supervisees reporting poor clinical supervision, descriptors such as distant, distracted, and uninvolved applied to the clinical supervisor lent tentative support to the proposition that supervisees' perceived their supervisors were not sufficiently invested in building, maintaining or enhancing the relationship in supervision. This finding is in contrast to the recommendation that clinical supervisors should consider maintaining a high Interpersonally Sensitive approach to supervisees in clinical supervision (e.g., Friedlander et al., 1989). In variation to this pattern, the style of approach adopted by the other two supervisors of interviewees reporting poor clinical supervision experiences did not clearly fit this description.

As with supervisees experiencing poor clinical supervision, a range of descriptions were generated by interviewees depicting their clinical supervisors in harmful supervision. In all cases however the descriptions of the clinical supervisor's manner of approach did not equate with a balanced use of styles. An absence of a collegial approach to clinical supervision (Attractive) was noted, with four supervisees in this study using terms such as insensitive, not encouraging, closed, and unsupportive to describe their clinical supervisors. There also appeared to be supervisee concerns about the clinical supervisor's commitment to the relationship in supervision (Interpersonally Sensitive). Terms such as unapproachable, critical and blaming, uncommunicative, distant, and lacking in rapport, suggested supervisory relationships that were perceived as remote or troubling for supervisees. This was also supported by interviewee descriptions of their supervisory relationships in Table 17.

The small number of interviewees in this study and variations in the amount of detail supervisees provided in their responses indicate that it was not possible to reach any firm conclusions about styles of approach adopted by clinical supervisors and how they might differ in poor and harmful clinical supervision. Nevertheless, it was evident that supervisees reporting harmful clinical supervision experiences

were commonly able to relate more deficiencies in the style of approach adopted by their clinical supervisors (both Attractive and Interpersonally Sensitive categories) relative to supervisees reporting poor clinical supervision. Whether this imbalance in styles was a direct contributing factor to harmful clinical supervision, or more a consequence of other underlying issues (e.g., a problematic working alliance), is not clear.

#### *8.4.4.3 Ethical Concerns in Less than Positive Clinical Supervision*

A diversity of supervisor behaviours may constitute unethical behaviour (APS Code of Ethics, 2003; APS Ethical Guidelines, 2006), with clinical supervisors required to be mindful of the potential impacts of their behaviour on supervisees (APS Ethical Guidelines, 2006). In the current study, supervisees who perceived their least positive supervision experience as poor related a range of experiences that could be construed as involving in some manner or form unethical conduct. The experiences described - a clinical supervisor being unavailable for an extended period during placement (APS Ethical Guidelines, 2006 Supervision Guideline 5.1), a placement setting where the supervisee was unable to see clients (Supervision Guideline 6.2), a lack of clarity about who was the actual supervisor (Supervision Guideline 7.8), supervisor disclosure to others of sensitive information about the supervisee (see APS Code of Ethics, Principle of Propriety), and a supervisor seemingly unable to make adequate time available for clinical supervision (see APS Code of Ethics, Principle of Propriety) - all appear to present ethical concerns. Perhaps in the case of the supervisee unable to see clients, some of the ethical responsibility for this was shared by the clinical supervisor and placement supervisor.

*8.4.4.3.1 Dual supervisor roles.* For supervisees reporting harmful clinical supervision experiences, the existence of ethical concerns was also evident. For three supervisees, dual supervisor roles appeared to present issues. Dual lecturer/clinical supervisor roles added extra dimensions to the nature of the supervisory relationship for two supervisees. For the remaining supervisee, the interplay between administrative and clinical issues fed his or her disappointment in the focus of clinical supervision. The APS Supervision Guidelines state that

attention should be directed to the potential for dual relationships in the process of selecting the supervisor or supervisee (6.1). The dual supervisor roles evident in this study were present from inception, and in no case did the supervisee appear to believe that the ensuing issues were addressed adequately.

*8.4.4.3.2 The evaluative role of the clinical supervisor.* APS Ethical guidelines (2006) also provide some guidance on the evaluative function that clinical supervisors perform (Supervision Guidelines 7.5 – 7.8). For instance, clinical supervisors should raise queries of competence as they arise in contrast to waiting until the end of the supervision period (7.6). For one supervisee reporting poor clinical supervision and another harmful clinical supervision, their experience of receiving unanticipated and belated negative feedback about suitability for entering the profession was a stressful experience. A general reading of the Supervision Guidelines indicates that if this behaviour led to negative impacts for the supervisee in question, it would be difficult for a clinical supervisor to justify such conduct.

*8.4.4.3.3 Confidentiality of supervisee disclosures.* In their American study, Ladany, Lehrman-Waterman, et al. (1999) reported that confidentiality issues within supervision were one of the most frequent ethical violations reported by supervisees. In the current study, breaches of confidentiality featured clearly in the transcript of one supervisee experiencing poor clinical supervision and another experiencing harmful clinical supervision. In both cases, information was imparted to colleagues in the workplace, although in one case the disclosures pertained to a work colleague of the supervisee and not the supervisee per se. It is worth noting that both these supervisees were in paid work after completion of four years of accredited studies. This arrangement adds the additional role of “employee” to the multiple roles that probationary psychologists are required to perform. It is plausible that requirements for work performance and clinical supervision may diverge in some workplaces, complicating the observance of confidentiality requirements in clinical supervision.

*8.4.4.3.4 A need for further research on ethical decision-making in clinical supervision.* Previous research has indicated that greater frequency of unethical behaviour has been associated with lower ratings of the working alliance in

supervision and less supervisee satisfaction with supervision (Ladany, Lehrman-Waterman, et al., 1999). Given the pervasive nature of ethical issues raised in this study, the nature of the relationship between unethical supervisor behaviour, the quality of the working alliance, and supervisee perceptions of supervision effectiveness, is a salient one warranting further inquiry. As there appears to be little research, if any, that considers the nature and impacts of ethical decision-making from the perspective of the clinical supervisor, this is also an area that remains relatively unexplored.

#### *8.4.4.4 Lack of Clear Goals, Role Ambiguity and Different Expectations of Supervisor and Supervisee*

If clinical supervision does not entail clear, specific delineation of supervision goals, it seems plausible that a possible outcome is lack of clarity for supervisees about their multiple roles in supervision. There is also the potential for supervisee and supervisor to have different expectations about what should occur in supervision. In the present study, two supervisees describing poor clinical supervision experiences reported both lack of clear goals directing supervision and ensuing issues pertaining to role ambiguity. For one participant, the placement began without clear goals or structure for the role to be performed. For the other, an inability to see clients led to lack of goals and to a range of roles being undertaken, some of which were clearly non-psychological in nature. As both supervisees in question did have supervision contracts to guide their placements, the presence of a contract alone does not appear to ensure clarity in goals and roles for supervisees. In both cases, there appeared to be a lack of preliminary planning about the role(s) that the supervisee would perform at their placement. Clinical supervision is not solely about the skills and qualities of the clinical supervisor and for these supervisees interaction between the placement context and clinical supervision was a salient one.

For supervisees experiencing harmful clinical supervision experiences, dialogues of most supervisees did not offer explicit examples of role ambiguity, either in terms of expectations for the role or how performance would be evaluated. However, the dialogues of two interviewees in paid work indicated that the content

of clinical supervision was predominantly administrative in focus and evaluative practices centred on the work role. This primary emphasis on work responsibilities raises an important question: to what extent was the learning or probationary role actually acknowledged, validated, and addressed by the supervisors within clinical supervision? While it appears on face value that role ambiguity was a more significant issue for supervisees experiencing poor relative to harmful clinical supervision, it is also possible that other more pressing issues may have obscured the importance of role ambiguity, or at least role imbalance, in supervisee experiences of harmful clinical supervision.

#### *8.4.4.5 Role Conflict in Less Than Positive Clinical Supervision*

Conflicting expectations arising from the different roles supervisees are required to undertake (e.g., student, psychologist, colleague, client) has been implicated in conflictual clinical supervision (Nelson & Friedlander, 2001). Within the present study, role conflict was a salient concern and presented in a range of different and interactive forms. For one interviewee reporting harmful clinical supervision, it was difficult to adopt the role of “psychologist” when their clinical supervisor was also a lecturer in their course program. For another, a difficult session in supervision had repercussions for future dealings when supervisee and supervisor later returned to their respective roles as student and lecturer. While many dual lecturer/clinical supervisor roles may be effectively managed, the potential for supervisee role conflict as an outcome requires careful consideration in the planning stages of placements.

In Victoria, the different pathways to full registration as a psychologist permits flexibility and recognises that accessibility to higher degree programs may not be a practical option for all probationary psychologists. Consequently probationary psychologists can complete their registration requirements through accredited higher degree studies (masters or doctoral coursework), through a research higher degree and subsequent supervised practice, or through 4 years of accredited studies followed by 480 days of supervised practice (or its equivalent). In the current research project, interviewees were from the first and last group of training psychologists.



It is common for supervisees undertaking the equivalent of 480 days of supervised psychological work on completion of their studies to be in paid work. While some supervisees may also be employed whilst undertaking higher degrees, usually they would be required to undertake other unpaid placements during their training program. When probationary psychologists take on the role of “paid employee,” an additional role is added to student, psychologist, client, and colleague. Arguably, the additional role of employee generates the hybrid role of “paid student.” While not necessarily a problem of itself, when supervisees are employed it is plausible that requirements and issues of an organisational nature may arise that heighten the risk of role conflict.

In the current study, only one supervisee of the five reporting poor clinical supervision was in paid work. However, three of the supervisees reporting harmful clinical supervision were being paid during their probationary period. One supervisee was a masters student who was being paid for work during studies. This supervisee raised the concern that the supervisor’s expectations of him or her were equivalent to that expected of a fully trained psychologist. The remaining two supervisees were undertaking 480 days of psychological work after completing 4 years of studies. In both cases, employment issues were significant themes within their dialogues. While the impact of paid employment on their probationary status was not specifically explored in their interviews, the presence of a paid work role and any relationship to role conflict during probationary registration does appear an area worthy of further empirical inquiry.

The Psychologists’ Registration Board of Victoria recently released detailed new Guidelines for Probationary Psychologists and Clinical Supervisors (2005). These guidelines cover the supervision arrangements of probationary psychologists who have completed 4 years of accredited studies and are undertaking 480 days of supervised psychological work or its equivalent. Part of the purpose of these new guidelines is to improve standards in the practice of psychology (PRB Guidelines, 2005). In light of some of the issues raised in the current study, there is a persuasive argument for systematic longitudinal evaluation of the supervision experiences of this group of supervisees, perhaps 6 months in, at the end of their supervision

program, and 12 months thereafter. Allowing supervisees to give feedback on the guidelines (which is being encouraged) and their experiences of clinical supervision may provide useful information for the PRB and the discipline of psychology.

Likewise, feedback from clinical supervisors could form an important component of any review.

#### *8.4.4.6 Supervisor Feedback and the Evaluative Component of Clinical Supervision*

The relationship between giving feedback in clinical supervision and all functions of the clinical supervisor is an obvious one. Whether educating, monitoring, or supporting, the clinical supervisor ideally provides ongoing, open, objective, and honest feedback to the supervisee. However, it is arguably in the evaluative role that the clinical supervisor's feedback skills are most tested (Bernard & Goodyear, 2004; Hoffman et al., 2005). Discussion of supervisee progress towards their goals is not always going to be a positive supervisor function (Bernard & Goodyear, 2004). Moreover, as supervisor feedback is delivered within the context of a dyadic relationship, the nature and quality of the supervisory relationship conceivably affects how feedback is imparted and whether it is delivered at all (Hoffman et al., 2005).

A key concern expressed by most supervisees in this study related to the nature and frequency of supervisor feedback. Three supervisees reporting poor clinical supervision raised lack of formative feedback as a matter of concern. For two of these supervisees the nature of feedback received was predominantly negative in nature, indicating that a balance between positive and negative feedback had not been achieved. For the other, formative feedback was generally belated and was incongruent with final summative feedback questioning the supervisee's motivations and suitability to enter the profession of psychology.

For interviewees reporting harmful experiences, one supervisee described a lack of clinically relevant feedback and three supervisees a lack of regular formative feedback. The fifth supervisee found supervisor feedback from one supervision session to be disturbing in its nature. Given the predominance of what supervisees perceived to be a lack of formative feedback in harmful (and poor) clinical supervision experiences, persuasive argument exists for the regularity of feedback

to be clearly specified within supervision contracts. However, as feedback occurs within the context of a supervisory relationship, it would be useful for empirical research to be undertaken investigating reciprocal feedback within specific working alliances. Arguably, it may have been the nature of the working alliances (and/or characteristics of supervisor and supervisee) that impeded supervisor delivery of timely, open, ongoing formative feedback.

In the role of gate-keeping the profession, clinical supervisors are called upon to provide objective summative feedback. In the current study, one supervisee reporting poor clinical supervision and one reporting harmful clinical supervision received unanticipated summative feedback with regard to their suitability to undertake a career in psychology. In both cases, supervisees did not believe that this type of evaluative feedback could have been predicted from formative feedback they had received beforehand. Empirical research on how supervisors and supervisees deal with giving and receiving evaluative feedback in clinical supervision, particularly when this may not be positive, is an area yet to be adequately addressed (Hoffman et al., 2005; Robiner et al., 1997;).

#### *8.4.4.7 The Impaired Clinical Supervisor*

While supervisor impairment has been implicated in harmful clinical supervision (Ladany, 2004), only one participant in the current study raised it directly as a key concern in harmful clinical supervision. However, it is plausible that impairment was a more important concern than is evident. For instance, there may have been a lack of recognition by supervisees of this as a potential reason for the clinical supervisor's manner of approach or behaviour. In addition, given the hypothesised link between supervisor impairment and misuse of power (Muratori, 2001) it is possible that the power issues reported by a further 2 supervisees (1 experiencing harmful supervision and 1 poor clinical supervision) may have both been related in some manner or form to supervisor impairment. At this point in time, limited empirical understanding of supervisor impairment makes it difficult to move beyond the tentative nature of this proposition.

As theory and empirical study of supervisor impairment is sparse, with conceptualisation to date centred largely on the internal state of the clinical

supervisor (e.g., arising from mental health or addiction issues), the discipline of psychology's understanding of precipitants of supervisor impairment is limited. Arguably, when organisational issues become so troubling that clinical supervisors confide in supervisees, it is possible that the functioning of the supervisor has become impaired. It seems timely for research to further explore the world of the clinical supervisor and the difficulties they may face in performing their educative, supportive, and evaluative functions.

#### *8.4.4.8 The Placement Context*

The nature of placement arrangements was not quite as straightforward as might be expected. In a couple of cases there appeared to be difficulties in obtaining independent and suitable placements for probationary psychologists. For one supervisee experiencing poor clinical supervision, the placement was unsuitable prior to its commencement yet such concerns were not directly discussed with the supervisee until after the placement had commenced. For another, both the parameters of the supervisee's role and who was to be the clinical supervisor were uncertain at the beginning. This supervisee stated that this particular organisation took many students and it was quite likely that what the probationary role would entail had not been decided prior to the placement. It does appear that suitable placements need to be carefully thought through and planned for, and even then unanticipated problems can transpire necessitating clear processes for impartial inquiry and where necessary grievance resolution.

Some supervisees in this study were aware of the pressures that clinical supervisors were experiencing in their workplaces that reduced their effectiveness. Insufficient time for supervision was raised by two supervisees experiencing poor clinical supervision. Unless adequate time is allotted for supervisors to perform their responsibilities effectively supervisees may feel a burden to their supervisors during placement. The potential for a supervisee to act independently without sufficient guidance is a possible outcome of having an overcommitted clinical supervisor.

A range of organisational issues were raised by supervisees in this study reporting harmful clinical supervision. Two supervisees reported significant

changes in the workplace, one with respect to accountability processes and another in regard to staff selection. For a third supervisee, the demands of setting up a new service represented a key issue in the interview. Clinical supervision is not disconnected from the context in which occurs (Davy, 2002), and for these three supervisees the nature of organisational change was significant enough to be raised in detail within their interviews.

#### *8.4.4.9 The Broader Relationships*

Most research and theory on clinical supervision discusses a discrete relationship between clinical supervisor and supervisee. Yet, for probationary psychologists, there are conceivably many people who may impact on their experience of clinical supervision. For one supervisee in this study who experienced poor clinical supervision, negative impacts were reported from dealings with the Program Coordinator as well as the clinical supervisor. Another supervisee reported a harmful experience that emanated from overhearing the clinical supervisor disclosing unfavourable opinion or information pertaining to another employee. Harmful clinical supervision for this supervisee appeared to arise predominantly from taking action with respect to an alleged ethical breach. It does seem that the impacts of clinical supervision perceived as less than positive may be felt by and involve other participants in the placement context.

#### *8.4.4.10 Inappropriate Supervisor Self-disclosure*

What constitutes inappropriate supervisor self-disclosure is arguably contextual, subjective and varies at least to some extent with the theoretical orientation of supervisor and supervisee. Self-disclosure may occur as part of supervisor feedback to the supervisee (e.g., disclosure of own counselling struggles), or be less concordant with supervisee needs (e.g., disclosure of personal concerns). In the current study, one supervisee reporting harmful clinical supervision related how he or she early on in the supervisory relationship became a confidant for the supervisor on organisational issues and his or her perceptions of members of the team. For another supervisee, harmful supervision centred on supervisor disclosure of what he or she speculated to be a client's likely feelings about the supervisee's physical characteristics. In both cases, the supervisee in question perceived the disclosures as

inappropriate and in all likelihood self-serving for the clinical supervisor. These findings are consistent with those reported in earlier studies supporting supervisee preference for self-disclosures that are concordant with and relevant to supervisee needs (Hutt et al., 1983; Ladany & Lehrman-Waterman, 1999).

#### *8.4.4.11 Clinical Supervision as a Developmental Process*

While the current study did not specifically examine the developmental process for supervisees over a clinical supervision experience or over the probationary registration period, a range of issues were raised that could have been analysed using a developmental perspective. For two supervisees reporting poor clinical supervision, their need for more direction and structure than provided by their clinical supervisors was apparent. Notably, both supervisees were at early stages in their higher degree studies. For another supervisee, the level of support from the clinical supervisor did not match the supervisee's needs. This probationary psychologist was in the first year of supervised psychologist work after completing 4 years of accredited studies.

Some of the key themes raised by interviewees reporting harmful clinical supervision experiences could also have been analysed from a developmental perspective. For one interviewee, feedback from the clinical supervisor may have been inappropriately chosen for a relatively new probationary psychologist. For another, supervisor expectations of the supervisee were described as beyond the supervisee's level of competence. This supervisee portrayed the client work as complex perhaps necessitating a higher degree of structure than the supervisor recognised. While a range of supervisor and supervisee factors may influence the level of support and structure afforded by a clinical supervisor (Ladany, 2004), awareness of developmental processes for supervisees may also be pertinent. Empirical investigation of less than positive clinical supervision from a developmental perspective appears a constructive area for future inquiry.

#### *8.4.5 The Impacts of Less Than Positive Clinical Supervision*

Supervisees' reporting poor and harmful clinical supervision described a range of impacts from their experiences. Tables 20, 21, and 30 through 33 provided examples of what supervisees perceived to be some of the personal and professional

impacts they experienced from their poor and harmful clinical supervision experiences. Contrary to what has been hypothesised by Ellis and his colleagues (e.g., Ellis, 2000; Ellis et al, 2000) some of the personal impacts raised by participants reporting poor supervision would be difficult to classify as relatively benign. Some supervisees did describe what might be perceived as more benign impacts such as frustration and disappointment, but they also depicted other effects such as the experience of stress, flat affect, and loss of confidence. It is conceivable that some of these impacts did psychologically injure supervisees, at least in the short-term. Perhaps more than lack of significant personal impacts arising from the experience, poor clinical supervision was defined more in this study by the eventual resolution of any internal conflict emanating from the experience (Table 40). To this extent, impacts were not long-lasting.

With respect to professional effects, supervisees reporting poor clinical supervision were able to specify short term impacts such as lack of professional development, and failure to develop necessary clinical assessment and group work skills. On a longer term basis, supervisees reported impacts on their clinical work, on employment prospects, and changes in their perceptions of what constitutes effective supervision as a result of their poor experiences. Once again, it would be difficult to categorise these impacts as relatively benign. Additionally, if interviewees were accurate in their assessments, the likelihood of negative impacts extending to client work is a matter of professional concern.

Relative to poor clinical supervision, a more diverse range of deleterious personal impacts appeared to be associated with harmful clinical supervision experiences. All supervisees experiencing harmful clinical supervision described a range of negative impacts arising from their experiences. These included the experience of emotional distress, anger, feelings of self-doubt and incompetence, health and sleeping problems, debilitating anxieties, breach of trust and development of mistrust, and unnecessary pain and suffering. These impacts are congruent with those hypothesised by Ellis and his colleagues (Ellis et al., 2000; Ellis, 2001) as emanating from harmful clinical supervision.

Despite the time that had elapsed since the harmful clinical supervision experiences at the time of interview (two experiences were approximately 3 years before, one was 2 years, and one was 1 year), for four supervisees there was lasting internal conflict emanating from the experience. One supervisee reporting some lingering uncertainties and anger towards the supervisor, another enduring feelings of guilt for taking action, a third supervisee reported anxieties about dealing with possible future contact with the clinical supervisor, and another some lasting distress. In contrast to most supervisees with poor supervision experiences, the experience of harmful clinical supervision remained a matter of internal conflict for four supervisees. That these personal impacts, or at least some of them, persisted over a number of years is clearly an issue for the profession of psychology.

A range of training and professional effects were associated with harmful clinical supervision for supervisees in this study. These included impacts on learning, on career choice, and on self-concept, but also positive effects such as learning about what the supervisee could handle and what matters most to working in this type of profession. Such effects could perhaps be described as self learning and also appear to be of importance to professional functioning. Interestingly, many of the professional effects raised by supervisees in the harmful supervision group appeared to have a positive slant, providing a reminder that impacts were not wholly negative.

#### *8.4.6 Benefits Arising from the Experience of Poor and Harmful Clinical Supervision*

Many supervisees in this study were also able to recognize that they had gained in some way from their supervision experience. Nine of the ten supervisees reporting poor and harmful clinical supervision experiences were able to pinpoint benefits including a change in their manner of approach to their future clinical supervision, recognition of the learning despite their struggles, and for one, there was appreciation that some of the belated supervisor feedback was in fact relevant. The ability to draw out of negative experiences some pertinent learning is arguably a crucial part of the experience of probationary psychologists.



#### *8.4.7 Discussing Supervision or Placement Concerns with the Clinical Supervisor*

In line with past studies that have noted supervisee reluctance to raise concerns about clinical supervision with their clinical supervisors (Gray et al., 2001; Ladany, Lehrman-Waterman, et al., 1999), this was also the general finding for supervisees in the current research. For two supervisees experiencing poor clinical supervision and four supervisees reporting harmful clinical supervision, there was no direct discussion of the issues that underlay their less than positive clinical supervision experience. Supervisees generally reported feeling uncomfortable with the process and/or distrustful of directly discussing their concerns, feelings, or issues with their clinical supervisors.

Despite the fact that concerns were never discussed or addressed, for the two supervisees who described their supervision experiences as poor there was no lasting sense of internal conflict reported at the time of the research interview. As reported by Gray et al. (2001) in their study of counterproductive events in supervision, lack of discussion of the issues or concerns per se was not in itself an impediment to the supervisee moving on. Likewise, discussing issues with the clinical supervisor provided no guarantee that concerns would be resolved in less than positive clinical supervision. In the current study, the only supervisee who engaged in direct discussion of supervision issues in the harmful group (albeit not in any way to the satisfaction of the supervisee) still reported enduring internal conflict in relation to the supervision experience. This concurs with the finding, reported by Nelson and Friedlander (2001), that supervisee engagement in discussion of issues with their clinical supervisor did not repair conflictual working alliances. Findings in the current study provide tentative support for the proposition that fractured and negative working alliances in some harmful clinical supervision experiences do not provide a resilient relational framework for supervisees to move forward from.

#### *8.4.8 Pursuing a Complaint about Less Than Positive Clinical Supervision*

There is a strong argument for ensuring that probationary psychologists are cognisant of all systems for airing concerns and where necessary instigating conflict resolution processes within clinical supervision. Three supervisees in the current

study reported a lack of clarity about the processes available to assist with resolving issues in clinical supervision and placement. Two of these were completing 2 years of supervised psychological work after 4 years of accredited studies. The third interviewee was completing doctoral level studies and whilst this probationer did initiate discussion of his or her concerns with a university supervisor, once that avenue was exhausted, he or she was uncertain what processes should have been pursued. Of supervisees unclear about processes, two reported poor supervision experiences and one harmful clinical supervision.

Of equal if not greater concern was the disappointment that many of the probationary psychologists in this study expressed in the systems in place for airing concerns and initiating conflict resolution processes. Seven supervisees tried to resolve placement/supervision issues by using processes available for airing concerns or registering a complaint (e.g., placement co-ordinator, manager). Of these, only two supervisees reported some satisfaction with how matters were followed through. It was noted that no supervisee in this study took up their concerns by contacting the Psychologists' Registration Board of Victoria. Hopefully, the inclusion of a detailed grievance procedure within the recent guidelines for supervisors and probationary psychologists will be a helpful tool for probationers outside the higher degree system (PRB, 2005).

The need for ongoing review and evaluation of systems for both airing concerns and resolving grievances in clinical supervision is an issue raised by the current study. Of the four supervisees experiencing poor clinical supervision who took their concerns further, only two reported any satisfaction with the processes their respective universities employed. Moreover, of the three supervisees reporting harmful clinical supervision who took matters further (one to the university, two to management where paid psychological work was being undertaken), none found the processes used were effective responses to the issues raised. This is a troubling finding particularly given the potential for negative impacts of a long-term nature and the difficulty for supervisees of trying to resolve supervision issues from a one-down position of power.

#### *8.4.9 Strategies Used to Deal With Less Than Positive Clinical Supervision*

As reported by Nelson and Friedlander (2001) in their study of conflictual supervisory relationships, participants in the current study also chose insightful and self-directed ways to deal with less than positive clinical supervision. Nine of the ten supervisees participating in this study referred to talking as a key strategy (perhaps of itself indicating some basis for their participation in this research study). This included talking to friends, colleagues, university supervisors, and a therapist. Also consistent with the reported findings of Nelson and Friedlander (2001), many supervisees in this study referred to use of self-reflection or putting the experience into some kind of broader perspective as a key strategy for dealing with poor and harmful clinical supervision. An important part of doing research of this nature may be to disseminate ways that supervisees can work through less than positive experiences in clinical supervision. Nonetheless, reliance on supervisees employing their own coping strategies is not a respectful solution when some are left with unresolved enduring internal conflict from their experiences.

#### *8.4.10 Learning and Doing it Differently Next Time Around*

There is conceivably a developmental aspect to what supervisees can take up and respond to in supervision. There are also individual differences in the ability to be assertive and whilst in hindsight, many supervisees in this study were able to envisage some additional or more suitable responses they could have applied in order to respond or repair a situation (e.g., being more upfront with the clinical supervisor), the power differential and the developmental process can make this a challenging task. Arguably hindsight is valuable but whether such hindsight could have been implemented is unknown. Consequently, surveying probationary psychologists after completing all placements might uncover some of the learning that they have been able to apply from earlier supervision experiences.

#### *8.4.11 What of Supervisee Readiness to Practice*

For three supervisees in this study, one reporting a poor clinical supervision experience and two reporting harmful experiences, the clinical supervisor in question appeared to have concerns about the supervisee's readiness to enter the profession. It is notable that two of these supervisees stated that they were

unsuspecting of the impending delivery of this type of feedback. Both supervisees reported feeling resistant and resentful, believing that the nature of the summative feedback was incongruent with formative feedback received during placement. For the third supervisee, the dual supervisor role was considered to be so problematic that it precipitated a range of issues that, from the supervisee's perspective, fed the supervisor's perception of his or her unsuitability for the profession. Whether, in what ways, and to what extent any of the supervisees participating in the current study were not ready for professional practice as a registered psychologist is unknown. However, the current findings suggest that as with supervisor impairment, supervisee readiness to practice should also be considered in its context. Arguably, decisions of this magnitude should not occur in isolation from the nature, strengths, and limitations of the placement context.

#### *8.4.12 The Nature of Poor and Harmful Clinical Supervision*

The definitions of poor and harmful definition proposed by Ellis and his colleagues (Ellis, 2001; Ellis et al., 2000) appear to assume that supervisory practices are the direct cause of less than positive supervision. According to their conceptualisation, poor (bad) clinical supervision arises when the supervisor is unwilling or unable to meet the training needs of the supervisee. While this may be a critical or overriding concern in poor clinical supervision, the current study indicates that it is unlikely to be the entire or underlying story. The organisational context in which clinical supervision occurs may impede the process of both supervisor and supervisee maximizing the benefits that can be obtained from clinical supervision.

While harmful clinical supervision has been differentiated by the psychological, emotional and physical impacts on supervisees (Ellis, 2001; Ellis et al., 2000), it was noted in the current study that harmful clinical supervision may also have impacts associated with poor clinical supervision (e.g., disappointment, frustration), and poor clinical supervision can likewise have effects for supervisees more in line with what has been proposed for harmful supervision (e.g., negative impact on self-esteem and mood). While impacts on supervisees experiencing harmful clinical

supervision did appear more deleterious in nature, there was some overlap in the impacts reported by supervisees experiencing poor and harmful clinical supervision.

Rather than differences in the nature of impacts alone, it appeared that the absence of enduring internal conflict may be more a characteristic of poor clinical supervision than harmful supervision. The harmful experiences and the associated impacts appeared to still resonate emotionally and in some cases physically for four of the five supervisees reporting harmful clinical supervision experiences. The presence of continuing preoccupation with or unresolved emotions pertaining to the less than positive supervision experience appeared to differentiate the two groups of supervisees. Whether this was due directly to the nature and intensity of the negative impacts or due to something else such as supervisee characteristics is yet to be fully explored.

The presence of enduring internal conflict for some supervisees reporting harmful clinical supervision suggests that the harmful supervision experiences of probationary psychologists should not go by unobserved or unexplored if the discipline of psychology wishes to minimise harm to supervisees (Ramos-Sánchez et al., 2002). The reality is that years down the track some supervisees in the current study still felt some distress and a sense of injustice emanating from their supervision experiences. Impacts for some supervisees appeared reinforced by their belief that the processes for airing issues and grievances did not adequately address their needs.

While the impacts of poor and harmful clinical supervision did overlap to some extent, there were some noted differences in the factors perceived by supervisees to underpin the experiences of poor and harmful clinical supervision. Effects from dual supervisor roles and supervisee role conflict appeared more of an issue for supervisees reporting harmful clinical supervision, and supervisees were unanimous in their concerns in relation to the working alliance in supervision. However, there were other variables that did present as important to both poor and harmful clinical supervision experiences. The nature and quality of supervisor feedback was a variable of primary concern in both poor and harmful clinical supervision

experiences. Given the small number of supervisees participating in this study, such findings are tentative in nature and further studies are needed.

Some of the issues supervisees brought to the interviews were placement or employment specific issues and were not solely pertaining to the quality of clinical supervision. Undertaking supervised psychological work was not only about the clinical supervisor. It was also about the organisational context, the other participants in work or placement contexts, and changes occurring at the workplace. This suggests that consideration of less than positive clinical supervision from a pure dyadic relational perspective may limit our understanding of its dynamic contextual nature.

#### *8.4.13 Providing Supervisees with Additional Information on Clinical Supervision*

A couple of interviewees chose to convey their belief that universities and boards need to provide additional or more detailed preparatory information to probationary psychologists about what to expect from clinical supervision and what supervisory relationships entail (see Sections 8.3.19 & 8.3.20). The need to provide probationary psychologists with comprehensive and clear information about the nature of clinical supervision was also supported by interviewees, predominantly those experiencing poor supervision that raised concerns about dissimilar supervisee and supervisor expectations within clinical supervision. While it is unknown how each educational institution prepares supervisees for placement and clinical supervision, it is arguable that preparatory discussions about the nature of clinical supervision and supervisory relationships, and the importance of clarifying supervisor and supervisee expectations and responsibilities, are critical areas.

#### *8.4.14 Clinical Supervision as a Heterogeneous Training Tool*

For many probationary psychologists (and others), the clinical supervisor is not a matter of choice. Placement or supervised work arrangements may be decided on the basis of many different criteria (e.g., timing, locality), and the quality of the match between supervisor and supervisee may be revealed later on in the process and outcome of clinical supervision. In the form of additional comments at the end of their interviews some interviewees experiencing poor clinical supervision made reference to the diversity in clinical supervisors out in the field, in their methods,

and the emphasis they place on specific aspects of clinical supervision (see Section 8.3.19). According to one supervisee, this diversity could also be extended to placement contexts which may require significantly different input and skills from probationary psychologists. Recognition that clinical supervision is a heterogeneous training tool (Davy, 2002) that varies by locality and context (Bernard & Goodyear, 2004) was part of the learning process for some interviewees participating in this research.

Diversity in clinical supervisors and the nature of supervision itself suggests that it is reasonable for the discipline of psychology to expect that some probationary psychologists will question the effectiveness of their clinical supervision. As part of the additional comments, it was interesting to note that one interviewee suggested that meeting potential clinical supervisors and having a choice of placement may reduce the incidence of less than positive clinical supervision. Any relationship between having a choice in selection of clinical supervisor and supervision effectiveness is an interesting area for further exploration. Likewise, the effectiveness of processes used to match supervisees with clinical supervisors appears an area worthy of further inquiry.

#### *8.4.15 A Clinical Supervision Impacts Scale*

In line with the theoretical structure presented by Ellis and his colleagues (Ellis, 2001; Ellis, et al., 2000), an alternative to a supervisee satisfaction scale worthy of further empirical consideration is a clinical supervision impacts scale. This could chart the negative and positive impacts that supervisees perceive have arisen from clinical supervision experiences over their probationary period. Such a scale could provide supervisees with self-report scales that track personal impacts (e.g., feelings of self-confidence, psychological and physical symptoms) and professional impacts (e.g., on clinical skills, and development of professional identity) over their placements or 2 years of supervised practice, thus providing supervisees with pertinent information about their supervision experiences and possible areas of future learning. Arguably this scale could also form part of a broader assessment package, thereby lessening the present monopoly of the clinical supervisor in assessing supervisee competencies (Ladany, 2004).

The advantage of an impacts scale also extends to calculating the incidence of less than positive clinical supervision by researchers and universities. One advantage of the current study was that use of the poor/harmful dichotomy facilitated consideration of the incidence of less than positive clinical supervision amongst a population of probationary psychologists. In theory, empirical data on impacts could also be used by universities and boards to inform supervisees of the key indicators of less than positive clinical supervision before they commence clinical supervision. Hopefully, combined with information on processes and procedures to air concerns in clinical supervision, supervisees will be more enabled to recognise issues early enough in a supervision experience to minimise deleterious impacts and seek appropriate assistance in resolving such matters.

While it remains inconclusive whether poor and harmful clinical supervision are different constructs, or differing degrees of the same phenomenon (Nelson et al., 2001), there appears to be persuasive argument for further attention to be directed towards conceptualisation of less than positive clinical supervision. Whether this be by way of empirical investigation of different gradations of ineffective clinical supervision through an impacts scale, or use of the poor and harmful dichotomy, collection of this information is important to the profession of Psychology. Further empirical data on less than positive clinical supervision may increase understanding of how to minimise its occurrence.

#### *8.4.16 The Process of Applying a Phenomenological Method*

##### *8.4.16.1 The Researcher-Interviewer's Perspective*

The human scientific phenomenological method (Giorgi, 1997), as interpreted by the principal researcher-interviewer, was the primary method for collecting and analysing information on supervisee experiences of poor and harmful clinical supervision. Given the small number of participants in this study, and its inherent exploratory nature, this method had as its advantage emphasis on detailed examination of the individual's subjective experience. As the phenomenological method seeks to represent similarity and diversity in experience, its use directed attention away from premature seeking of an underlying unified structure for poor and harmful clinical supervision.



#### *8.4.16.2 Participant Corroboration of Individual Supervision Experiences*

Participant involvement in auditing the qualitative data afforded a check on both the accuracy of and the emphasis or balance in the information reported on each supervision experience. As the current study used direct quotes, participant involvement was considered a valuable mechanism for double-checking the nature of verbal data reported. While five interviewees responded affirmatively to the researcher's choice of key phrases, it was noted that the other interviewee wanted to clarify the emphasis taken by the principal researcher-interviewer. This interviewee did not request any changes to wording or phrases, but as a result of feedback the researcher-interviewer made some small changes that increased the specificity of information provided on the nominated harmful clinical supervision experience. Feedback from interviewees provided some support for double-checking when phrases or quotes are used to portray participant experiences.

Protecting participant confidentiality is also of paramount concern in research of this nature. While every attempt was made to protect the confidentiality of participants, involving them in the auditing process does provide an opportunity not only for expression of any concern they may have about the verbal data selected to represent their experiences but also to reassure them that confidentiality requirements have been met. Weighed against this must the fact that two interviewees were not contactable and two did not respond to the auditing process.

Participant corroboration afforded an opportunity for interviewees and the principal-researcher interviewer to revisit the supervision experience 2 years on. While this provided an invaluable opportunity to learn about how participants now viewed the supervision experience and had progressed in their careers, it also appeared to be a respectful process. Research is about the participants, and providing them with an opportunity to review the research and feedback information to the researcher may have validated to some degree the importance of their involvement, and the time and effort they put into the project.

#### *8.4.16.3 Impacts for Supervisees of Participating in this Study*

A number of participants reported experiencing a range of emotions on seeing the publicity for this study. While the nominated less than positive clinical

supervision experiences were in the past, interviewees were asked to recall experiences that for some had adverse personal and professional impacts. Moreover, a request to talk freely and openly about an experience that may have called into question their competency and suitability for the profession is a challenging call. While supervisees did not feedback any concerns in relation to participating in this study, some did report a re-emergence of some of the feelings and thoughts that accompanied the original supervision experience, both at interview and follow-up stages.

#### *8.4.17 Use of N Vivo to Elucidate Underlying Themes in Supervisee Experiences of Poor and Harmful Clinical Supervision*

To some extent use of N Vivo 2.0 to uncover underlying themes in supervisee dialogues revealed previously identified information derived from using the human scientific phenomenological method. This included information on working alliances and the role of contextual factors in less than positive clinical supervision. However, construction of theme documents was primary in revealing detail on supervisee experiences of role conflict and the impacts from dual supervisor roles in some harmful supervision experiences. Without use of theme documents, these variables may not have been examined in detail.

While phenomenology afforded a means of exploring individual subjective experiences of less than positive clinical supervision, N Vivo 2.0 presented a method for seeking out any unifying structure in poor and harmful clinical supervision experiences. While by no means pinpointing a unified structure to poor or harmful supervisory experiences, N Vivo 2.0 did provide a constructive method for exploring some of the hypotheses derived from theory and research and reported in Chapter 6.

### 8.5 Conclusion

#### *8.5.1 A Multi-Variable Model of Less Than Positive Clinical Supervision*

While troubling working alliances, infrequent, belated and unexpected feedback in supervision, supervisor dual roles, supervisee role conflict, and unethical supervisor behaviours were some of the key areas perceived by supervisees to underpin experiences of poor and harmful clinical supervision in this research, other

variables also played an important role. Interestingly, the experience of less than positive clinical supervision could have been analysed in detail using a number of different themes or variables including the broader context of supervision, supervisor styles, and supervisee developmental level. There remains a great deal to be learnt about variable interrelationships in less than positive clinical supervision experiences.

#### *8.5.2 Clinical Supervision as a Contextual Experience*

The qualitative study adds weight to the proposition that clinical supervision is an embedded experience. It occurs within a context and plausibly both supervisor and supervisee behaviour are influenced by aspects of that context. The qualitative interviews provided a means to expose the broader context of clinical supervision, with the interviews uncovering the interplay of factors that impacted on supervisee experiences of less than positive clinical supervision. Further qualitative studies eliciting a wider range of poor and harmful clinical supervision experiences should afford an opportunity for refutation or verification of some of the tentative findings reported in this study. Given our limited understanding of less than positive clinical supervision, there appears scope for additional inquiry.

#### *8.5.3 Supervisee Wellbeing as an Overriding Consideration*

Ellis and his colleagues (e.g., Ellis, 2001; Ellis et al., 2000), amongst others (e.g., Nelson & Friedlander, 2001), have drawn attention to the potential for deleterious impacts to arise from less than positive clinical supervision. The flip side of this issue is the nature and quality of support provided to probationary psychologists when issues inevitably arise in clinical supervision. Findings from the current study suggest that provision of support and where necessary the ready availability of effective grievance resolution processes is an overriding ethical imperative. If, as some supervisees perceived in this study, the ability to obtain support is inadequate or delayed, the potential for harm may be magnified. The fact that some interviewees were still experiencing negative impacts from a less than positive supervision experience occurring five years before is of concern to the profession of psychology.

It seems pertinent for universities, employers, and registration boards involved in the training and support of probationary psychologists to obtain regular feedback, where this is not already the case, about how probationary psychologists have found mechanisms of support and grievance resolution in clinical supervision. It is possible that the experiences of interviewees in the current study were not representative of the population of probationary psychologists in Victoria. However, unless regular evaluative feedback is collected, analysed, and reported, a question mark remains about the accessibility and adequacy of processes for discussing concerns and grievance resolution.

### 8.6 Study Limitations

The participants in our study provided rich data on their individual experiences of less than positive clinical supervision. Their experiences however do not generalize for the whole population of probationary psychologists. In addition, participants self-selected for this study, and their willingness to be involved in research of this nature and discuss their less than positive supervision experiences may differentiate them in some way from the wider population of supervisees who have experienced less than positive clinical supervision. For instance, they may have obtained enough distance from the experience to discuss it, or alternatively they had an unresolved grievance that they wished to air.

The perspective of less than positive supervision represented in this research is that of the probationary psychologist and it is unknown to what extent the accounts are objective. In this respect, no attempt was made to assess the individual supervisee's contribution to their less than positive clinical supervision experience. In line with a phenomenological method, emphasis was placed on representing the individual experience. As clinical supervision is an interactive relational experience, the interpretability of the data is limited by the absence of the clinical supervisor's account.

The interviews conducted were guided by questions, and this conceivably limited the ability of supervisees to provide all relatable information to the researcher-interviewer. While interviewees were provided with an opportunity to relate any additional information at the conclusion of interviews, it is plausible that

some of the variables that underlie poor and harmful clinical supervision were not discussed in the interviews, and supervisee dialogues cannot be perceived as full accounts of the phenomena under investigation.

Supervisees in this study classified their own experiences as either poor or harmful. The suitability of this classification does depend to some unknown degree on factors such as supervisee individual characteristics and their awareness of the impacts that the supervision experience has had on their emotional and physical well being. It is also conceivable that less than positive clinical supervision experiences may vary in their classification overtime and in light of where the supervisee is within their probationary period.

This study was retrospective in nature, and participants were not only considering an experience occurring at different times during their probationary period, but also different time periods had elapsed since the nominated poor or harmful supervision experience (6 months to 3 years). Thus, caution needs to be exercised in analysing similarities and differences between the poor and harmful clinical supervision experiences.

As one researcher conducted all interviews, this research may have been influenced by the beliefs and attitudes of that person. While the researcher endeavoured to partition off existing knowledge and biases, it is unknown to what degree their values and beliefs influenced both the choice of questions and the interpretation of information from the participants.

As interviewees provided differing amounts of verbal information on the variables that they believed had contributed to their poor and harmful clinical supervision experiences, a lack of information in some cases may have reduced the principal researcher's ability to select key themes to effectively represent these variables. In addition, it is credible that there is a level of subjectivity to any one person's perception of themes within verbal data.

An ongoing challenge in analysis of the verbal data was to represent the individual experience of less than positive clinical supervision whilst also eliciting themes common to experiences of poor and harmful clinical supervision. The decision to report common themes in less than positive clinical supervision

inevitably lessened primary focus on the individual experience, which is the hallmark of a phenomenological analysis.

While telephone interviews provide a means of accessing a more geographically diverse population, it is also recognised that use of telephone interviews prevents attention to visual cues. Body language is not available, and verbal language is given primacy for descriptive and interpretive purposes. By seeking participant verification of verbal data, an attempt was made to minimise limitations associated with telephone interviews.

An important issue arising in the current study was the different pathways to registration, and the likelihood that supervisee experiences of clinical supervision may be dissimilar when undertaken over multiple placements as part of a higher degree as opposed to only one or two clinical supervisors over two years or more of supervised practice. Additionally participants who undertook the two years of supervised psychological work after completion of four years of studies were more likely to be employed and experiencing different pressures to supervisees in full time study. As these pathways to registration incorporate different structures, it may be useful for future research to target one group or the other.

## **CHAPTER 9: CRITIQUE OF MODEL OF CLINICAL SUPERVISION EFFECTIVENESS**

The preliminary model, presented as Figure 3 in Chapter 6, made predictions about contributory variables to poor and harmful clinical supervision experiences. Using applicable data reported in Chapters 7 and 8, this chapter presents a preliminary evaluation of the utility of this model. Quantitative and qualitative data are integrated to examine the exploratory model predictions. This has sometimes been referred to as using a mixed methods research design (e.g., Creswell, 2003; Hanson et al., 2005).

### **9.1 Rationale for Integrating Data Sets**

The primary rationale for integrating parts of the quantitative and qualitative data sets was to expand the sources of information available for exploring contributory factors to supervisee experiences of less than positive clinical supervision. In addition, a mixed methods research design facilitates consideration of some of the assumptions underlying the quantitative component of the research. The quantitative study (Study 1) was based on extant theory and research and largely employed valid and reliable measures used in previous research on clinical supervision (Bernard & Goodyear, 2004). While this is a pragmatic approach, it is conceivable that some of the variables salient to less than positive clinical supervision may have been omitted from consideration in the quantitative study. The addition of in-depth accounts of poor and harmful supervision experiences affords the opportunity to investigate any contributory variables raised by supervisees that have not been comprehensively covered in extant theory and research.

Detailed accounts of poor and harmful supervision experiences offer a window into how issues in supervision unfold for probationers and the potential interactive nature of factors underpinning poor and harmful clinical supervision experiences. In the quantitative study, participants indicated the variables they perceived had contributed to their poor and harmful clinical supervision experiences. The qualitative component was intended to build on the quantitative study by facilitating some consideration of the interactive nature of variables that might be implicated in

context specific settings such as university clinics and community agencies (Ponterotto, 2005). For instance, when evaluative feedback was delayed or supervision spasmodic did the supervisee attribute any responsibility to the organisational context in which the clinical supervision was conducted? The verbal data provided a means for considering the holistic and interactive nature of poor and harmful clinical supervision experiences.

The two types of data used to evaluate the preliminary model supply different levels of information on the nature of less than positive clinical supervision. The quantitative study yielded data that was intended to generally assess the nature, incidence, and perceived causes of poor and harmful clinical supervision amongst a sample of probationary psychologists in Victoria, Australia. In contrast, the qualitative data was used to uncover the individual subjective experience of poor or harmful clinical supervision. The two sources of data were collected under different assumptions as to the nature of the social world (notably, post-positivism and phenomenology) and are integrated without an overarching theoretical lens. Thus, where quantitative and qualitative data are available to evaluate the same hypothesis, they are not ranked in terms of importance. Using an exploratory focus, quantitative and qualitative findings are integrated to evaluate hypotheses underlying the preliminary model and make suggestions for future model development.

## 9.2 Aims

Specifically the aims of this chapter are to:

1. Synthesise data from the quantitative and qualitative studies and compare findings with model predictions as to factors hypothesised to underlie poor and harmful clinical supervision from the supervisee's perspective;
2. Outline limitations of the preliminary model;
3. Make suggestions for future model development and testing; and
4. Outline limitations in the research design.



### 9.3 Evaluating Model Predictions

#### *9.3.1 Multiple Determinants of Poor and Harmful Clinical Supervision*

Both qualitative and quantitative data indicate that there are likely to be multiple determinants of poor and harmful clinical supervision experiences. Thus, it is unlikely that poor or harmful clinical supervision arise solely from one cause such as a poor working alliance or an impaired clinical supervisor, and there are likely to be interactive effects amongst the factors that contribute to less than positive clinical supervision. For instance, a failure to provide clear regular formative feedback to a supervisee may be related to a weak or distant working alliance in supervision.

Qualitative and quantitative findings indicate that harmful clinical supervision may be a more complex phenomenon relative to poor clinical supervision, with more variables typically involved. Specifically, quantitative findings supported the presence of a greater number of underlying issues for most supervisees reporting harmful clinical supervision relative to poor. Moreover, a review of in-depth interview transcripts indicated that a greater number of common factors were reported by interviewees who described their least positive supervision experience as harmful. Specifically, issues pertaining to the working alliance, the nature and quality of evaluative feedback in supervision, and personality and work style differences, were evident in all supervisee dialogues.

The salience of specific contributory variables and the nature of their interactive effects conceivably will differ amongst supervisees and in all likelihood some variables will present as more critical to harmful clinical supervision. For instance, qualitative findings indicated that negative impacts arising from dual supervisor roles and role conflict for supervisees may be raised as more frequent concerns in harmful clinical supervision experiences.

#### *9.3.2 The Working Alliance in Supervision*

In both qualitative and quantitative studies, the significance of the quality of the working alliance as an explanatory variable for less than positive clinical supervision was strong. The weaker emotional bond between supervisor and supervisee in harmful clinical supervision experiences relative to poor supervision

suggested by the quantitative findings was also evident in the qualitative interviews. A lack of trust, an inability to find a way to be heard by the supervisor, and the sense of being in a no-win situation where there was no way to repair ruptures within the supervisory relationship were key themes amongst the words of most supervisees' experiencing harmful clinical supervision. Supervisee descriptions of their supervisors using terms such as impaired, critical and blaming, manipulative, insensitive, uncommunicative, and unsupportive, in four of the five harmful experiences suggest something more problematic than a weak emotional bond underlay the experiences. There appeared to be critical fractures in the emotional bond within the working alliances.

In contrast, the working alliance in poor clinical supervision experiences was not a general concern for all supervisees interviewed, with a distant clinical supervisor used as a more common description. However, as with harmful clinical supervision, there were also concerns voiced about the level of trust and negativity within the working alliance for some supervisees. In particular, two supervisee descriptions of their clinical supervisors were more reminiscent of those used by supervisees reporting harmful clinical supervision. It is conceivable that for these supervisees, supervisee/supervisor characteristics or context related variables may have sustained supervisees in these experiences, reducing the harm or trauma that potentially could have arisen.

While working alliances appeared more generally problematic in harmful clinical supervision experiences, this was not a universal pattern. Qualitative findings indicated that some supervisory relationships in poor supervision experiences were also emotionally laden and negative. This suggests that a fractured emotional bond alone is unlikely to differentiate all poor and harmful clinical supervision experiences and the model's prediction that fractured, negative supervisory relationships will be more evident in harmful supervision experiences is only partially supported. Variables other than the nature of the working alliance may also be salient in differentiating poor and harmful clinical supervision.

### *9.3.3 Inadequate Conceptualisation of Supervision Goals, Tasks and Roles*

The quantitative data indicated that issues pertaining to activities, roles, goals, expectations, and time spent in supervision were the most nominated unitary and contributory explanation for poor clinical supervision experiences in the current study. In contrast to model predictions, quantitative data also supported the importance of these concerns to harmful supervision experiences, although not as a sole explanation for its occurrence. Problems with goals, tasks, roles, and expectations were one of a number of issues within harmful clinical supervision. To some degree, the accuracy of these findings were also supported by scores on two sub-scales of the Working Alliance Inventory (Goals, Tasks) and one sub-scale of the Evaluation Process Within Supervision Inventory (Goal-setting), which did not significantly differentiate supervisees reporting poor and harmful clinical supervision experiences.

Analysis of qualitative data, both individually using a human phenomenological scientific method and thematically through N Vivo 2.0, indicated that issues pertaining to different expectations from supervision, inadequate conceptualization of goals, and the presence of role ambiguity, were issues for some supervisees who reported poor clinical supervision experiences. Only one supervisee reporting harmful clinical supervision directly raised concerns about these factors, specifically about lack of clarity in goals of clinical supervision. While these findings appear on face value to support the model prediction that such issues are more evident in poor supervision experiences, it is also possible that issues of this nature were not given priority in discussions by supervisees reporting harmful clinical supervision. When a number of concerns contribute to harmful clinical supervision experiences, it is plausible that other contributory variables may have been perceived as more critical amongst this small sample of probationary psychologists.

### *9.3.4 The Nature of Evaluative Feedback in Supervision*

Quantitative findings indicated that the nature and/or intensity of evaluative feedback from the clinical supervisor significantly differentiated supervisees in the current research who reported experiencing poor and harmful clinical supervision.

Supervisee ratings on the Evaluation Process Within Supervision (EPSI) Feedback sub-scale suggested that evaluative supervisor feedback was likely to be less impartial, open, understandable, balanced, goal-related, and less based on direct observation of the supervisee's work in harmful clinical supervision experiences.

The qualitative study also pinpointed a range of concerns in relation to supervisor feedback in poor and harmful clinical supervision experiences. Inadequate formative feedback was a key issue in both poor and harmful clinical supervision experiences, and for one supervisee from each group the receipt of unanticipated summative feedback about suitability to enter the profession of psychology was a disturbing experience. A lack of balance in evaluative feedback, with negative feedback the predominant type delivered by clinical supervisors, was also a concern in some poor and harmful supervision experiences. Thus, relatively similar concerns about supervisor feedback were raised by supervisees reporting poor and harmful clinical supervision experiences.

The preliminary model predicted that negative, judgemental, and/or personal supervisor feedback would be a key issue in harmful clinical supervision. While there was evidence of underlying hostility and negativity in feedback from some supervisors in the qualitative study, such concerns were not limited to harmful experiences. Thus, while quantitative findings indicated that evaluative feedback differentiated supervisees experiencing poor and harmful clinical supervision, qualitative findings did not unambiguously explicate how such feedback differs. One possible explanation for this finding is that it is more the intensity of negative evaluative feedback, in contrast to the type of feedback that significantly differentiated poor and harmful clinical supervision experiences.

#### *9.3.5 Supervisor Impairment and Misuse of Power*

Supervisor impairment was defined in Study 1 to include issues such as sexual contact or exploitation, poor boundaries, and personal issues of the supervisor intervening in the supervision process. It was selected as an explanatory factor in harmful clinical supervision experiences by 50% of supervisees in Study 1 ( $n = 5$ ). In contrast, only two supervisees (8%) believed it contributed to the occurrence of poor clinical supervision. While supervisor impairment may have

partially explained some instances of less than positive clinical supervision, according to participants in this study, it was not a sole explanation.

In Study 2, interview participants were not directly asked about supervisor impairment as a contributory factor to poor and harmful clinical supervision. It was raised spontaneously by one supervisee who reported harmful clinical supervision, thereby not overtly presenting as a significant contributory factor in most in-depth accounts of poor or harmful clinical supervision in this study. This does not negate its significance or potential to harm. Arguably, supervisor impairment may be a hidden issue as supervisees may not be privy to the clinical supervisor's personal concerns or understand why he or she is displaying certain manners of approach or behaviour.

It was noted in the qualitative findings that misuse of power by the clinical supervisor was raised as a factor in two cases of harmful clinical supervision and one experience of poor clinical supervision. At this point in time, it is empirically unclear how the misuse of power by a clinical supervisor and supervisor impairment are related. If as Muratori (2001) hypothesised the risk of misuse of power is magnified by supervisor impairment, then arguably the risk of harm to supervisees may also be greater.

#### *9.3.6 Role Conflict*

Role conflict, in the form of opposing expectations for supervisee behaviour (as measured by the Role Conflict and Role Ambiguity Inventory [RCRAI] – Role Conflict sub-scale), did not differentiate supervisees reporting poor and harmful clinical supervision in the quantitative study. In contrast, qualitative findings revealed a range of competing role expectations impacting on most supervisees reporting harmful clinical supervision experiences. When probationary psychologists are called upon to concurrently fulfil the roles of student and psychologist, they perform multiple tasks and function at significantly different levels of power (Olk & Friedlander, 1992). The qualitative findings suggested that for some probationary psychologists meeting the expectations of both roles can be particularly challenging when the clinical supervisor is also their university lecturer. This type of role conflict can occur when supervisees undertake placements within

university based psychology clinics supervised by university lecturing staff. Dealing with the potential for blurring of boundaries between clinical and academic evaluations may be challenging for some supervisors and/or supervisees. Given the small qualitative sample, whether this type of role conflict presents as a frequent problem is unclear.

Perhaps less anticipated were the potential conflicts arising between the roles of student and employee revealed in the qualitative findings. For three supervisees reporting harmful clinical supervision, there was the sense that expectations related to their employment were primary, and learning needs were not always adequately addressed. Yet interviewee dialogues also indicated that competing expectations arising from the roles of employee and student, while illustrated in numerous examples in the verbal data, were not always recognised by supervisees as role conflict per se. Some supervisees acknowledged that their working alliances were not working, but did not specifically attribute this to role conflict. While a number of professions use apprenticeship-type arrangements, perhaps not dissimilar in role to those used for probationary psychologists completing registration through supervised practice, it is plausible that the ongoing monitoring and meeting of student needs in paid work roles may present additional challenges for supervisors and organisations.

While quantitative and qualitative findings appeared to attribute different levels of importance to supervisee role conflict as a variable significantly differentiating poor and harmful clinical supervision experiences, this may at least in part be due to the nature of role conflict revealed in the qualitative study. An examination of the self-report items in the RCRAI – Role Conflict sub-scale (Appendix 7) used in the quantitative study indicated a primary emphasis on supervisee perceived differences or disagreements with the clinical supervisor on ways of working with clients. Such items appear to target potential conflicts between the supervisee's growing autonomy (psychologist) and the need to follow the directions of the clinical supervisor (supervisee). In contrast, the themes related by supervisees in the qualitative study pertained to types of role conflict that may not have been adequately picked up by items on this sub-scale. The potential for role conflict

arising from employment (employee role) and educational contexts (student role) does not appear on face value to be the main focus of this self-report measure. Further empirical study may clarify whether some types of role conflict evident in harmful clinical supervision experiences are broader in nature than can be captured by the RCRAI. For the qualitative sample used in this research, it did appear that role conflict was a salient issue in some harmful clinical supervision experiences and was a more important explanatory variable in harmful clinical supervision relative to poor. This is in line with the model predictions in relation to role conflict and less than positive clinical supervision.

### *9.3.7 Dual Supervisor Roles*

The quantitative study did not attempt to measure the prevalence of dual supervisor roles and their impact on less than positive clinical supervision. Qualitative interviews provided some thought-provoking information on how dual supervisor roles, or perhaps lack of consideration of their potential effects on the supervisory relationship, can impact on the effectiveness of clinical supervision. In some cases, such roles were directly linked with role conflict for supervisees. For example, two supervisees reporting harmful clinical supervision provided examples of different manifestations of negative impacts arising from dual lecturer/clinical supervisor roles. One probationary psychologist felt constrained in performing the psychologist role by the supervisor also lecturing in the higher education program. For the other, the ongoing lecturer/student relationship was adversely affected by previous interactions in their roles of clinical supervisor/supervisee. In both cases, deleterious impacts were experienced by supervisees over a number of years, and are still being felt. Whether early collaborative discussion of the potential for issues to arise from dual supervisor roles would have prevented the concerns from escalating is unknown.

In the qualitative study another form of supervisor dual role presented where the allocated clinical supervisor for registration purposes was also performing some program management functions. This is perhaps most likely to occur where probationary psychologists complete registration requirements through 2 years of supervised practice or its equivalent. For one supervisee reporting harmful clinical

supervision, the inability of the clinical supervisor to differentiate and address organisational and clinical supervision needs in different settings was described as leading to many deleterious impacts including the complete breakdown of the supervisory relationship. For another, a decision to implement administrative action in response to the supervisor's breach of confidentiality led to negative impacts on the working alliance that were never remedied. Again, an interaction between dual supervisor roles and supervisee role conflict was evident.

While themes centring on dual supervisor roles were most clearly apparent in verbal data relating to harmful clinical supervision experiences in accord with the prediction of the preliminary model, there was also some evidence of dual roles impacting on poor clinical supervision experiences. For one supervisee reporting poor clinical supervision, an opportunity to change the placement site (a recommendation made by the placement co-ordinator) was not taken up at least partly because of the potential negative impacts on a pre-existing relationship with the clinical supervisor. While dual supervisor roles appeared to impact on some supervisee experiences of and decision-making in poor and harmful clinical supervision, they were not always raised directly by supervisees as issues of concern. Perhaps reflecting the inherent complexity of dual supervisor roles, their potential negative impacts were unseen by some supervisees.

#### *9.3.8 Inadequate and Inappropriate Supervisor Self-disclosure*

Quantitative findings did not indicate that levels of supervisor self-disclosure differentiated supervisees reporting poor and harmful clinical supervision experiences. As the measure used (see Appendix 8) summed different kinds of supervisor self-disclosure it was difficult to determine whether certain self-disclosures (e.g., disclosures not concordant with supervisee needs; supervisor disclosure of intimate information) in contrast to other forms might be more evident in harmful clinical supervision experiences.

Qualitative findings did not provide direct information on how levels of supervisor self-disclosure impacted on poor and harmful clinical supervision. However, it is plausible that inadequate supervisor self-disclosure may have been a factor in the distant supervisory relationships reported by some interviewees



reporting poor clinical supervision. Further research on the nature of distant supervisory relationships may provide more information in this area.

Qualitative findings tentatively indicated that inappropriate supervisor self-disclosure, from the supervisee's perspective, may be a factor in at least some instances of harmful clinical supervision. It is arguable that disclosure by a clinical supervisor of his or her impressions of how a client may have perceived the physical characteristics of the probationary psychologist (reflections that were regarded by the supervisee as distorted) may have constituted inappropriate supervisor self-disclosure for a supervisee on first placement. Likewise, disclosures by the clinical supervisor about the dynamics of a work team and his or her impressions of work colleagues to a probationary psychologist may be conceptualised as inappropriate self-disclosure.

A difficulty with using supervisor self-disclosure as a variable in the preliminary model is that what represents inappropriate self-disclosure is unlikely to be clear-cut and unequivocal. As the construct of inappropriate supervisor self-disclosure has not been clearly operationalised, there is room for further conceptualization of what might constitute inappropriate or unethical supervisor disclosures. Moreover, as certain supervisor disclosures have the potential to place supervisees in a position of role conflict, the interactive nature of this variable with others needs to be acknowledged.

#### *9.3.9 Unethical Supervisor Behaviour*

The quantitative study did not use any measures pertaining to unethical supervisor behaviour, although ethical, legal and multicultural issues were used as a general category that supervisees were able to select to explain why their nominated least positive supervision experience was poor or harmful. Arguably, the generalised nature of this category limited its explanatory power for assessing unethical supervisor behaviour and its role in poor and harmful clinical supervision experiences. For this reason, the data were not used to evaluate the preliminary model.

Many of the model variables already discussed including inadequate and belated evaluative feedback and negative impacts arising from supervisor dual roles could

also be described as unethical supervisor behaviour. However, use of more specifically operationalised variables in contrast to the more generalised category of unethical supervisor behaviour may increase discipline understanding of the specific and interactive nature of variables implicated in less than positive clinical supervision. Rather than retain unethical supervisor behaviour as a model variable, a preference for more narrowly defined constructs appears justified.

Confidentiality breaches by the clinical supervisor were raised as a key concern for two supervisees in the qualitative study, one reporting poor and another harmful clinical supervision. This finding, combined with previous research indicating that confidentiality breaches can diminish supervisee satisfaction with supervision (Ladany, Lehrman-Waterman, et al., 1999), offers some tentative support for inclusion of confidentiality issues in supervision as a variable in the preliminary model. At this point in time, empirical knowledge of any differences in the nature and impact of confidentiality breaches on supervisee experiences of poor and harmful clinical supervision is limited.

#### *9.3.10 Organisational and Site Factors*

Organisational and site factors as influences on poor and harmful clinical supervision experiences were not directly considered in the quantitative component of this research study. Qualitative findings indicated that the nature of placement arrangements led to a number of challenges and impacts for supervisees reporting poor clinical supervision. These included inadequate time for effective clinical supervision, a concern about the suitability of a placement, and for another supervisee, inadequate preliminary planning as to what would occur on placement. Such issues appeared to relate to organisational goals, culture, and structure as well as the quality of clinical supervision. Concerns of an organisational or site nature potentially intervene in the supervisory relationship, impacting on clinical supervision effectiveness.

Interviewees reporting harmful clinical supervision experiences related a range of organisational challenges in their interviews. Three supervisees characterised their organisational settings as requiring quite challenging work responses as their respective organisations went through periods of significant change. It was noted

that the nature of organisational and site factors impacting on clinical supervision in the current study appeared somewhat different for supervisees experiencing poor and harmful clinical supervision. Some supervisees reporting harmful clinical supervision related broader organisational change issues in their interviews. While this equates with model predictions, further empirical study in this area is needed.

#### *9.3.11 Other Participants in Clinical Supervision*

Clinical supervision is a dynamic interactive process involving a range of participants in critical to minor roles. Arguably, each experience of clinical supervision has a different relational structure which can vary over the supervision experience. For instance, involvement of the placement co-ordinator in a debriefing role for a supervisee includes a significant other as an adjunct to the supervisory relationship. Quantitative data did not consider the importance of other participants in less than positive clinical supervision. Qualitative findings indicated that a range of other participants were relevant to poor and harmful clinical supervision experiences. These included placement co-ordinators, program managers, lecturers, work peers, other supervisees, and administrative staff. This is an area rarely considered in previous research and while no predictions were made as to their importance in poor and harmful clinical supervision experiences, the importance of other participants to less than positive clinical supervision requires acknowledgement.

### **9.4 Limitations of Model**

#### *9.4.1 Variables Not Covered in the Model*

The preliminary model made no predictions about the importance of tailoring clinical supervision to the supervisee's developmental level. As supervisee development across the probationary period can be conceptualised in many different ways, any relationship to less than positive clinical supervision appeared to warrant more thorough consideration than this study could offer. Interestingly, despite limited coverage of developmental supervision models, some of the themes uncovered in the qualitative interviews displayed a definite developmental slant. Themes such as lack of adequate direction, structure, and support in the dialogues of supervisees reporting poor clinical supervision, and questions about the nature of

supervisor feedback and unfulfilled expectations of a supervisee in harmful experiences, indicate this is an area requiring further exploration. As most of these supervisees were early in their probationary period, their experiences do raise questions of a developmental nature.

Some previous research has indicated that an imbalance of supervisor styles may be associated with less than positive supervision (Allen et al., 1986; Nelson & Friedlander, 2001). Supervisor style and manner of approach in clinical supervision was not measured in the quantitative data. While tentative at this time, qualitative findings did support supervisee concerns with the supervisor's manner of approach in less than positive clinical supervision. Insufficient supervisor focus on the supervisory relationship may be pertinent to poor clinical supervision, with lack of investment in the relationship and failure to adopt a strong collegial approach with supervisees as possible concerns in some harmful clinical supervision experiences. It was unclear in the present study how adopting a high task-oriented approach impacts on less than positive clinical supervision. Supervisor styles may be an important exploratory variable for inclusion in the preliminary model. Further research in this area appears warranted.

The qualitative study asked interviewees to describe themselves in relation to their clinical supervisors and to consider both similarities and differences. This question tended to draw from interviewees reporting poor clinical supervision some similarities (e.g., in theoretical orientation and commitment to the work) and differences (e.g., in empathy shown to clients, level of knowledge, expectations from supervision) predominantly relating to the supervisor's work style. Interviewees who described harmful clinical supervision experiences only related differences (also usually pertaining to supervisor work style), including in their orientation to theory and the level of help and support provided to clients. Significant differences in work style between supervisor and supervisee may in part be related to differences in theoretical orientation. In hindsight, it would have been useful to collect information on the theoretical orientation of supervisor and supervisee in Study 1. This, combined with use of the Supervisor Styles Inventory

(Friedlander & Ward, 1984), may have afforded some additional information on poor and harmful supervision experiences.

#### *9.4.2 Mechanisms Underlying the Occurrence of Poor and Harmful Clinical Supervision*

At this point in our understanding of less than positive clinical supervision, much is still unknown about the interactive nature of variable influences on poor and harmful clinical supervision over time. While potential interrelationships have been discussed, further qualitative studies would in all likelihood reveal a range of other potential connections. Discipline understanding of what variables may represent causes and/or effects in less than positive supervision is limited. There is also a need for further exploration of precipitant and maintaining variables, and how they interact over the supervisory experience. For example, supervisee role conflict appeared to be a product of supervisor dual roles in some instances. The fact that many clinical supervision experiences in the current study appeared to begin positively and then deteriorated over time suggests that in-depth study of supervision dyads and their interactions may be helpful in eliciting the salience of and interplay between variables over a supervision experience.

#### *9.4.3 Variable Overlap and Definitional Refinement*

One of the most noticeable issues in the design of this model is the overlap amongst variables. Belated supervisor feedback in relation to supervisee progress and failure to consider the possible impact of dual supervisor roles are ethical transgressions and at the same time can be treated as separate variables. Unethical supervisor behaviour can operate as a catch-all category without the necessary specificity to separate different behaviours.

### **9.5 Revised Model of Variables Hypothesised to Underlie Supervisee Experiences of Poor and Harmful Clinical Supervision**

Figure 6 provides a revised version of the preliminary model previously presented as Figure 3. Included in the revised preliminary model are predictions pertaining to supervisory style and tailoring supervision to the developmental level of the supervisee as potential predictors of less than positive clinical supervision. Unethical supervisor behaviour has been removed as a variable in the model.

Preference has been given to more narrowly defined variables, with the inclusion of confidentiality issues in supervision as a variable warranting further investigation.

Some revisions have been made to the predictions as they relate to variables presented in the preliminary model. A hypothesised relationship between supervisor misuse of power and supervisor impairment has been included in the model. In addition, dual supervisor roles have been provisionally linked to supervisee role conflict. This recognises a potential complexity in maintaining clear boundaries when clinical supervisors also perform lecturer or managerial roles in relation to their supervisees. The need to consider other participants and their possible influence on clinical supervision is also specifically noted in the revised model. Other participants such as program managers or clinic directors may be perceived by some supervisees as playing a role in poor or harmful clinical supervision experiences. Inadequate and untimely supervisor feedback has been linked to poor and harmful clinical supervision experiences. In the preliminary model, inadequate feedback was included as a potential factor underlying only poor supervision experiences. This has been broadened to recognise that inadequate and untimely supervisor feedback may also be a factor implicated in harmful clinical supervision. These modifications have been based on the empirical data reported in Chapters 7 and 8.

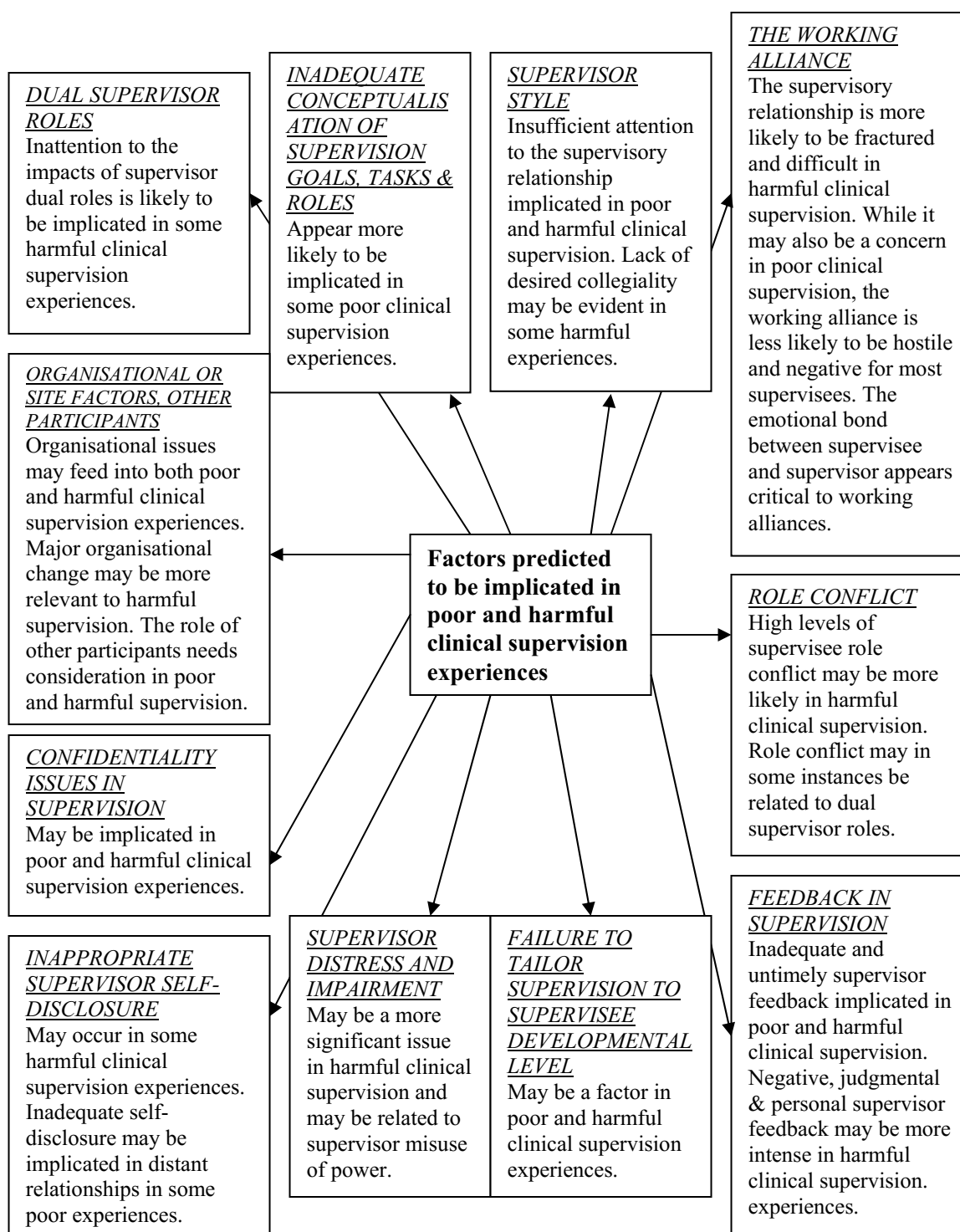


Figure 6. A revised diagrammatic representation of some of the variables hypothesised to underlie supervisee experiences of poor and harmful clinical supervision.

### 9.6 Future Model Development

A validated and reliable measure of clinical supervision effectiveness would be useful for future testing of this model. This could comprise of an impacts scale as suggested in Chapter 8. Self-rating and monitoring of the personal and professional impacts of clinical supervision experiences could present a more comprehensive, valid and reliable means of classifying different types of supervision effectiveness. In the current study, only brief definitions were provided to supervisees to guide selection of their least positive clinical supervision experience. It is quite plausible that for some supervisees these definitions did not provide the level of detail required for clear differentiation of different levels of clinical supervision effectiveness.

As the model is at a developmental stage, some of the variables represented in the model were not specifically defined or operationalised. Attention to refinement of variable definitions and their operationalisation would be beneficial to any future testing of this model. In addition, multiple measures of variables and use of a predictive modelling process such as regression may facilitate greater understanding of the salience of variables to poor and harmful clinical supervision experiences. While qualitative studies draw out in-depth information on variables that supervisees perceive as causative in less than positive clinical supervision, quantitative techniques potentially play an important role in clarifying the relative predictive importance of specific variables and the interactive or moderator effects.

### 9.7 Conclusion

The preliminary model was used to combine existing theoretical and empirical knowledge on less than positive clinical supervision, and to commence building a testable model of variables that may predict poor and harmful clinical experiences for supervisees. Predictions were predominantly based on existing theory and research, and represent early theorisation about the significance of a range of factors to the occurrence of less than positive clinical supervision. Quantitative and qualitative methods of data collection were applied sequentially in an attempt to collect a broad base of information, while also attending to the need for depth in exploration. Rather than viewing the empirical studies as a means of validating



model predictions, early model testing presented a process for evaluating a number of the model's preliminary predictions and drawing out some of the model's limitations.

### 9.8 Limitations of the Research Design

This chapter involved integrating quantitative and qualitative findings for the purpose of preliminary evaluation of the model predictions. Implied in this process is the proposition that there is some validity in combining data collected under different assumptions or beliefs about how the social world can be understood for exploratory purposes.

The potential contribution of underpinning variables to poor and harmful clinical supervision experiences was evaluated in some cases using both qualitative and quantitative data. This was undertaken to assess the exploratory hypotheses generated from extant theory and research and it should not be assumed that integrating more than one set of data increases the reliability or validity of reported findings.

Only some of the quantitative and qualitative data were overlapping, thus limiting the ability to compare and contrast data from the two sources. Additional research on the preliminary model is required to elaborate on, confirm, or refute the tentative hypotheses generated.

## **CHAPTER 10: SOME CONCLUDING REMARKS ON CLINICAL SUPERVISION**

### 10.1 The Nature of Clinical Supervision

Clinical supervision serves educative and evaluative purposes, but it is by no means unvarying in nature. Each supervision experience comprises of variables and influences that exist in dynamic relationship to each other. Thus, the nature of clinical supervision varies with context and over time and other participants' impact on its quality. When clinical supervision is conceptualised solely from the supervisor's perspective, it is easier to attribute primary responsibility for the occurrence of less than positive experiences to the clinical supervisor. This constricted focus denies the embedded nature of clinical supervision.

#### *10.1.1 An Intervention Provided by a Senior Member of the Profession to a More Junior Member*

While clinical supervisors have essential professional experience and clinical skills to impart to probationary psychologists, clinical supervision is best conceptualised as a collaborative interactive training tool (Efstation, Patton, & Kardash, 1990; Holloway, 1995). The experiential flows are not one way, and the impacts of clinical supervision are unlikely to be unidirectional. Exploration of bi-directional and interactional flows in clinical supervision is warranted.

#### *10.1.2 Clinical Supervision Occurs Within an Ongoing Relationship*

There is persuasive argument for conceptualising clinical supervision as occurring within a collaborative working alliance which is impacted upon by a range of events over the relationship. In some experiences of clinical supervision, interpersonal conflicts will arise (Nelson et al., 2001). On occasion such ruptures to the supervisory relationship may be difficult to repair without resort to assistance from external parties. It is important, where possible, for the nature of such assistance to be predetermined and pro-active, to aid, not impede, repair to the supervisory relationship.

#### *10.1.3 The Supervisor has a Number of Critical Functions to Perform*

While enhancing professional functioning and monitoring client care are critical supervisor functions (Bernard & Goodyear, 2004), clinical supervisors are also called upon to function as or manage other key roles. One of these functions is gate-keeping the

profession. It is important to recognise the balancing act that clinical supervisors are called upon to perform. While many supervisees may find their professional functioning augmented by their clinical supervisor providing empathic, non-judgemental support, validation, and encouragement (Worthen & McNeill, 1996), the functions of monitoring client care and gate-keeping the profession conceivably require a more evaluative stance from the clinical supervisor. The interplay amongst supervisor functions may at least in part account for the inevitability of some interpersonal conflict in many supervisory relationships.

#### *10.1.4 Evaluation can be viewed as the Nucleus of Clinical Supervision*

Attention to the nature and delivery of formative and summative evaluative feedback in supervision appears to be a critical supervisor function. It is probable that the salience of this function is heightened by principal reliance on the clinical supervisor to assess supervisee competency. Ladany's (2004) proposal that consideration should be given to broadening and objectifying evaluation of supervisee competency and readiness to practice appears a valid one, particularly in light of supervisee concerns pertaining to evaluative feedback in both quantitative and qualitative components of the current study.

#### 10.2 Conceptualising Effective and Ineffective Clinical Supervision

The limited theoretical framework for conceptualising gradations of clinical supervision effectiveness at the current time has already been noted. Despite this limitation, the conceptualisation of effective clinical supervision as hinging on two critical competencies (the ability of the clinical supervisor to establish strong and effective working alliances with supervisees, and their ability to manage interpersonal conflicts in supervision) is an empirically useful one for which there appears some tentative support (Nelson et al., 2001). While the quality of clinical supervision is undoubtedly affected by other variables, these factors present a starting point for operationalising effective clinical supervision.

The constructs of bad and harmful clinical supervision developed by Ellis and his colleagues (Ellis, 2001; Ellis et al, 2000) afforded a useful preliminary framework for conceptualising supervisee experiences of less than positive supervision. While the evident overlap in impacts arising from poor and harmful clinical supervision suggest this

differentiation is far from clear cut, further empirical studies can build on and revise this conceptual framework.

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## APPENDIX 1

### Supervisee Tasks within Clinical Supervision<sup>a</sup>

Tasks for Supervisee Development	Definition of Tasks	Examples of Task Components
1. Counselling skills	Actions to be taken with clients and how actions will be implemented	Communication patterns, empathy, counselling techniques
2. Case conceptualisation	Understanding the client's psychosocial history and presenting problems within a conceptual framework	Reflecting on client behaviour, the relationship, and potential interventions
3. Professional role	How the supervisee uses external resources for the client, applies professional and ethical principles, learns tasks of therapist, and participates in the supervisory relationship	Ongoing examination of how the supervisee is adapting to counsellor's role; supervisee interactions within the supervisory relationship
4. Emotional awareness	Relates to the supervisee's self-awareness of feelings, thoughts and actions that result from working with the client and supervisor	Analysis of own feelings during a client session
5. Self-Evaluation	Ability to recognize the limits of competence, effectiveness, and evaluate client progress	Viewing of counselling sessions, developing self-evaluation skills

<sup>a</sup> Table contents adapted from E. Holloway (1995), *A Systems Approach to Clinical Supervision*.

## APPENDIX 2

### Study 1 Information Sheet: Supervisee Experiences of Clinical Supervision

We are conducting a study to investigate the least positive clinical supervision experiences of probationary psychologists. For this purpose, we need to learn more about experiences of effective and ineffective clinical supervision. It is anticipated that the results of this study will facilitate further understanding of the nature, characteristics, and consequences of clinical supervision experienced by supervisees as less than positive. As a relatively new and significant area of research, it is our belief that this project is very important.

If you volunteer to participate in this project, you will need to choose your least positive supervision experience occurring during the last three years, excluding any current one. You will be asked to complete a questionnaire taking about 30 minutes. This will relate to your least positive clinical supervision experience. The questionnaire includes:

1. Some background questions;
2. A series of questions about the supervision experience nominated;
3. A set of questions about the supervisory relationship;
4. A scale which measures role conflict and role ambiguity in supervision;
5. An inventory that measures goal setting and feedback within supervision; and
6. A scale that measures supervisor self-disclosure.

Your responses will be completely anonymous and confidential. The results of this study may be published in a scientific journal; however no individual will be identifiable.

It is possible that participating in research of this nature may evoke some uncomfortable or unpleasant emotions or thoughts related to the earlier supervision experience. Your participation is completely voluntary and it is important that you carefully consider whether you would like to be involved at this time. Your initial decision to participate does not stop you from discontinuing participation and you are free to withdraw at any time. Please consider the purposes of this study before you decide whether or not to participate.

This research conforms to the principles set out in Swinburne University of Technology Policy on Research Ethics and the NHMRC guidelines as specified in the National Statement on Ethical Conduct on Research Involving Humans.

If you have any questions about this study, please contact the investigators:

<p>Colleen Lovell (Student Investigator)          Dr. Naomi Crafti (Senior Investigator)          School of Social and Behavioural Sciences          Swinburne University of Technology          Mail H24, Hawthorn, Victoria, 3122          Telephone: 03 9214 5355</p>
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If you have any queries or concerns which the Senior Investigator was unable to satisfy, contact:

The Chair, SBS Research Ethics Committee  
School of Social & Behavioural Sciences  
Mail H24  
Swinburne University of Technology, Hawthorn, Victoria, 3122

If you have a complaint about the way you were treated during this study please write to:

The Chair  
Human Research Ethics Committee  
Swinburne University of Technology,  
Hawthorn, Vic, 3122

NOTE: Your participation in this study is completely voluntary. Completion and electronic return of the questionnaire will be taken as your consent to participate in the study.



### APPENDIX 3

#### Study 2 Information Sheet: Supervisee Experiences of Poor and Harmful Clinical Supervision

**PLEASE NOTE:** There is a second part to this study involving in-depth **phone interviews** (about 45 minutes in length), with supervisees who have described their least positive supervision experience as **poor or harmful**. Information on the second study and contact information should you wish to be involved are included below.

**Project Title:** Supervisee Experiences of Poor and Harmful Clinical Supervision  
**Investigators:** Ms C.M. Lovell, Student & Dr. N. Crafti, Supervisor

#### Explanation of Project

The second part of this study involves in-depth interviews with supervisees who have described their least positive supervision experience as poor or harmful. The objective of this part of the study is to obtain more detailed understanding of the nature, characteristics and consequences of supervision experiences perceived by supervisees as poor or harmful.

We are seeking volunteers to participate in a confidential phone interview in order to provide detailed information on their supervision experience. Interviews would take about 45 minutes at a time convenient to each participant. It would be helpful in the interests of accuracy if such interviews could be audio taped and later transcribed. No personal or identifying information would be collected and tapes and transcripts would be securely stored in a locked cabinet. We would not want your name or location, and would not want any identifying information on your supervisor, training institution or site for supervision.

Research of this nature may evoke some uncomfortable or unpleasant emotions or thoughts related to the earlier supervision experience. Your participation is completely voluntary and it is important that you carefully consider whether you would like to be involved at this time. Your initial decision to participate does not stop you from discontinuing participation and you are free to withdraw at any time.

Should you wish to be involved in this research there are two additional issues you need to consider before consenting. Firstly, you would need to consider whether you would be agreeable to your interview being audio-taped. Secondly, you would need to decide whether you would be agreeable to phrases or sentences from your interview being quoted in any publication as illustrations of the nature, causes and consequences of harmful or poor supervision. Care would be taken to ensure that such responses would be typical and not identifiable by context. If you wanted to review the investigation findings prior to publication, you could nominate to receive a summary copy of the findings, which can be reviewed and amended.

It is possible that during or after participation in this research uncomfortable or unpleasant emotions or thoughts may arise unexpectedly. If this is the case, you will

be free to contact either the student researcher or the principal supervisor to seek appropriate referral to counselling/psychological services.

In circumstances where information divulged during the interview involves potential harm to the interviewee or to third parties, it would be the responsibility of the student investigator to report such information to the senior investigator. This reporting procedure, and any action arising, would be undertaken in consultation with the interviewee.

This research conforms to the principles set out in Swinburne University of Technology Policy on Research Ethics and the NHMRC guidelines as specified in the National Statement on Ethical Conduct on Research Involving Humans.

Please consider the purposes of this study before you decide whether or not to participate. If you are interested in participating in this second more in-depth part of the study, please read the remainder of this page. You are then welcome to ask further questions or indicate your interest in being involved in the research by e-mailing the student investigator at the e-mail address below (or making contact by mail or phone if you would prefer this). If you would like to participate, a time, date and method of contact for the interview would be arranged. Contact details would only be known by the student investigator and would be destroyed on completion of the research.

If you have any questions about this study, please contact the investigators:

Colleen Lovell (Student Investigator)  
Dr. Naomi Crafti (Senior Investigator)  
School of Social & Behavioural Sciences,  
Swinburne University of Technology  
Mail H24, Hawthorn, Victoria, 3122.  
Telephone: 03 9214 5355

If you have any queries or concerns, which the Senior Investigator was unable to satisfy, contact:

The Chair, SBS Research Ethics Committee  
School of Social & Behavioural Sciences, Mail H24  
Swinburne University of Technology,  
Hawthorn, Victoria, 3122

If you have a complaint about the way that you were treated during this study please write to:

The Chair, Human Research Ethics Committee  
Swinburne University of Technology,  
Hawthorn, Victoria, 3122

E-MAIL DETAILS FOR ADDITIONAL INFORMATION OR INDICATING  
INTEREST IN BEING INVOLVED IN THIS STUDY:

[4041712@swin.edu.au](mailto:4041712@swin.edu.au)

**APPENDIX 4**Study 1: Self-Report Measure

1. Before you proceed to the rest of the questionnaire, would you please provide us with the following personal information. Some information may be used in data analysis, but most importantly, these details enable us to describe the sample on which the results are based.

Age in years: \_\_\_\_\_

2. Gender: ☐ Male ☐ Female

3. Please describe your ethnicity.

4. Highest Education Achieved:

☐ (a) Completed an accredited four year sequence of study in psychology and engaged in work of a psychological nature under the supervision of a registered psychologist; or

☐ (b) Completed an approved four year sequence in psychology and currently enrolled in an accredited coursework higher degree in psychology.

(c) Other: Please Specify.

5. Education level currently seeking:

☐ Doctoral

☐ Masters

☐ None

Other: Please Specify

6. Number of clinical supervisory relationships experienced as a supervisee:

☐ Less than 5

☐ 5-9

☐ 10 and over

7. Approximate number of months of counselling experience with individual clients you have completed to date:

- ☐ Less than 12 months  
☐ 12 to 24 months  
☐ 25 to 48 months  
☐ 49 months and over

**8. Your Least Positive Clinical Supervision Experience** (Note that an experience is defined as a period of time in contrast to a single event.) All questions in the remainder of this questionnaire relate to this supervision experience.

Choose your least positive clinical supervision experience occurring over the last three years, excluding any current one. Using the definitions below, please indicate which description best fits your nominated experience.

<input type="checkbox"/> Effective Supervision - results when supervision involves the development of a strong working alliance and effective management of supervision conflicts
<input type="checkbox"/> Somewhat Effective Supervision – results when supervision is a learning experience but the nature of the working alliance and/or management of interpersonal conflicts reduce its effectiveness to a degree
<input type="checkbox"/> Neither Positive nor Negative Supervision - supervision cannot be described as either effective or poor or harmful
<input type="checkbox"/> Poor Supervision – occurs because your supervisor was unable or unwilling to meet your training needs or it entails a poor supervisory relationship
<input type="checkbox"/> Harmful Supervision - results in psychological, emotional, or physical harm or trauma to the supervisee

9. What was the gender of your supervisor?

- ☐ Male      ☐ Female

10. What was the ethnicity of your supervisor?

--

11. Did your least positive supervision experience involve use of a supervision contract?

- ☐ Yes  
☐ No

12. Please answer this question ONLY if you rated your least positive supervision experience as POOR or HARMFUL. Go directly to Question 13 if you rated your nominated experience as effective, somewhat effective, or neither positive nor negative supervision.

**PARTICIPANTS WITH POOR OR HARMFUL SUPERVISION EXPERIENCES:**  
Please indicate which of the following categories (you can choose more than one) is important in explaining your least positive supervision experience.

<input type="checkbox"/> Interpersonal relationship and style - differing attitudes, personality conflicts, communication difficulties, including the supervisor being critical, disrespectful and unsupportive
<input type="checkbox"/> Conceptualization and theoretical orientation - conflicts involving client conceptualization, diagnosis, treatment decisions, and interventions, such as disagreements related to different theoretical orientations
<input type="checkbox"/> Supervision tasks & responsibilities - Issues pertaining to activities, roles, goals, expectations and time spent in supervision, including lack of supervision, inadequate knowledge and/or skills of the supervisor
<input type="checkbox"/> Ethics, legal and multicultural issues - ethical and legal considerations pertaining to the professional practice of psychology, including multicultural competence, clinical issues, and case management
<input type="checkbox"/> Supervisor distress or impairment - issues such as sexual contact or exploitation, poor boundaries, personal issues of supervisor intervening in the supervision process
Other: Please Specify

## APPENDIX 5

### Working Alliance Inventory – Trainee Version (WAI-T) (Bahrck, 1990)

Instructions: On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her supervisor. As you read the sentences, mentally insert the name of your supervisor in place of \_\_\_\_\_ in the text.

Beside each statement there is a seven-point scale:

1	2	3	4	5	6	7
never	rarely	occasionally	sometimes	often	very often	always

If the statement describes the way you always feel (or think), circle the number "7"; if it never applies to you, circle the number "1". Use the numbers in between to describe the variations between these extremes. Please work fast: your first impressions are what is wanted.

1. I felt uncomfortable with \_\_\_\_\_. 1   2   3   4   5   6   7
2. \_\_\_\_\_ and I agreed about the things I will need to do in supervision. 1   2   3   4   5   6   7
3. I was worried about the outcome of our supervision sessions. 1   2   3   4   5   6   7
4. What I was doing in supervision gives me a new way of looking at myself as a counsellor. 1   2   3   4   5   6   7
5. \_\_\_\_\_ and I understood each other. 1   2   3   4   5   6   7
6. \_\_\_\_\_ perceived accurately what my goals were. 1   2   3   4   5   6   7
7. I found what I was doing in supervision confusing. 1   2   3   4   5   6   7
8. I believe \_\_\_\_\_ liked me. 1   2   3   4   5   6   7
9. I wish \_\_\_\_\_ and I could have clarified the purpose of our sessions. 1   2   3   4   5   6   7
10. I disagreed with \_\_\_\_\_ about what I ought to get out of supervision. 1   2   3   4   5   6   7

11. I believe the time \_\_\_\_\_ and I were spending together  
was not spent efficiently. 1 2 3 4 5 6 7
12. \_\_\_\_\_ does not understand what I wanted to accomplish  
in supervision. 1 2 3 4 5 6 7
13. I was clear on what my responsibilities were in supervision. 1 2 3 4 5 6 7
14. The goals of these sessions were important to me. 1 2 3 4 5 6 7
15. I found what \_\_\_\_\_ and I were doing in supervision  
was unrelated to my concerns. 1 2 3 4 5 6 7
16. I felt that what \_\_\_\_\_ and I were doing in supervision  
helped me to accomplish the changes that I wanted in order  
to be a more effective counsellor. 1 2 3 4 5 6 7
17. I believe \_\_\_\_\_ was genuinely concerned for my  
welfare. 1 2 3 4 5 6 7
18. I was clear as to what \_\_\_\_\_ wanted me to do in our  
supervision sessions. 1 2 3 4 5 6 7
19. \_\_\_\_\_ and I respected each other. 1 2 3 4 5 6 7
20. I feel that \_\_\_\_\_ was not totally honest about his/her  
feelings toward me. 1 2 3 4 5 6 7
21. I was confident in \_\_\_\_\_'s ability to supervise me. 1 2 3 4 5 6 7
22. \_\_\_\_\_ and I were working towards mutually agreed  
upon goals. 1 2 3 4 5 6 7
23. I feel that \_\_\_\_\_ appreciated me. 1 2 3 4 5 6 7
24. We agreed on what was important for me to work on. 1 2 3 4 5 6 7
25. As a result of our supervision sessions, I was clearer as  
to how I might improve my counselling skills. 1 2 3 4 5 6 7
26. \_\_\_\_\_ and I trusted one another. 1 2 3 4 5 6 7
27. \_\_\_\_\_ and I had different ideas on what I needed  
to work on. 1 2 3 4 5 6 7

28. My relationship with \_\_\_\_\_ was very important to me. 1 2 3 4 5 6 7
29. I had the feeling that it was important that I say or do the "right" things in supervision with \_\_\_\_\_. 1 2 3 4 5 6 7
30. \_\_\_\_\_ and I collaborated on setting goals for my supervision. 1 2 3 4 5 6 7
31. I was frustrated by the things we were doing in supervision. 1 2 3 4 5 6 7
32. We had established a good understanding of the kinds of things I needed to work on. 1 2 3 4 5 6 7
33. The things that \_\_\_\_\_ was asking me to do didn't make sense. 1 2 3 4 5 6 7
34. I didn't know what to expect as a result of my supervision. 1 2 3 4 5 6 7
35. I believe the way we were working with my issues was correct. 1 2 3 4 5 6 7
36. I believe \_\_\_\_\_ cared about me even when I did things that he/she didn't approve of. 1 2 3 4 5 6 7

Scoring:

Task Sub-scale:

Positively scored items: 2, 4, 13, 16, 18, 24, 35

Negatively scored items: 7, 11, 15, 31, 33

Bond Sub-scale:

Positively scored items: 5, 8, 17, 19, 21, 13, 26, 28, 36

Negatively scored items: 1, 20, 29

Goal Sub-scale:

Positively scored items: 6, 14, 22, 25, 30, 32

Negatively scored items: 3, 9, 10, 12, 27, 34



## APPENDIX 6

### Evaluation Process Within Supervision Inventory (EPSI) (Lehrman-Waterman & Ladany, 2001)

Please specify the degree to which your nominated supervision experience was characterized by the following.

Beside each statement is a 7-point scale:

---

1	2	3	4	5	6	7
strongly disagree	disagree	somewhat disagree	neither agree or disagree	somewhat agree	agree	strongly agree

---

1. The goals my supervisor and I generated for my training seem important. 1 2 3 4 5 6 7
2. My supervisor and I created goals, which were easy to understand. 1 2 3 4 5 6 7
3. The objectives my supervisor and I created were specific. 1 2 3 4 5 6 7
4. My supervisor and I created goals that were realistic. 1 2 3 4 5 6 7
5. I think my supervisor would have been against my reshaping/  
changing my learning objective over the course of our work  
together. 1 2 3 4 5 6 7
6. My supervisor and I created goals which seemed too easy for me. 1 2 3 4 5 6 7
7. My supervisor and I created objectives which were measurable. 1 2 3 4 5 6 7
8. I felt uncertain as to what my most important goals were for this  
training experience. 1 2 3 4 5 6 7
9. My training objectives were established early in our relationship. 1 2 3 4 5 6 7
10. My supervisor and I never had a discussion about my objectives  
for my training experience. 1 2 3 4 5 6 7

11. My supervisor told me that he or she wanted me to learn from the experience without inquiring about what I hoped to learn. 1 2 3 4 5 6 7
12. Some of the goals my supervisor and I established were not practical in light of the resources available at my site 1 2 3 4 5 6 7
13. My supervisor and I set objectives which seemed practical given the opportunities available 1 2 3 4 5 6 7
14. My supervisor welcomed comments about his or her style as supervisor. 1 2 3 4 5 6 7
15. The appraisal I received from my supervisor seemed impartial. 1 2 3 4 5 6 7
16. My supervisor's comments about my work were understandable. 1 2 3 4 5 6 7
17. I didn't receive information about how I was doing as a counsellor until late in the semester. 1 2 3 4 5 6 7
18. I had a summative, formal evaluation of my work at the end of semester. 1 2 3 4 5 6 7
19. My supervisor balanced his or her feedback between positive and negative statements. 1 2 3 4 5 6 7
20. The feedback I received from my supervisor was based upon his or her direct observation of my work. 1 2 3 4 5 6 7
21. The feedback I received was directly related to the goals we established. 1 2 3 4 5 6 7

Scoring:

First, reverse score the following items: 5, 6, 8, 10, 11, 12 and 17.

Goal Setting: Sum items 1 through 13.

Feedback: Sum items 14 through 21.

## APPENDIX 7

### Role Conflict & Role Ambiguity Inventory

(Olk & Friedlander, 1992)

Please respond to the questions based on your experience with your nominated supervisor.

Beside each statement there is a five-point scale:

1	2	3	4	5
not at all	rarely	occasionally	sometimes	very much

- |   |           |
|---|-----------|
| 1. I was not certain about what material to present to my supervisor.   | 1 2 3 4 5 |
| 2. I wasn't sure how best to use supervision as I became more experienced, although I was aware that I was expected to behave more independently. | 1 2 3 4 5 |
| 3. My supervisor expected me to come prepared for supervision, but I had no idea what or how to prepare.  | 1 2 3 4 5 |
| 4. I wasn't sure how autonomous I should be in my work with clients.  | 1 2 3 4 5 |
| 5. My supervisor's criteria for evaluating my work were not specific.   | 1 2 3 4 5 |
| 6. I was not sure that I had done what the supervisor expected me to do in a session.   | 1 2 3 4 5 |
| 7. The criteria for evaluating my performance in supervision were not clear.  | 1 2 3 4 5 |
| 8. The feedback I got from my supervisor did not help me to know what was expected of me in my day to day work with clients.                      | 1 2 3 4 5 |
| 9. Everything was new and I wasn't sure what would be expected of me.   | 1 2 3 4 5 |
| 10. I was not sure if I should discuss my professional weaknesses in supervision because I was not sure how I would be evaluated.                 | 1 2 3 4 5 |
| 11. My supervisor gave me no feedback, and I felt lost.   | 1 2 3 4 5 |
| 12. My supervisor told me what to do with a client but didn't give me very specific ideas about how to do it.                                     | 1 2 3 4 5 |

13. There were no clear guidelines for my behaviour in supervision. 1 2 3 4 5
14. The supervisor gave no constructive or negative feedback and, as a result, I did not know how to address my weaknesses. 1 2 3 4 5
15. I didn't know how I was doing as a therapist and, as a result, I didn't know how my supervisor would evaluate me. 1 2 3 4 5
16. I was unsure of what to expect from my supervisor. 1 2 3 4 5
17. I have felt that my supervisor was incompetent or less competent than I. I often felt as though I was supervising him/her. 1 2 3 4 5
18. I have wanted to challenge the appropriateness of my supervisor's recommendations for using a technique with one of my clients, but I have thought it better to keep my opinions to myself. 1 2 3 4 5
19. My orientation to therapy was different from that of my supervisor. She or he wanted me to work with clients using his or her framework, and I felt that I should be allowed to use my own approach. 1 2 3 4 5
20. I have wanted to intervene with one of my clients in a particular way and my supervisor wanted me to approach the client in a very different way. I am expected to both to judge what is appropriate for myself and also to do what I am told. 1 2 3 4 5
21. My supervisor told me to do something I perceived to be illegal or unethical and I was expected to comply. 1 2 3 4 5
22. I disagreed with my supervisor about how to introduce a specific issue to a client, but I also wanted to do what the supervisor recommended. 1 2 3 4 5
23. Part of me wanted to rely on my own instincts with clients, but I always knew that my supervisor would have the last word. 1 2 3 4 5
24. I was not comfortable using a technique recommended by my supervisor; however, I felt that I should do what my supervisor recommended. 1 2 3 4 5
25. I disagreed with my supervisor about implementing a specific technique, but I also wanted to do what the supervisor thought best. 1 2 3 4 5
26. My supervisor wanted me to use an assessment technique that I considered inappropriate for a particular client. 1 2 3 4 5

27. I have believed that my supervisor's behaviour in one or more situations was unethical or illegal and I was undecided about whether to confront her/him. 1 2 3 4 5
28. I got mixed signals from my supervisor, and I was unsure of which signals to attend to. 1 2 3 4 5
29. When using a new technique, I was unclear about the specific steps involved. As a result, I wasn't sure how my supervisor would evaluate my performance. 1 2 3 4 5

Scoring:

Role Ambiguity: Sum items 1 to 16 and divide by number of items on scale

Role Conflict: Sum items 17 to 29 and divide by number of items on scale

## APPENDIX 8

### Supervisor Self-Disclosure Index (SSDI)

(Ladany & Lehrman-Waterman, 1999)

Please respond to the questions based on your experience with your supervisor.

---

Beside each statement there is a five-point scale:

1 = not at all    2 = rarely    3 = occasionally    4 = sometimes    5 = often

---

- |   |           |
|---|-----------|
| 1. My supervisor self-discloses favorable information (e.g. strengths or success experiences) about herself or himself.                   | 1 2 3 4 5 |
| 2. My supervisor self-discloses unfavorable information (e.g. failure experiences or weaknesses) about herself or himself.                | 1 2 3 4 5 |
| 3. My supervisor self-discloses information related to her or his present experiences.  | 1 2 3 4 5 |
| 4. My supervisor self-discloses information related to her or his past experiences.   | 1 2 3 4 5 |
| 5. My supervisor self-discloses intimate information about herself or himself.  | 1 2 3 4 5 |
| 6. My supervisor self-discloses non-intimate information about herself or himself.  | 1 2 3 4 5 |
| 7. My supervisor self-discloses information about herself or himself that is similar to the issues and concerns on which I am working.    | 1 2 3 4 5 |
| 8. My supervisor self-discloses information about herself or himself that is dissimilar to the issues and concerns on which I am working. | 1 2 3 4 5 |
| 9. My supervisor makes self-involving disclosing statements about how he or she is feeling about me in-the-moment in supervision.         | 1 2 3 4 5 |

Scoring: Sum items 1 through 9.

## APPENDIX 9

### STUDY 2: Semi-structured Interview Guide

Age

Sex

#### Opening Questions:

1. Where are you now in your studies and training?
2. How long ago was the supervision experience that you will be talking about?
3. Where were you in your studies then?
4. What kind of site were you working at? (eg. University clinic, community agency, etc)
5. Was there a supervision contract?
6. How did you rate this experience on the questionnaire?
7. How many supervisors had you had prior to this one?
8. How many supervisors have you had since?

#### In-depth Questionnaire Guide:

1. Describe your least positive supervision experience.
2. Can you describe what your supervisor was like?
3. What was your relationship with your supervisor like?
4. How would you describe yourself in relation to your supervisor?
5. What was this supervision experience like for you personally?
6. Why do you think this experience was less than positive?
7. What factors seemed to contribute? (personal, interpersonal, client, institutional)?
8. What was the supervision experience like at the beginning?
9. Was there one particular incident or a number of incidents with your supervisor that contributed to the less than positive nature of the supervision experience?  
What was this event or events like?
10. Did this supervision experience affect your progress through training? (If yes) In what ways?
11. Did the experience affect you personally?
12. Did the experience affect you professionally?

13. Did you attempt to resolve the conflict or issues directly with your supervisor? (If yes) How?
14. Was it resolved?
15. Were you aware at the time of any procedures in place to deal with less than positive clinical supervision?
16. Have you resolved any conflict within yourself?
17. Have any benefits emerged from your supervision experience? If so, what?
18. Were there strategies you applied that have helped you to resolve the conflict for yourself?
19. In retrospect, can you think of anything that could have been done to repair or improve the situation?
20. Is there anything else you would like to tell me you haven't mentioned?



## APPENDIX 10

### Semi-structured Interview Guide (Nelson & Friedlander, 2001)

#### Opening Questions

1. Where are you now in your graduate training, or have you completed your degree?
2. How long ago was the supervision experience that you will be talking about?
3. What was your level of training at the time?
4. What kind of site were you working at (university clinic, hospital, community agency)?
5. How many supervisors had you had prior to this one?
6. How many supervisors have you had since this one?

#### Questions about Clinical Supervision

1. Can you describe in as much detail as possible your relationship with your former supervisor? How would you describe the supervisor? How would you describe yourself in relation to your supervisor?
2. Can you describe a critical incident or incidents that occurred with your supervisor that resulted in your feeling conflicted?
3. What factors seemed to contribute to the conflict? (personal, interpersonal, client, institutional)?
4. If there was an impasse, what was it like? How did you experience it?
5. Did the experience in any way impede your progress through your training program? If so, how?
6. How has the supervisory experience affected your sense of self, both personally and professionally?
7. Did you resolve the conflict directly with the supervisor at any point? How did that take place? (if relevant: what factors seemed to influence the resolution?)
8. Have you resolved the conflict for yourself without the participation of the supervisor? If so, what factors have contributed to that resolution?
9. Could the supervisor have done anything to help the situation? If so, what?
10. Have any positive benefits emerged from the situation? If so, what?
11. Is there anything else you would like to tell me that you haven't mentioned?

**APPENDIX 11**Letter 1 to Supervisees

August 12 2004

Dear

We are currently undertaking research on probationary psychologists' experiences of clinical supervision. As this research commenced earlier this year, it is likely that some of your students have been contacted directly and informed of the research. However, we are keen to obtain a larger number of participants than we currently have. With this purpose in mind, we are now contacting Directors and Convenors of Masters and Doctoral level programs in Psychology within Victoria to inquire whether information on the research can be disseminated to probationary psychologists at the university level.

To facilitate easy dissemination of information, a flyer on the first part of the research is attached. This flyer includes the web address and associated hyperlink for the questionnaire on clinical supervision. If you can distribute this information to your students, it would be greatly appreciated. We are hopeful of completing data collection by the end of September 2004.

Please contact us if you have any questions.

Thank you for any assistance or support you are able to provide.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Colleen Lovell'.

Colleen Lovell (Student Investigator) [4041712@swin.edu.au](mailto:4041712@swin.edu.au)  
Doctorate of Psychology (Counselling Psychology)  
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## APPENDIX 12

### Letter 2 to Supervisees



August 12, 2004

Dear Probationary Psychologist

#### RESEARCH ON SUPERVISEE EXPERIENCES OF CLINICAL SUPERVISION

Research is currently being undertaken to explore probationary psychologists' clinical supervision experiences. It is hoped that research of this type will be able to foster greater understanding of the supervision experiences of probationary psychologists.

We are seeking probationers to complete measures of the supervisory relationship, evaluation in supervision and supervisor self-disclosure. This will take about 30 minutes of your time.

There are two ways to find information on the research, access the questionnaire, and provide responses anonymously.

1. You can go to:

<http://www.swin.edu.au/sbs/studentresearch/studentresearchers.htm>

Our project is listed as: "Supervisee Experiences of Clinical Supervision."

3. Alternatively you can go directly to our study through the following URL address:

<http://www.media.swin.edu.au/surveyor/survey.asp?s=01206156211073040>

Your involvement would be much appreciated.

A handwritten signature in black ink, appearing to read "Colleen Lovell".

Colleen Lovell (Student Investigator) [4041712@swin.edu.au](mailto:4041712@swin.edu.au)

Dr Naomi Crafti (Senior Investigator)

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## APPENDIX 13

### Letter to Qualitative Research Participants Regarding Auditing Process



Hello

Just some notes to accompany the audit process. On your e-mail should appear a number which will coincide with your position in the poor or harmful verbal data tables. eg., 1H would mean 1<sup>st</sup> participant in the harmful supervision tables.

Note: The initial descriptions of each experience do not match the table numbers. They are presented in a different sequence.

When you look over the tables, I would like you to put yourself back at where you were about 18 months ago, at the time of the interview. Do the responses chosen seem to represent your least positive supervision experience then? I would like you to let me know if something needs rewriting. Perhaps I have not described something to the level that is needed or perhaps you might feel uncomfortable with the detail I have included and would like to discuss this.

You may feel quite different 18 months to 2 years down the track....or you may not. I would like to know if something(s) has changed for you since the time of interview. Where are you now in terms of your feelings and thoughts about the experience? I would also like to know whether you believe that any changes that have occurred are as a result of participating in the research, due to time or something else, or a combination of things, if this is possible to determine. I am happy for responses to be by e-mail. Let me know if this isn't suitable for you and I will provide a contact phone number.

Please feel free to raise any concerns or queries directly with me or the Principal Researcher (Dr. Naomi Crafti, 0392145355; [ncrafti@swin.edu.au](mailto:ncrafti@swin.edu.au) ).

If you have any queries or concerns, which the Senior Investigator was unable to satisfy, contact:

Research Chair, School of Life & Social Sciences Research Ethics Committee  
School of Life & Social Sciences,  
Swinburne University of Technology, Hawthorn, Victoria, 3122

If you have a complaint about the way that you were treated during this study please write to:

The Chair, Human Research Ethics Committee

Swinburne University of Technology, Hawthorn, Victoria, 3122

Thank you for your continued interest and participation in this research.

Regards

Colleen Lovell (Student Investigator)